The Leeds "food deserts" intervention study: what the focus groups reveal

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Abstract

This paper outlines the research agenda of the food deserts in British Cities project, and reports findings from a set of qualitative focus group studies conducted following a major retail provision intervention in a low-income, deprived area of Leeds. It explores the impacts of the transformation of physical access to full-range retailing in the area, and assesses the views of the residents who had switched their main food source as a result of the intervention compared to those who had not. Finally, it interrogates residents' perceptions of the impact (if any) of the intervention on their food consumption habits and their potential to eat a more healthy diet.

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1 "Food deserts" in British cities: the research agenda

Deprived areas of British cities with poor access to the provision of healthy affordable food became known in the late 1990s as "food deserts" (Beaumont *et al.*, 1995; Department of Health, 1996; Whitehead, 1998). It was a metaphor which caught the imagination of policy makers. *The Independent Inquiry into Inequalities in Health* (Acheson, 1998) and the *National Strategy for Neighbourhood Renewal* (Social Exclusion Unit, 1998) both assumed such areas to exist and recommended the implementation of policies to tackle their problems. The report of Policy Action Team 13 (Department of Health, 1999, p. 2) painted a grim picture of such areas in which:

> ... once vibrant local shopping centres or neighbourhood stores that provided a safe place for the local community to meet and access a range of services to meet their everyday needs have mostly disappeared. Boarded up small shops on street corners or in small neighbourhood parades, with only the locals knowing which are open for business and which are not, remain. And only people left with no other choice shop there ... ,

and supported a proactive approach to the regeneration of retailing within them which favoured local-community-based and small-scale retail oriented solutions. Ministerial statements (e.g. Beverley Hughes in DETR, 2000) accepted the importance of the challenge, defining "food deserts" as areas lacking retail services within roughly a 500m radius.

For many academics, however, as Cummins and Macintyre (2002) and Wrigley (2002) have argued, the food deserts debate was an example of policy development running significantly ahead of systematic evidence-based research. There was a pressing need to fill critical gaps in the scientific evidence base. In particular, three tasks were vital:

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(1) To probe the links assumed to exist in the official reports of the late 1990s between poor food retail access, compromised diets and poor health in deprived urban areas. To what extent was poor access to food retail provision in "food deserts", of itself, a critical barrier to improved diets and, by extension, diet related health?
(2) To investigate whether "food deserts" could be shown to exist using a range of food retail access measures – including the 500m criterion favoured by government. And, by considering the evolution of areas of poor food retail access in particular cities, to investigate the extent to which "food deserts" had been created by out-of-town superstore development in the 1980s and 1990s and by the uneven stripping of food retailing out of parts of British cities which accompanied that development.
(3) To investigate, at the level of the household/individual, the experience of poor food retail access and the nature of what Speak and Graham (2000) refer to as the vicious cycles of compound exclusion faced by those living in a "food desert" – not least the nature of the complex coping mechanisms which the often car-less residents of such areas are forced to employ to budget for and access food.

Fortunately, a number of those gaps in the evidence base are now in the process of being filled. Several cross-disciplinary investigations of food access and food poverty in British cities have been funded by the UK research councils and government departments (see Wrigley, 2002 for details) and are beginning to reveal their results. In particular, the ESRC/Sainsbury Food Deserts in British Cities project involving a team of geographers, public health nutritionists, and city and regional planners from the universities of Southampton, Leeds and Cardiff has made several contributions.

First, via a large-scale study of food retail access and diet in the deprived area of Seacroft, Leeds, the project has provided insight into three significant issues:

(1) The nature of the food consumption patterns typical of people living in "food deserts". In particular, using the fruit and vegetable consumption of 1,009 respondents in Seacroft as a measure of a "healthy diet", it has explored the extent to which diets in such areas fall short of Department of Health recommended intakes, and has established the characteristics of those with the poorest diets (Wrigley *et al.*, 2002a). Conversely, it has also explored the characteristics of those residents of Seacroft who, despite facing the same problems of what has been termed "the struggle to eat well on a low income" in British cities (Hitchman *et al.*, 2002), are "diet rich" in the sense of achieving government-recommended dietary targets (Wrigley *et al.*, 2003a). In addition, it has asked what can be learned from the identification of these groups about the likely effectiveness of particular types of policy initiatives in improving diet.
(2) The impacts on the diets of people living in a "food desert" which might result from a sudden amelioration of their food retail access problems. Using a "before/after" (intervention) study of the diets of 615 respondents, prior to and following, the opening of a large full-range superstore in the centre of Seacroft, it has provided evidence of a positive but modest impact of the retail intervention on diet – specifically for those groups whose access to full-range food retailing was unambiguously improved by the opening of the new store and who were within walking distance of the store (Wrigley *et al.*, 2003b; Margetts *et al.*, 2003a). The Seacroft intervention study has been viewed as offering the first opportunity in the UK to assess the impact of a retail provision intervention on food consumption patterns in a compoundly deprived previously poor-retail-access community. Significantly it is being followed up and extended in the Department of Health funded research of Petticrew *et al.* (2002) in Glasgow – a study which will also consider the impact of such a retail provision intervention on the self-esteem and general well-being of residents of a similar previously marginalized area.
(3) The extent of "food insecurity" and "hunger" typical of people living in "food

