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# Social supermarkets, nutritional implications and healthy eating: exploration of members and their views

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## Abstract

**Background:** The Covid-19 pandemic has increased the need for food support but simultaneously enabled substantial innovation in food support provision, including the evolution of social supermarkets (SSM). These allow consumers to choose from a range of low-cost products, minimise stigma and reduce food waste. Data from members of two Sussex SSM were gathered for their perspectives and experiences, as well as potential nutritional implications of the SSM.

**Methods:** Questionnaires administered face-to-face during site visits and optional telephone interviews were used. Data were collected during three site visits; 111 participants completed questionnaires, and an additional 25 detailed interviews with members of the SSM were completed. All data were gathered between December 2021 and May 2022.

**Results:** Overall, the SSMs were valued by their members. Social, economic and nutritional benefits were identified. SSM increased consumer choice and reduced stigma. Most members visited regularly, using SSM to supplement other food purchases. They valued the opportunity to choose their own foods and opportunities to socialise, in addition to the range of food and household items offered. The majority agreed that healthy eating was important but time and cost were barriers especially for younger members. SSM introduced members to novel foods and dishes, potentially diversifying dietary intakes. Challenges included restrictions on the amounts of food available, depending on the timing of visits. This was a greater challenge for those more reliant on SSM for household needs.

**Conclusions:** SSM represent an innovative and less stigmatising model of food support. Greater variety of food offered suggests their potential to diversify and improve dietary intakes. Challenges include ensuring stability of food supply and reducing stigma further.

KEYWORDS

choice, food bank, food support, healthy eating, social supermarkets, stigma

## Key points

- Social supermarkets represent a beneficial shift from the foodbank model offering more choice and less stigmatisation, with the potential to contribute towards healthy nutritional intakes.

## INTRODUCTION

Increasing attention is being paid to the impact of the pandemic and subsequent cost-of-living crisis on nutritional intakes and food insecurity, particularly for those on low incomes. Food insecurity is the inability to access or afford sufficient quantities of healthy food to meet nutritional needs.[1–3] It is identified both as an indicator of wider poverty and a marker of the social and political construction of poverty.[4] It has been rising in the UK since 2010, but particularly since 2020,[5] and is estimated to affect over 16% of all households, and over 25% of those with children.[6] Inflation is higher in the poorest than the richest 10% of the population (10.9% vs. 7.9% in April 2022),[7] with highest 12-month inflation rises in the bottom three income deciles in October 2022.[8] Increased food prices disproportionately affect those on lowest incomes, particularly those vulnerable to price rises because the proportion of their income spent on essential items (e.g., housing) is greater.[9] This means they cannot afford to risk buying foods that may not be accepted and consumed,[10] potentially limiting their dietary diversity. Even before the pandemic and cost-of-living crisis, deprivation was recognised as adversely affecting the quality of nutritional intakes. Those on low incomes have lower intakes of fruit and vegetables, and higher intakes of low nutritional value foods usually high in fat, salt and sugar.[11,12]

It is not only dietary quality, but also access to food, especially fresh foods, that is a concern. Before the pandemic, much discussion about emergency food support concentrated on food banks, which generally supply 3 days of food parcels over a limited time period to referred clients.[13,14] More than 2.1 million food parcels were distributed by the largest network of food banks in the UK, the Trussell Trust, between April 2021 and March 2022, which is more than before the pandemic.[14] A survey of independent UK food banks found that 91% experienced an increase in demand since July 2022, with one in four needing to reduce the size of food parcels to meet increased demand.[15] Food bank clients have not only expressed gratitude for the support, praising the efforts of food bank volunteers, but have also criticised the nutritional quality and limited food choices provided, and many have experienced embarrassment and stigma.[16,17] Although intended to provide emergency and temporary support,[13,14] many food bank clients are referred repeatedly, highlighting the deep-seated nature of their problems,[18] which in turn has negative implications for their nutritional status. Food banks are a final resort, used when other options have been depleted.[17,19] The appropriateness of using them as a model of food support has been questioned. They represent a shift away from state responsibility to feed its citizens towards a reliance on voluntary and charitable sectors, because a right to food is not included in UK domestic law.[20] Provision of food support is becoming institutionalised and normalised, moving from emergency supply to supporting people with ongoing difficulties.[21,22] This is of concern to providers, who do not welcome the normalisation of social food provision as a response to food insecurity such that food banks have become part of the unofficial welfare state.[23]

The Covid-19 pandemic, although dramatically increasing the need for emergency food support as a result of lockdowns, work closures and furlough,[13] simultaneously enabled substantial innovation to meet increased need at short notice.[13,24] Innovations included a move from traditional food bank models to more inclusive food support with some, albeit limited, food choice. This includes social supermarkets (SSM), also known as community supermarkets or affordable food clubs. SSM practices vary in relation to membership, payment models, food sources and products offered. One definition suggests that they fulfil four criteria: food is sold, below market price, in the form of groceries (rather than pre-prepared meals) with the ethos of tackling food poverty.[25] Another identified three criteria to distinguish SSM from food banks: they offer choice, enable access to low-cost food within a retail-like environment and they provide social support to their members.[26]

This research aimed to capture the experiences and perspectives of SSM members and nutritional implications of SSM at two Sussex locations, SSM1 (established March 2021) and SSM2 (established August 2021). It explored the importance of SSM as an innovation in food support and the agency of members in relation to dignity, food choice and nutrition. Little is known about the views of UK SSM members in relation to how the SSM works for them, and also whether and how it affects their ability to eat healthy foods. Their views on the importance of healthy eating, as well as barriers to and facilitators of, healthy eating were also explored because assumptions about this may be held about those using food support. For context, both SSM are in highly deprived areas, serving neighbourhoods in the 20%–30% most deprived in England. Both offer a limited range of products, including tinned, fresh and frozen produce – fruit, vegetables, pre-prepared salads, soups and frozen meals. The latter are prepared from scratch by chefs/trained cooks using fresh ingredients. Household and personal hygiene items are also available. Both SSMs use a pay-as-you-feel model, enabling members to make a small payment if possible but without obligation. Both venues levy a small charge for staples (milk and eggs) to ensure their availability. Most of the food is surplus, accessed using Fareshare and supermarket donations, supplemented by purchases of staple items as needed. Limits on quantities of items that can be taken are decided depending on family size and what is supplied each week. Both supermarkets open weekly for 2 h and members can register as members with one, but not both, SSM. The only criterion for membership is that members must be resident in specific local postcodes. SSM1

currently has 297 households as members (450 adults and 206 children) and SSM2 has 402 households as members (660 adults and 416 children), with approximately 70–80 households a week using the service at each location. One (SSM1) incorporates a small café offering hot drinks, cakes and an opportunity to socialise. Both venues signpost members to additional support including cooking lessons and financial support; both are highly reliant on volunteers.

# METHODS

## Ethics and methodological approach

Ethics approval for the project was granted by the Kingston University Research Ethics Committee on 8 November 2021 (reference 2786). A qualitative description approach,[27,28] based on naturalistic inquiry,[29] was used. The only inclusion criterion was adults utilising SSM1 or SSM2.

## Data tools

Data were gathered using bespoke questionnaires administered face-to-face on two occasions at SSM1 and one at SSM2 between December 2021 and May 2022. Optional telephone interviews were held within 2 weeks of the visits.

## Questionnaires

Questionnaires were co-developed with the Community Development Manager and chair of the District Food Partnership who oversees the SSMs. Demographic data comprised factors likely to impact on SSM use (age, gender, ethnicity, housing and disability status). SSM-related questions included duration of use and whether it was a main source of household food. Participants rated levels of agreement with statements about the SSM and healthy eating using a five-point Likert rating scale from 'strongly agree' to 'strongly disagree'. Additional questions added to the original questionnaire used in the first SSM1 visit are indicated in the tables. In total, 111 participants completed questionnaires.