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deserts". Using a follow-up investigation of the 615 respondents who completed the Seacroft intervention study, and methods tested extensively in the USA, it has provided evidence of considerable household food insecurity in such areas, and a food poverty problem in British cities of a significant and previously unquantified level (Margetts *et al.*, 2003b).

Second, via city-wide studies of contemporary food retail access in Leeds/Bradford and Cardiff, and of changes in retail access over time, the project has provided insight into three issues:

(1) How to identify "food deserts" (if such areas exist) using a range of indicators of food retail access – in particular a spatial interaction model based "effective delivery" or food retail provision per household measure – which attempt to capture both the absolute and relative nature of underprovision (Clarke *et al.*, 2002).

(2) The extent to which the development of "food deserts" over the last 20 years can be associated in particular cities with the polarising effects of out-of-town superstore development and the uneven stripping of food retailing out of parts of those cities via closure of smaller food stores and/or the repositioning of provision downwards in range and quality terms relative to the food choice offerings of the superstores (Thomas and Bromley, 1993; Guy, 1996; Wrigley, 1998). Guy *et al.* (2003) consider this issue in the context of Cardiff. They show that although access to food retail provision has increased in general across the city since the 1980s following the development of a ring of ten large food superstores, this has been accompanied by a polarisation effect. Improvements in access and provision have been greater in higher income areas than lower income areas, and some of the poorest areas of the city have become worse off in terms of access to high quality food retailing following two decades of store building and rationalization.

(3) Whether the amelioration of a "food desert" via a major retail provision intervention may have adverse consequences for food retail provision in surrounding areas. That is to say, does that amelioration create, in turn, micro "food deserts" elsewhere in the city? Clarke, Guy and Douglas in a paper yet to be published are considering this issue in the context of the Seacroft intervention, attempting to predict the "deflection" of trade experienced by other food retail outlets in east Leeds as a result of the opening of the new superstore in the Seacroft area.

Third, via qualitative focus group studies in the Seacroft area of Leeds, both prior to and following the retail provision intervention, the project has attempted to "triangulate" some of the findings of the quantitative food-consumption diary and household questionnaire elements of the Leeds "food deserts" study, and to complement other focus group based studies of food poverty problems in the UK reported by Hitchman *et al.* (2002), Robinson *et al.* (2001) and others. In particular, Whelan *et al.* (2002) have explored "life" in the Seacroft area prior to the amelioration of its food retail provision problems – interrogating the food shopping behaviour, food consumption habits, and attitudes towards a healthy diet revealed by focus group participants, and seeking to understand some of the complex coping mechanisms which residents of the area were forced to employ to budget for and access food.

What was revealed by a second wave of focus groups conducted in the Seacroft area following the retail provision intervention (opening of the new superstore) remains to be reported and provides the topic of this paper. It is to this study, appropriately contextualized by the wider agenda of research outlined above, that this paper now turns.

2 The post-intervention focus groups: design and conduct

The Seacroft intervention study involved two waves of data collection – a "before" (pre-intervention) wave in June/July 2000, approximately five months prior to the opening of the new store (Tesco, Seacroft Green), and an "after" (post-intervention) wave in June/July

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2001 seven to eight months beyond the opening of the new store (Wrigley *et al.*, 2003b). In wave one 1,009 respondents completed a seven-day food-consumption diary, supplemented by a wide-ranging household questionnaire exploring issues of:

- household composition;
- welfare benefits and income;
- education and work status;
- disabilities and long-term health problems;
- smoking habits;
- attitudes to healthy eating;
- food-store choice;
- mode of travel to stores;
- car ownership and access; and
- perceived constraints on choice of foods bought, etc.

In wave two, 615 (61 per cent) of the original respondents completed a second seven-day food-consumption diary and household questionnaire – intense efforts having been made by the survey design and fieldwork teams to minimize sample attrition between the two waves of the survey.

The post-intervention focus groups took place in September 2002, a little over a year on from the main post-intervention food-diary/household-questionnaire surveys, and one year ten months from the opening of the new store. The post-intervention quantitative surveys and focus groups were spaced in this fashion to permit findings from the quantitative surveys to feed into and guide the design of the focus groups – both in relation to stratification of the groups, and in relation to the selection of topics to be discussed within the groups. It was not the intention in the post-intervention focus group study to replicate the design of the pre-intervention groups reported by Whelan *et al.* (2002) or to discuss an identical range of topics. Rather, the primary orientation of the post-intervention groups was to explore changes which had accompanied the intervention – specifically the views of Seacroft residents who had switched to using the new store as their main food source as a result of the intervention, compared to those who had not. An additional purpose of the focus groups was to explore some of the changes in travel behaviour which had clearly been observed in the quantitative data collected in the main intervention study, and to interrogate residents' perceptions of the impact (if any) of the new store on their potential to eat a more healthy diet.