## Interviews

Optional telephone interviews using an interview guide for consistency were held with participants. These were audio-recorded for accuracy and additional contemporaneous notes taken. Interviewees received a £10–20 Amazon voucher for their time (£20 for those interviewed in December 2021 and £10 for those interviewed in May 2022). This was a result of differences in funding provision during this period and the recognition that interviews carried out in December were at a particularly fraught time for families. In total, 25 interviews were conducted: 16 at SSM1 (eight in December 2021; eight in May 2022) and nine at SSM2 (May 2022). Interviews explored experience of food support before and during the pandemic, their views on changes which had occurred and the effect of the SSM on nutrition (e.g., use of new recipes, introduction of new foods). Interviews lasted 30–45 min.

## Quantitative data analysis

Questionnaires were coded and data entered manually into an Excel (Microsoft Corp.) spreadsheet. Statistical analysis was carried out using SPSS, version 26 (IBM Corp.). Differences in levels of agreement with statements by demographic characteristics were assessed using Kruskal–Wallis tests with post hoc Dunn's and Bonferroni correction, whereas differences in responses between venues were tested using chi-squared tests. $p < 0.05$ was considered statistically significant. Levels of similarity between statements were tested using Cronbach's analysis.

## Qualitative data analysis

Audio recordings of interviews were transcribed and analysed independently by two members of the research team. An iterative process was used to identify the main themes and subthemes which were manually coded[30] and collated. Illustrative quotes using pseudonyms for participants were chosen for each theme. These are integrated within the following text and used alongside the quantitative data throughout to demonstrate and contextualise typical participant responses.

# RESULTS

## Demographics

Most SSM members at both venues were female and white. Almost half considered themselves to have a disability. All age ranges were represented, although > 50% in both SSM were aged ≥ 45 years (Table 1). There were no significant differences in age, gender, ethnicity or disability distribution between locations.

Over half the sample were either single, separated or widowed. Housing types varied; 32% overall (37% in SSM1 and 25% in SSM2) lived in private rented accommodation, 25% overall (23% in SSM1 and 30% in SSM2) lived in homes owned by themselves or their families; and 24% overall (21% in SSM1 and 30% in

**TABLE 1** Age, gender and ethnicity characteristics of social supermarket members.

| **Age (years)** | | | | | | | $p$[a] |
|---|---|---|---|---|---|---|---|
| | **18–24** | **25–34** | **35–44** | **45–54** | **55–64** | **65+** | $p = 0.49$ |
| SSM1 ($n = 71$) | 6 (8.5) | 9 (12.7) | 13 (18.3) | 15 (21.1) | 12 (16.9) | 16 (22.5) | |
| SSM2 ($n = 40$) | 3 (7.5) | 6 (15.0) | 8 (20.0) | 9 (22.5) | 9 (22.5) | 5 (12.5) | |
| **Gender** | | | | | | | |
| | **Woman** | | **Man** | | **PNS** | | $p = 0.17$ |
| SSM1[b] ($n = 37$) | 22 (59.5) | | 14 (37.8) | | 1 (2.7) | | |
| SSM2 ($n = 40$) | 31 (77.5) | | 9 (22.5) | | 0 (0.0) | | |
| **Ethnicity** | | | | | | | |
| | **White** | **Black** | | **Asian** | | **Mixed** | $p = 0.06$ |
| SSM1[c] ($n = 70$) | 57 (81.4) | 3 (4.3) | | 2 (2.9) | | 8 (11.4) | |
| SSM2 ($n = 40$) | 40 (100.0) | 0 (0.0) | | 0 (0.0) | | 0 (0.0) | |
| **Do you consider yourself to have a disability?** | | | | | | | |
| | **Yes** | | **No** | | **Prefer not to state** | | $p = 0.73$ |
| SSM1 (n = 37)[b] | 18 (48.6) | | 17 (45.9) | | 2 (5.4) | | |
| SSM2 (n = 40) | 18 (45.0) | | 21 (52.5) | | 1 (2.5) | | |

*Note*: Data are expressed as *n* (%). SSM, social supermarket.