Taking into account findings from the quantitative studies (Wrigley *et al.*, 2002a; 2003a, b; Margetts *et al.*, 2003a) on issues of age and diet, children in the household, the type of store used in the pre-intervention period as the main food shopping source, and travel mode on food shopping trips, a set of eight focus groups (each with a target of eight participants) was designed (Table I). Five of the groups were to be devoted to residents of the area who had switched their main food shopping source in the post-intervention period to the new store. Within these there was to be an age gradient, with groups consisting of those aged 17-34, 35-54 and 55 years and older. Additionally, within the younger group – consistently observed in the quantitative studies to be those with the poorest diets (i.e. those most "at risk" in nutritional terms) – there was to be a three-fold division to take account of and explore constraints associated with the presence of children in the household and transport access/travel mode. Finally, an attempt was to be made to balance the composition of each group based on their previous main food retail source – with a target of 50 per cent of each group being drawn from those who had previously used a full-range major retailer (Asda, Tesco, Sainsbury, Safeway, Morrison) and 50 per cent from those who had previously used a limited-range/budget retailer (Netto, Aldi, Lidl, Kwiksave, Iceland, etc.).

In contrast, three of the focus groups were to be devoted to residents of the area who had not switched in the post-intervention period to the new store, and whose main food source continued to be either a limited-range/discount store (Netto), or the full-range major retailer store (Asda) that was the closest major store for most residents of the area in the pre-intervention period. Additionally, the limited-range/discount store shoppers were to be stratified by age into two groups.

A recruitment questionnaire was developed to screen potential participants in the focus groups to ensure fit to the target profiles outlined in

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Table I Focus group characteristics

	Target characteristics		Focus group size	
Group	**Age**	**Additional**	**Target**	**Achieved**
Groups consisting of "switchers" to intervention store (Tesco, Seacroft Green). Target for each group 50:50 split between previous main food store full-range retailer and limited-range/budget retailer				
1	17-34	Children in household, walk to store	8	4
2	17-34	Children in household, non-walkers to store	8	3
3	17-34	No children in household	8	6
4	35-54		8	6
5	55 plus		8	7
Groups consisting of "non-switchers" to intervention store				
6	17-34[a]	Use limited-range-budget store (Netto) as main source	8	7
7	45 plus[a]	Use limited-range/budget store (Netto) as main source	8	9
8	35-54	Use full-range major-retailer store (Asda) as main source	8	7

Note: [a] In practice, because of recruitment difficulties it became necessary to extend these age ranges to 17-39 and 40 plus

Table I. Additionally, as in the main quantitative surveys and the National Food Survey, participants were to be selected solely from those primarily responsible for the domestic food arrangements of the household. Recruitment was conducted by experienced fieldworkers in accordance with the Market Research Society (MRS) Code of Conduct outside the relevant stores (Tesco, Asda, Netto) – permission having been obtained from the store operators/managers where applicable. The focus groups, each lasting approximately 75-90 minutes, were conducted at a variety of venues in the vicinity of the intervention store, and each group was moderated by the same highly experienced professional qualitative researcher to MRS standards and codes of conduct. The topics to be discussed and questioning routes to be followed in the case of each group were developed by the Southampton project team with assistance from industry specialists at the project's industrial partner (J. Sainsbury plc), and are available on request from the principal author. Each session was audio taped with consent from the participants, and was transcribed and analysed by the moderator using the standard content analysis approach to identify and categorise key themes (Hennik and Diamond, 1999). Participants were given a small monetary incentive to attend the focus groups.

A total of 49 individuals participated in the focus groups (Table I). Turnout amongst those recruited was satisfactory (77 per cent of the target) with the exception of groups 1 and 2 (younger switchers) where nine individuals had been recruited for each group but only 4 and 3 respectively attended despite "reminder" telephone calls and letters. These younger groups were those shown by the quantitative surveys to be the most "at risk" in nutritional terms and had consistently caused similar "non-response" problems elsewhere in the study. Fortunately, in anticipation of potential non-response problems amongst younger participants, the focus group design (Table I) had incorporated three groups (i.e. an over-sampling) within this critical age group. The result was that 50 per cent (13 out of 26) participants who were "switchers" to the intervention store were in fact drawn from the important 17-34 age group.

The socio-economic profile of the focus group participants is summarised in Table II. It can be seen that the focus groups were predominantly composed of social group D/E residents of Seacroft who were local authority renters; a majority being drawn from

Table II Indicators of the socio-economic profiles of the focus group participants

Social group	No.	Housing tenure	No.	Children in household	No.
A/B	2	Rent: local authority	38	0	19
C1	10	Rent: private	1	1	14
C2	7	Owner occupier	10	2	10
D/E	30			3+	6

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households with children under 16 in the home. The higher proportion of C1 participants than might be expected results from the assignment of "students" to this social group, whilst the A/B participants were drawn from a small area of private housing on the edge of Seacroft.

3 What the post-intervention focus groups reveal

3.1 Switching to the intervention store and its consequences

In the main quantitative post-intervention survey, 45 per cent of respondents were found to have switched their "main" food retail source to the new store. This was accompanied (Table III) by substantial shifts in travel behaviour – with the average distance travelled to their main food store amongst those who had switched falling from 2.25km in the pre-intervention period to 0.98km in the post-intervention period, and an approximate threefold increase in walking as the mode of travel (Wrigley *et al.*, 2003b). Walking trips to the main food store increased from 12.3 per cent to 30.8 per cent, and from the store from 6.5 per cent to 22.8 per cent, whilst the use of taxis – a critical coping mechanism in the pre-intervention period by residents of this deprived poor-retail-access area – declined substantially. Overwhelmingly, the reasons main survey respondents suggested for switching to new store concerned accessibility ["easy to get to" (79 per cent), "near to home" (67 per cent)], and convenience ["all under one roof" (58 per cent) and the store's late opening hours (43 per cent)].

What insights into these statistics were the focus groups able to offer? Overall the reasons given for switching to the new store by focus group participants confirmed what had been reported in the main household questionnaire. The majority had switched to the store purely for reasons of accessibility and convenience, and there was a strong sense of the potential saving of money and time that entailed compared to accessing their previous main food store:

> You can save yourself £10 in taxi fares or £3 in bus fares (Switcher, 17-34, children, walk to store),

and/or compared to being forced (as in the pre-intervention period) to make top-up purchases at the small number of local food stores operating in the area:

> The local shops charge a ridiculous amount for the basics so it's actually cheaper to go to Tesco and get your bread and milk (Switcher, 17-34, children, non-walker to store).

The consequence was not only, as suggested by figures on travel behaviour from the main survey, that walking for food shopping became a viable option for many in the area, but also that the frequency of food shopping trips were perceived to have increased significantly. Indeed, the majority of "switchers" reported shopping at the new store three or four times per week and a substantial minority were visiting daily:

> I don't do a bulk shop like I used to do, I just get things as I need them (Switcher, 35-54).
>
> I treat it like my corner shop (Switcher, 55+).

Table III Transport mode (per cent split) revealed by main intervention study. Respondents ($n = 276$) who switched to the new store as their main food purchasing source in the post-intervention period

	Pre-intervention		Post-intervention	
Travel mode	**To store**	**From store**	**To store**	**From store**
Walk	12.3	6.5	30.8	22.8
Own car	47.5	47.5	43.8	44.2
Other's car[a]	8.3	9.1	5.8	5.4
Taxi	7.6	18.5	1.8	11.6
Bus (standard)	20.3	15.6	17.0	15.2
Bus (free shuttle)[b]	1.8	2.2	0.7	0.7
Missing observations	2.2	0.4	–	–

Notes: [a] Shared use (i.e. "lift") in friend's/neighbour's car; [b] Designated bus serving a major retailer's store only

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For a minority that increased frequency was a means of killing time in an otherwise mundane existence:

> It's time-wasting for me. I'll have a look round and half the day might be gone (Switcher, 17-34, children, walk to store).
>
> End up staying there longer "cause I've nothing else to do (Switcher, 17-34, no children).

However, for others, increased frequency was highly purposeful and associated with the search for the "bargain" – both the reduced prices offered at a particular time of day on food which had reached its "sell-by" date or, the temporarily more random, reductions in the non-food section of the store (e.g. the mountain bikes reduced from £199 to £20 or vacuum cleaners for £10 which had become something of a local legend). Indeed, for some of the focus group participants the thought that they might miss a bargain was quite distressing:

> If I don't go and have a look my life might be over! (Switcher, 35-54).

Together with the stress a majority of "switchers" placed on the importance of "buy one get one free" offers at the new store, this evokes clear overtones of what Miller in *A Theory of Shopping* (1998) and *The Dialectics of Shopping* (2001) describes as "moral shopping" – "almost entirely defined by the act of thrift and saving money" (Miller, 2001, p. 134).