[a]Chi-squared test.

[b]Not asked at first SSM1 visit.

[c]One participant (2.7%) did not state ethnicity data.

SSM2) lived in local authority rented accommodation. Overall, 45% of participants had no dependents (38% and 46% in SSM1 and SSM2, respectively). By contrast, 18% had three or more dependents (15% and 23% in SSM1 and SSM2, respectively). There was no difference by demographic characteristics (age, gender, ethnicity, disability, marital status or dependants) between the two locations (data not shown).

## Do SSM members think healthy eating matters? What affects this?

For most SSM members, healthy eating was viewed as a priority. In SSM1, 70.4% ($n = 50$) and in SSM2 65.0% ($n = 26$) of respondents disagreed with the statement 'healthy eating is not a priority for me at the moment' (Table 2). Neither cooking equipment, nor knowledge were barriers but time was, more so for SSM2 members, 35% of whom agreed that time was a barrier to preparing healthy meals (vs. 18.3% of SSM1 members; $p = 0.04$) (Table 2). Age and gender also had an impact. Older respondents (≥ 65 years) were more confident than younger that they knew what a healthy meal was. For example, significantly more older ($n = 20$; 95.2% aged ≥ 65 years) than younger respondents ($n = 12$; 57.1% aged 55–64 years and $n = 4$ [44.4%] aged 18–21 years), disagreed with the statement 'I am not sure if my meals are healthy' (≥65 years compared with 55–64 years, $p = 0.04$; 18–24 years, $p = 0.01$, respectively). Money and time were less problematic for older compared to younger respondents. Older respondents (≥ 65 years) were less likely than younger (45–54 years) to agree that healthy eating was too expensive for them (28.6% [$n = 6$] vs. 70.8% [$n = 17$], respectively, $p = 0.01$). Older respondents (≥ 65 years) also disagreed that time was a barrier to preparing healthy meals more than those aged 18–24 years ($p = 0.03$), 25–34 years ($p = 0.001$) or 35–44 years ($p = 0.005$). All of those aged ≥65 years ($n = 21$; 100%) disagreed that time was a barrier compared to 55.6% ($n = 5$) aged 18–24 years ($p = 0.03$), 46.7% ($n = 7$) aged 25–34 years ($p = 0.001$) and 42.9% ($n = 9$) aged 35–44 years ($p = 0.005$). No one aged ≥ 65 agreed that time was a barrier compared with 11.1% ($n = 1$) of those aged 18–24 years, 53.3% ($n = 8$) of those aged 25–34 years and 52.4% ($n = 11$) of those aged 35–44 years. Females were significantly more likely than males to agree that time was a barrier ($p = 0.013$). No differences in responses by ethnicity or marital status were found. However, cost was a barrier to healthy eating, especially for those in insecure housing or with disability. SSM members in temporary local authority accommodation were significantly more likely to find healthy eating too expensive than those in their own homes (92% vs. 37%, respectively; $p = 0.005$). Those with disability were significantly more likely to agree that healthy eating was too expensive for them than those without (69% vs. 50%, respectively; $p = 0.004$). However, healthy eating was important to SSM members, who considered it a priority (Table 2).