3.2 Temptation

The same sense of food shopping for many participants in the focus groups being defined in terms of "a practice that consists of the dutiful attempt to save money on behalf of the household at large" (Miller, 2001, p. 134) – a "moral activity" which then conversely legitimates the "treat" – pervaded discussion of the temptation to overspend meagre household budgets which accompanied the sudden availability of a full-range store in the centre of Seacroft. Many participants reported making a determined effort not to stray into what they regarded as the "luxury aisles" of the new store in an attempt to stick to their budget and not to overspend:

> Cause temptation isn't there to think oh, I'll have something else instead of that (Switcher, 17-34, children, walk to store).

Indeed, the threat posed by the new full-range store to tempt the low-income shopper away from their usual pattern of food purchasing and to overspend/waste money (an issue raised by Barrett (1997) and others in the public health nutrition literature) featured strongly in most of the focus groups:

> If you've got a limited income Tesco is no good, "cause there's too much range (Switcher, 35-44).
>
> I never used to look at owt else except what I came in to buy (Switcher, 17-34, children, walk to store).
>
> I don't just get a loaf of bread, I come back with half the store (Switcher, 17-34, children, walk to store).
>
> What hits you as soon as you walk in there? Toys, magazines, you've got the pressure if you're with a child, they don't understand – you're constantly making excuses (Switcher, 35-44).

With limited-range/budget stores such as Netto being seen as much "safer" in terms of the temptation to overspend:

> Makes sure you don't spend nowt else (Non-switcher, Netto, 17-39).

However, as Miller suggests, dutiful and disciplined attempts to resist the threat posed by the temptations of the full-range superstore legitimated for many focus group participants the "treat":

> Stick to the list, get home, put it away, then I've got £5 extra this week, let's go and that's when we get the "treats" [multi-pack chocolate bars, comics, etc.], or let's get a pizza or fish and chips (Switcher, 35-54).

In that context, the threat posed by the new store was then re-interpreted by many focus group participants as the "promise":

> My kids' idea of a treat if I've got money at the end of the week is a take-away up at Tesco's (Switcher, 35-54).
>
> If there's something I can't get at Netto or if I've got a bit of extra money and I want to treat myself [I will go to the new Tesco] (Non-switcher, Netto, 40+).

3.3 Alienation and betrayal

A strong case has been made by the major UK retailers concerning the regenerative potential of large urban renewal stores such as that in Seacroft (see Wrigley *et al.*, 2002b for a review of the arguments). Regeneration partnerships

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such as that in Seacroft, which involved Tesco, Leeds City Council, the property developers Asda St James, the employment services agency, the shop workers' union USDAW, and the East Leeds Family Learning Centre have linked new store development to programmes of skills training and to employment recruitment favouring the local community, particularly the long-term unemployed. On this basis, the major retailers have emphasized their contribution to the tackling of social exclusion. In particular, they have stressed the special contribution which large scale reputable employers such as themselves could offer in areas of long-term unemployment and low standards of motivation and skills amongst the workforce, and the wider benefits to the self-esteem of residents of the area which flow directly from such skills training and employment, and indirectly from the changed perceptions brought about by commercial investment in previously marginalized areas (see Tesco plc, 2003 for a clear statement of this position). The research of Petticrew, Cummins and Sparks in Glasgow is currently investigating the latter issues of self-esteem and general well-being of residents following a retail provision intervention similar to that in Seacroft. Nevertheless, the Seacroft post-intervention focus groups brought to light several issues worthy of report which relate to issues of self-esteem and, conversely, alienation engendered by the new store.

On the one hand, there were clearly benefits to self-esteem from the new store (and the new Seacroft Centre of which it formed the core) perceived by many focus group participants:

> The whole place [the old Seacroft Centre] was dismal, cold, dirty, freezing even in summer, everyone just looked so miserable ... It was horrible, I used to be ashamed to say I lived near the centre (Switcher, 35-54).

In addition, there were benefits related to ease and cost of access and convenience in an area where food retail provision in the pre-intervention period had been poor, and where small local shops were expensive, inadequate and presented a perceived crime risk in terms of shopping out of daylight hours:

> You need a bravery award to go down there on a night (Switcher, 35-54, referring to the Co-op "village store" in the centre of Seacroft).

Nevertheless, on the other hand, a store of the size of the new Seacroft superstore was clearly not designed to be supported solely on the basis of trade drawn from the local (low-income) area. As a result, focus group participants perceived it to be targeted at more affluent "outsiders":

> Seacroft Centre was created for upmarket people (Non-switcher, Netto, 40+).
>
> There are people from all over Leeds (Switcher, 17-34, children, non-walker to store).
>
> More outsiders (Switcher, 55+).

Participants on the most limited incomes spoke about feeling intimidated by these "outsider" shoppers at the store:

> You see people with a full basket of shopping and you think that must be a hundred quid. I could never spend that much (Non-switcher, Netto, 40+).