**TABLE 2** Aspects of healthy eating for participants, by location.

| **Preparing healthy meals is too expensive for me** | | | | ***P*[a]** |
|---|---|---|---|---|
| | **Strongly agree and agree** | **Neither agree nor disagree** | **Disagree and strongly disagree** | ***p* = 0.77** |
| SSM1 (*n* = 71) | 43 (60.6) | 8 (11.3) | 20 (28.2) | |
| SSM2 (*n* = 40) | 25 (62.5) | 9 (22.5) | 6 (15.0) | |
| **Healthy eating is not a priority for me at the moment** | | | | |
| | **Strongly agree and agree** | **Neither agree nor disagree** | **Disagree and strongly disagree** | ***p* = 0.06** |
| SSM1 (*n* = 71) | 8 (11.3) | 13 (18.3) | 50 (70.4) | |
| SSM2 (*n* = 40) | 10 (25.0) | 4 (10.0) | 26 (65.0) | |
| **If I knew how, I could prepare healthier meals** | | | | |
| | **Strongly agree and agree** | **Neither agree nor disagree** | **Disagree and strongly disagree** | ***p* = 0.90** |
| SSM1 (*n* = 71) | 11 (15.5) | 14 (19.7) | 46 (64.8) | |
| SSM2 (*n* = 40) | 6 (15.0) | 5 (12.5) | 29 (72.5) | |
| **Time is a barrier to me preparing healthier meals** | | | | |
| | **Strongly agree and agree** | **Neither agree nor disagree** | **Disagree and strongly disagree** | ***p* = 0.05** |
| SSM1 (*n* = 71) | 13 (18.3) | 4 (5.6) | 54 (76.1) | |
| SSM2 (*n* = 40) | 14 (35.0) | 4 (10.0) | 22 (55.0) | |
| **I am not sure if the meals I eat are healthy** | | | | |
| | **Strongly agree and agree** | **Neither agree nor disagree** | **Disagree and strongly disagree** | ***p* = 0.22** |
| SSM1 (*n* = 71) | 7 (9.9) | 12 (16.9) | 52 (73.2) | |
| SSM2 (*n* = 40) | 10 (25.0) | 4 (10.0) | 26 (65.0) | |

*Note*: Data are expressed as *n* (%). SSM, social supermarket.

[a]Chi-squared test.

Qualitative comments from questionnaires and interviews demonstrated this:

> Yeah, I definitely try and consider healthy eating when I cook, I'm always trying to sneak vegetables into meals, I always try and add a minimum of one to two vegetables with every meal that I make (Betsy, SSM1; married, four children, working on zero hour contract, never previously claimed benefits/food support, household income fell when partner lost job and started new job on lower salary)

## Does the SSM impact upon healthy eating?

Almost two-thirds of respondents agreed that the SSM helped them prepare healthier meals (data not shown). Qualitative comments from participants showed that this included direct effects such as trying new types of healthy foods such as vegetables and freshly prepared salads, helped by the provision of frozen meals, salad boxes and recipe cards:

> I never would have thought about eating pumpkin, you know. And they put some different things in the salad like that quinoa and peas […] and it's actually alright, the salads are nice (Joanna, SSM1; Divorced, one dependant, benefits don't cover costs)

The SSM was valued as a source of new foods otherwise difficult to access:

> Yeah, oh yeah definitely, I mean it's, there's things that I'm eating now that I could not afford in a million years, healthy things and I've learned to eat new things as well (Daisy, SSM1; Single with disability and mental health problems, difficulty managing on benefits. Now volunteering with SSM)

> … people say it's not expensive to eat healthy, actually it really is because we live on rice and pasta and potatoes because it's the cheapest option things to eat that fill you up, and you buy the cheaper stuff because it's cheaper because that's what you can afford, but it's not necessarily the healthier option (Julie, SSM1; Recently widowed, money tight)

> I've never before bought and cooked a cauliflower. So, the first two times I went, I didn't get a cauliflower because I just thought I don't know what I'd do with it, I haven't got the

money or the ingredients to make cheese sauce … (Daisy, SSM1; Single with disability and mental health problems, difficulty managing on benefits. Now volunteering with SSM)

The SSM also had an indirect effect on healthy eating. It enabled members to make their money go farther because they could access food otherwise unobtainable but were also signposted to recipes and alternative ways of using the foods supplied, especially vegetables. This helped mitigate the effect of managing on limited incomes:

> I'm probably still less healthy now because I buy cheaper food and the social supermarket helped me be a bit more healthy again by sort of … they've got beans, sort of vegetables, it helps me gain the ideas of cooking more vegetarian meals which are obviously cheaper because that's what they provide and sometimes recipes and things as well (Louise, SSM2; Divorced, two dependants, working, struggling with household costs)

> I make up meals I wouldn't necessarily do because I'm being frugal using the groceries there and making something out of those […] I was spending about £140 a week food shopping … Now I would say I'm spending £95 and that's not just because I'm getting that saving purely from the supermarket, it's because I'm adapting to doing cheaper meals but still really mindful that they're nutritious (Dinah, SSM1; In long-term relationship, no information on dependants, struggling with household costs)

Participants overwhelmingly agreed that they valued choice in relation to food, and that their food waste was reduced as a consequence. As shown in Table 3, 94.4% ($n = 67$) in SSM1 and 87.5% ($n = 35$) in SSM2 agreed or strongly agreed that choosing their foods rather than being given no choice mattered to them. This in turn impacted upon food waste; 73.2% ($n = 52$) in SSM1 and 82.5% ($n = 33$) agreed or strongly agreed that this helped them reduce their food waste. The qualitative data also highlighted this:

> I mean there's so much choice and if I don't want something I don't take it and if I want something they'll do everything they can to try and get it to me' … [contrast with prior visit to food bank] 'And I've got four cans of things in the cupboard that I don't even understand what they are or how to use them (Daisy, SSM1; Single with disability and mental health problems, difficulty managing on benefits. Now volunteering with SSM)

> I can pick up what I need and leave what I don't need (Joanna, SSM1; Divorced, one dependant, benefits don't cover costs)

## Importance of the SSM for wellbeing

The opportunity to sit, have a hot drink and socialise with others (including the volunteers) was highly valued.

**TABLE 3** The value of the social supermarket for participants by location.

| **Choosing the foods I eat rather than being given no choice matters to me** | | | | ***P*[a]** |
|---|---|---|---|---|
| | **Strongly agree** | **Neither agree nor disagree** | **Disagree and strongly disagree** | **$p = 0.89$** |
| SSM1 ($n = 71$) | 67 (94.4) | 2 (2.8) | 2 (2.8) | |
| SSM2 ($n = 40$) | 35 (87.5) | 4 (10.0) | 1 (2.5) | |
| **The social supermarket has helped me reduce food waste** | | | | |
| | **Strongly agree and agree** | **Neither agree nor disagree** | **Disagree and strongly disagree** | **$p = 0.96$** |
| SSM1 ($n = 71$) | 52 (73.2) | 16 (22.5) | 3 (4.2) | |
| SSM2 ($n = 40$) | 33 (82.5) | 6 (15.0) | 1 (2.5) | |
| **Social elements of the social supermarket are important to me** | | | | |
| | **Strongly agree and agree** | **Neither agree nor disagree** | **Disagree and strongly disagree** | **$p = 0.90$** |
| SSM1 ($n = 37$)[b] | 25 (67.6) | 6 (16.2) | 6 (16.2) | |
| SSM2 ($n = 40$) | 31 (77.5) | 7 (17.5) | 2 (5.0) | |

*Note*: Data are expressed as numbers (%). SSM, social supermarket.

[a]Chi-squared test.

[b]Question not asked in first visit to SSM1.

Although some members were too busy to take advantage of this feature (especially mothers with children), overwhelmingly they expressed enormous satisfaction with it at both locations (Table 3). For example, 67.6% ($n = 25$) and 77.5% ($n = 31$) respectively in SSM1 and SSM2 agreed or strongly agreed that social elements of the social supermarket mattered to them, and this was also raised in the qualitative comments:

> You can sit down, you can chat to the people. It's a really lovely place even to get that bit of socialisation out of it as well (Judy SSM1; Married, four dependants, struggling to manage on benefits)