In addition, a surprising degree of resentment emerged amongst focus group participants about the form the new Seacroft Centre had actually taken. Many (particularly "non-switchers" to the new store) felt betrayed by the local authority and the retail developer in relation to how the public consultation exercise had fed into the design of the new centre:

> We were promised it'd be like the Arndale [shopping centre] at Cross Gates but it's not a bit like that ... It doesn't even look like a shopping centre".
>
> They were supposed to do a big market research thing and nothing that they've said has gone into it ... Not one shop has been done as they said it'd be done ... They promised a fish & chip shop (Non-switcher, Netto, 17-39).
>
> It looks like a Tesco superstore with a few shops added (Non-switcher, Netto, 17-39).

There were complaints about the loss of community spirit that was perceived to have existed in the old centre:

> Although it was grimy it was local and it had everything you wanted, it was very much a community based thing (Switcher, 17-34, children, non-walker to store).

In addition, particular annoyance was expressed at the non-incorporation into the new Seacroft

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Centre of the small market which had taken place on Friday and Saturday in the old centre, the downgraded accommodation and services of the Post Office:

> The Post Office is just like a caravan and it's permanent (Non-switcher, Netto, 17-39),

and the poor quality and expense of the in-store restaurant in the new superstore which was perceived to provide a poor substitute for the meeting place previously offered by cafés in the old centre. Finally younger participants resented what they regarded as oppressive levels of surveillance, differentially directed at local residents of their age with little money to spend, by the security staff in the privatised space of the new store:

> I used to be always walking up there [to the old centre], you'd meet your mates. You could spend the whole day there, now you feel you have to move on (Non-switcher, Netto, 17-39).
>
> [I always feel] what if they're watching me (Switcher, 17-34, children, walk to store).

3.4 Non-switching to the intervention store

In the main quantitative post-intervention survey, the reasons respondents suggested for not switching to the new store related to concerns about the relative "expensiveness" of food shopping at the new store (28 per cent), the store's large size and layout (21 per cent), plus satisfaction with their existing routine (25 per cent) – a likely proxy for many for relative accessibility/convenience of their existing main food source. Once again, the "non-switching" focus group participants confirmed what had been reported in the main household questionnaire:

> Pricing and convenience – Netto is just up the road and it's cheap (Non-switcher, Netto, 17-39).

However, the relative strength of these issues varied in important ways between those who used a limited-range/budget store (Netto) as their main food source in the pre-intervention period, and those who used another full-range major-retailer store (Asda) in preference to the similar offer available at the new store.

For both groups of "non-switchers", thrift and saving money were important. And, in that context, the new store was perceived to be expensive:

> I've nothing positive to say [about the new store], the prices are horrendous (Non-switcher, Netto, 17-39).
>
> Asda has low prices all of the time (Non-switcher, Asda, 35-54).

However, these issues were clearly far more important for those whose main food source was the budget store Netto, who clearly perceived themselves as trading off limited food choice (in the sense of range) for price:

> It's for people who don't have a lot of money. More down to earth, what you see is what you get (Non-switcher, Netto, 17-39).

A view shared by "switchers" to the new store who would trade down to the budget store when money was tight:

> If you're on a short wage, you go to Netto (Switcher, 17-34, no children).
>
> You can get a full trolley in Netto for £30 but if you fill up in Tesco's you pay £100 Switcher, 17-34, children, walk to store).

The issue of food "quality" was rarely mentioned. Indeed many of the budget store shoppers professed to believe that there was very little difference in quality despite significant price differences:

> Chicken fillets £4.99 at Tesco, but £2.00 Netto, they're all the same aren't they? (Non-switcher, Netto, 40+).

This was despite the peer-group sensitivities of their children who were embarrassed by symbols of the fact that their mothers shopped at discount stores:

> I'm not taking that bag to school [a Netto plastic carrier bag], they'll think you're shopping at second-hand food stores (Non-switcher, Asda, 35-54, referring to her children's views of the discount stores).

Sensitivities which, interestingly, appeared to have little effect on focus group participants' determination to continue using the discount stores.

As noted above, what was far more important for the discount store shoppers was the ability to avoid the temptation to overspend associated with the new superstore:

> There's just so much to choose from [in the new store] whereas places like Netto you go in and there's the basics and you get the basics (Non-switcher, Netto, 40+).

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And, closely linked to that, was the importance they attached to the fact that the layout of the discount store rarely changed:

> With Netto you know exactly where everything is when you go in (Non-switcher, Netto, 17-39).

In contrast the layout of the new store was perceived to change often, in the process exposing the low-income shopper to unacceptable risk of "wandering round, picking up extra stuff" as the focus group participants put it – that is to say, to the temptation to overspend:

> It's too big. I can't find things, they're swapping and changing things all the time (Non-switcher, Netto, 40+).

In contrast, what was far more important for the non-switchers who preferred the offer of a competing full-range major retailer store (Asda) rather than the new store, and who were slightly more affluent on average than the discount store "non-switchers", was the atmosphere and perceived friendliness of the store:

> It's got no atmosphere [referring to the new store], you walk into Asda and you feel the atmosphere (Non-switcher, Asda, 35-54).
>
> It's a big barn [referring to the new store], its such a cold place I don't like it . . . The staff don't know where anything is (Non-switcher, Asda, 35-54).

In addition, particularly for younger respondents (both "non-switchers" and "switchers" alike), the competing full-range store was perceived to have a much better range of take-away meals – an issue we will return to below in the context of focus group participants' perceptions of the impact (if any) of the new store on their potential to eat a more healthy diet.

3.5 Healthy eating and perceptions of the impact of the intervention store

Based on its intensive coverage of food consumption patterns in Seacroft, the main intervention study (with its large samples of 1,009 and 615 respondents in waves 1 and 2) had been able to offer important findings regarding: the extent to which diets in the pre-intervention "food desert" fell short of government recommended targets, and the characteristics of those with the poorest, and in relative terms, better diets in the area. It had also been able to offer evidence of a positive but modest impact of the retail intervention on diet – particularly among those whose access to full-range food retailing was unambiguously improved by the opening of the new store and who were within walking distance of the store. What insight into these findings was exploration of issues of food consumption and "healthy eating" with the focus groups able to add?

Many of the participants (particularly the middle aged and older) were aware of what constituted a "healthy diet". Terms often used centred on having a varied diet, eating fresh foods rather than convenience foods, eating more fruit and vegetables, and trying to use healthier methods of cooking (such as grilling rather than frying):

> Try to level out your diet in a more sensible way, less quick and easy food and more veg and more fruit (Switcher, 35-54).

However a minority took objection to having information about healthy eating thrust upon them:

> Don't need it to be shoved in my face, if you want to eat healthily, you know what is and what isn't (Non-switcher, Netto, 40+).

In addition, confirming what had been found in the main quantitative food consumption survey, negative attitudes towards "healthy eating" and anecdotal evidence of poor diets, were consistently expressed by the younger (17-34) participants:

> Unhealthy eating is a fashion (Switcher, 17-34, no children).
>
> I don't do healthy eating. I just eat what's there, when I was pregnant I went to McDonald's regularly and got two Big Macs (Switcher, 17-34, children, walk to store).
>
> There's no bad food, it's just the time when you eat it (Non-switcher, Netto, 17-39).

It was evident that in many households (particularly with mothers in the younger age group), that children had a major effect on the type of food being consumed. Children refusing to eat a varied diet and existing on pizza, burgers and chips:

> . . . meatballs, pizza and hot-dogs were all he would eat (Non-switcher, Netto, 17-39).

In low-income households in which (often because of part-time shift-based work) it was

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highly unusual for everyone to sit down together and eat a "family meal", resulted in mothers taking the line of least resistance and adopting similar dietary patterns:

> I just do what the kids want and its mostly chips and stuff (Non-switcher, Netto, 17-39).

In consequence, a considerable consumption of microwave meals was widely reported by the focus groups:

> Slug it out of the freezer, into the microwave and two minutes and it's done (Switcher, 17-39).

With respect to budgetary priorities, food shopping was viewed by a majority of focus group participants as a lower priority than paying housing and utility bills. Reinforcing findings on "food insecurity" (Margetts *et al.*, 2003b) obtained from the quantitative surveys, most mothers in the focus groups maintained that they would (and frequently had) cut down on their own food intake rather than affect their children:

> I'd go without rather than see them go without (Non-switcher, Asda, 17-39).

In addition, among the considerable number of heavy smokers in the focus groups, many also admitted that they often sacrificed their own food consumption in order to buy cigarettes:

> If it was choice between having something to eat myself and a cigarette, I'd take the cig (Non-switcher, Asda, 35-54).
>
> I'd have a bowl of cereal and go and buy my fags (Non-switcher, Netto, 40+).
>
> It's a luxury for me [smoking], as long as the kids have got everything they need and the gas and electricity is paid (Non-switcher, Netto, 17-39).

The result was highly irregular eating patterns for many, accompanied by snacking and/or "binge" eating of "unhealthy" food when hungry.

There was a perception, particularly among the younger focus group participants, that it was now cheaper to buy convenience food than to buy the raw ingredients and prepare food. In addition, take-away food (although regarded by those on the lowest incomes as expensive and a "treat") featured prominently in discussion. There was clearly increasing dependence on this type of food among focus group participants as its availability (not least through the stores of the major food retailers) continued to increase. Consistent with our quantitative analysis of the relatively "diet rich" in the area (Wrigley *et al.*, 2003a), it was mainly the older and middle-aged participants who disputed these perceptions and, to a certain degree, resisted the trends. As a group, they had clearly grown up in a rather different food consumption culture – learning from their mothers (and to a lesser extent from schools) food preparation and cooking skills:

> Everything was fresh, do what your mother did, she's your role model (Switcher, 55+).
>
> I've seen my Mum cook a dinner out of nothing (Switcher, 55+).