> I've been looking forward to going all week, not just because of the food you know it's, there's a couple of regulars there who I know … [.] A couple of the staff always ask me how I'm doing and we have a chat. It's nice, it's friendly, so rather than dreading it, I actually look forward to it now, it's the only thing I've got to look forward to every week … I've found that I've had very traumatic experiences with the foodbank in the past (Daisy, SSM1; Single with disability and mental health problems, difficulty managing on benefits. Now volunteering with SSM)

> They remember your name, they say 'hi [name] … how are you? How's your little girl? They want to give you things, they want to help you (Joanna, SSM1; Divorced, one dependant, benefits don't cover costs)

This was contrary to what some had expected prior to visiting:

> I thought I was going to go somewhere really impoverished, probably full of a certain demographic if you like and maybe be spoken to like sympathy or like pity (Dinah, SSM1; In long-term relationship, no information on dependants, struggling to manage for food)

## Is the SSM a major source of food for members?

For most members, the SSM was used for only part of the weekly shop; only 2.7% of respondents in SSM1 and 5.0% at SSM1 got their entire weekly shop there. A range of mainstream supermarkets were also used (Table 4), including lower cost supermarkets (e.g., Iceland, Aldi, Lidl) depending on local availability. For about one-third, SSM supplied about half of the weekly household food, whereas almost half of SSM2 members and almost one-third of SSM1 used the SSM only for the basics. This was illustrated in the qualitative comments:

> […] when I get home I'll unpack that and be right, "Now I'm going to the actual supermarket to buy a bit of meat or some fresh fridge food" and that sort of thing […] I work around what I've got from the SSM but I never need eggs, cereal, potatoes, carrots, fresh veg because I will use what's on offer that week and work around that (Dinah, SSM1; In long-term relationship, no information on dependants, struggling to manage for food)

> 'It's not my only source of food […] it essentially helps whatever I get there I can save on the shopping bill and it'll just be that bit, yes, it just helps out (Louise, SSM2; Divorced, two dependants, working, struggling with household costs)

Qualitative data suggested that for long-term SSM members and those who had suffered a sudden change in circumstances (e.g., bereavement, job losses), it was either their main or an essential source of the weekly food:

> I still have to get some stuff outside obviously but yeah, it really, it does help me a lot. But I think if I didn't go there, we'd go without a lot to tell you the truth, we'd just go without and that's it because that's the way it is (Elise, SSM2; Separated, no dependants, struggling to manage on Universal Credit and carers allowance)

Almost half of the SSM members in both locations identified as having a disability (Table 1). Significantly more of those with disability used the SSM for most or half of their household food ($p = 0.04$), whereas twice as many of those without disability used them only for the basics.

## Do SSM members access other food support?

Most SSM members had used it before, visiting weekly (Table 4). By venue, most SSM1 (64.8%) and a substantial minority (45%) of SSM2 members had never previously used food support services. Both age and housing status affected this. A greater proportion of younger than older SSM members had accessed other food support; 9.5% of those aged ≥ 65 years compared to 73.3% of those aged 25–34 years ($p = 0.002$), 57.1% of 35–44-year-olds ($p = 0.01$) and 54.2% of those aged 45–54 years ($p = 0.04$). Similarly, significantly less of those aged