In turn, this raises important public health concerns. To what extent will the younger focus group participants in this deprived area retain these perceptions and their negative attitudes towards issues of "healthy eating" as they age? Or will their attitudes and associated diets and lifestyles change as they age?

Finally, given these prevailing perceptions of food consumption patterns and "healthy eating" amongst the focus group participants, what evidence (if any) emerged from the focus groups concerning the impact of the new store on the potential of participants to eat a more healthy diet? Overall, and in line with the modest (albeit significant) impact on diet reported from the quantitative surveys (Wrigley *et al.*, 2003b; Margetts *et al.*, 2003a), there was rather little. What evidence there was suggested that a minority of participants were using the transport cost savings associated with improved access to full-range food retail provision to buy fresh food:

> I can get an extra packet of apples or bananas with the money I save on bus fares (Switcher, 35-54).

In addition, it was clear in the consistent discussion of the temptation to overspend presented by the new store, that those temptations had for many frequently extended to fresh fruit and vegetables – sometimes purchased, perhaps in the search for the "bargain", close to its sell-by-date:

> I'm sick of throwing their fruit away, you pick it up and the "sell by" date is that day (Switcher, 35-54).

However, the only groups consistently to express the view that they perceived the new

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store to have had an impact on their potential to eat a healthier diet were: first, older "switchers" to the new store who frequently commented on the availability to them, post-intervention, of

> ... less junk food and more fresh food (Switcher, 55+),

and second, certain middle-age (35-54) "switchers" who said that they were conscious of consuming more fruit and vegetables and chicken since the opening of the new store. Younger "switchers" perceived little impact on their diet, other than that associated with increased temptation to purchase "buy one get one free" special offers, and the risks associated with navigating the layout of the store in order to purchase "basic" items:

> Passing the crap to get the good stuff, you're bound to pick something up (Switcher, 17-34, children, walk to store).

4 Conclusion

Consistent with the strengths of qualitative focus group research (Krueger, 1998; Morgan, 1998) – research recognized to be particularly valuable in:

> ... situations in which there is little pre-existing knowledge, the issues are sensitive or complex, and the maximum opportunity for exploration and inductive hypothesis generation is desired" (Bowling, 1997, p. 312).

– insights from the post-intervention focus groups reported in this paper permit both a "triangulation" of the quantitative findings of the main Seacroft intervention study, and a deeper understanding of the nature of how life in this previously poor retail access area had been changed by the sudden amelioration of those access problems. One of the main messages of the pre-intervention focus group research reported by Whelan *et al.* (2002) concerned the intensely complex coping strategies required by many households to overcome the physical and economic access constraints typical of the "food desert" (see Caraher *et al.*, 1998; Ellaway and Macintyre, 2000; Robinson *et al.*, 2001 for related work). In that context, the opening of the full-range food store in the heart of Seacroft (the retail provision intervention) had clearly transformed physical access for many. Walking to the "main" food source, with its associated flexibility and cost-savings, had become a viable option for focus group participants and physical access coping strategies had significantly altered. However, economic access constraints (with the exception of certain direct reductions in the transport costs of food shopping) had for many remained fundamentally unaltered. In that sense, the new store (given its positioning as a main stream, full-range, non-discount outlet) was merely another factor to be coped with in their struggle to eat adequately on a low income. It offered opportunities (not least for accessing a wide range of "healthy" food) previously not easily available in the area, but it also increased temptation and the risks of overspending. As a result, an important group of residents, although experimenting with the new store, chose to remain loyal to food sourcing options which they perceived to be both lower cost, and to offer (via restricted range, more slowly changing store layouts, etc.) lower risk of overspending meagre household budgets. Others, despite switching to the new store, clearly attempted to remain consistent to their previous food purchasing habits, and attempted to control their use of the store (including navigating their way around it) in such a way that its impacts on their food consumption and diet were likely to be relatively modest. It follows, as we stressed in the preface to our quantitative analysis of food consumption in Seacroft, "that the effects (if any) of improved retail access on the consumption of healthy food in the research area were likely to reveal themselves in complex and subtle ways" (Wrigley *et al.*, 2003b, p. 161).

The value of the focus groups reported here is that the insights they generate help us to understand more of those subtle shifts in food consumption which accompany a retail provision intervention. Our argument, is that those shifts are mediated through complex and purposeful coping mechanisms, and additionally through food consumption cultures, attitudes regarding food preparation and healthy eating, and motivations to consider

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health, which differ considerably across age groups. For that reason, assessing to what extent improvement in physical access to food in low-income areas of British cities represents a critical barrier to improvements in diet and diet-related health is never likely to be straightforward. Both qualitative and quantitative assessments of the amelioration of food access problems are an essential component of the ongoing process of understanding food poverty in British cities.

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