**TABLE 4** Other shops used by social supermarket members.

| **Do you shop elsewhere, in addition to the social supermarket?** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **Yes** | | | | **No** | | | | ***p*[a]** |
| SSM1 ($n = 37$)[b] | 36 (97.3) | | | | 1 (2.7) | | | | |
| SSM2 ($n = 40$) | 38 (95.0) | | | | 2 (5.0) | | | | |
| **If so, what other shops do you use?** | | | | | | | | | |
| | **Asda** | **Aldi** | **Co-op** | **Iceland** | **Lidl** | **Sainsbury** | **Tesco** | **Morrison** | - |
| SSM1 ($n = 14$)[b] | 4 (26.7) | 0 (0.0) | 1 (6.7) | 0 (0.0) | 5 (33.3) | 1 (6.7) | 3 (20.0) | 0 (0.0) | |
| SSM2 ($n = 26$) | 3 (11.1) | 3 (11.1) | 1 (3.7) | 1 (3.7) | 12 (44.4) | 3 (11.1) | 1 (3.7) | 2 (7.4) | |
| **How much of your household food comes from the social supermarket in an average week?** | | | | | | | | | |
| | **All** | **Most** | **About half** | **Use for the basics** | **Other** | | | | ***p* = 0.52** |
| SSM1 ($n = 37$)[b] | 1 (2.7) | 11 (29.7) | 12 (32.4) | 11 (29.7) | 2 (5.4) | | | | |
| SSM2 ($n = 40$) | 2 (5.0) | 7 (17.5) | 14 (35.0) | 17 (42.5) | 0 (0.0) | | | | |
| **Have you used the social supermarket before?** | | | | | | | | | |
| | | **Yes** | **No** | **PNS** | | | | | ***p* = 0.22** |
| SSM1 ($n = 71$) | | 62 (87.3) | 7 (9.9) | 2 (2.8) | | | | | |
| SSM2 ($n = 40$) | | 39 (97.5) | 0 (0.0) | 1 (2.5) | | | | | |
| **How often do you use it?** | | | | | | | | | |
| | **First time** | **Used a few times** | **Fortnightly** | **Weekly** | **Other** | | | | - |
| SSM1 ($n = 71$) | 7 (9.9) | 3 (4.2) | 4 (5.6) | 44 (62.0) | 13 (18.3) | | | | |
| SSM2 ($n = 40$) | 1 (2.5) | 0 (0.0) | 3 (7.5) | 34 (85.0) | 2 (5.0) | | | | |
| **Have you used other food support services (e.g., food banks)?** | | | | | | | | | |
| | **Yes** | | | | **No** | | | | ***p* = 0.41** |
| SSM1 ($n = 70$)[c] | 24 (33.8) | | | | 46 (64.8) | | | | |
| SSM2 ($n = 40$) | 22 (55.0) | | | | 18 (45.0) | | | | |

*Note*: Data are expressed as *n* (%). SSM, social supermarket.

[a]Chi-squared test.

[b]Question not asked in first visit to SSM1.

[c]One respondent did not answer this question.

55–64 years used other services than those aged 25–34 years ($p = 0.01$) and 35–44 years ($p = 0.04$), 19% versus 73.3 and 57.1%, respectively.

Significantly less of those living in privately owned accommodation had used other food support services compared with those in temporary local authority ($p = 0.01$) or rented local authority accommodation ($p = 0.00$; 11.1% vs. 71.4% and 75% respectively).

## Why use the SSM?

Qualitative data (questionnaires and interviews) highlighted multiple reasons for using SSM. Most prominent were financial difficulties resulting from the pandemic and/or the cost-of-living crisis, including changes to benefits and other support received; rising food and fuel/electricity/heating costs; and adverse changes to physical and mental health. However, significantly more SSM1 than SSM2 members said they would use it anyway (57.7% vs. 27.5%, $p = 0.00$). In the April/May 2022 data collection period, several members also highlighted the importance of food waste as a reason for accessing the SSM.

> I think [choice] is important, I hate, absolutely hate waste, I don't agree with it, I don't agree with throwing things away that you could eat. And if someone gave you or made you, made that choice for you, you might not be able to eat it and want to eat it (Mary, SSM2; Single parent, three dependants with special needs, works part-time, struggling to manage on Universal Credit)

The most important feature of the SSM in both venues was the importance of food choice (92.1% agreement). This was followed by reducing food waste (75.6% agreement), the pay-as-you-feel model and social aspects of the social supermarket (72.6% agreement each) (Table 3). SSM1 members highly rated the wide range of foods available, while SSM2 members rated the convenience of the location.

## What about the downsides of SSM?

Most frequent frustrations expressed by SSM members fell into three categories: changes to the SSM over time; not being able to get what they required; and the suspicion that availability of provisions varied throughout the day.

In interviews some long-time members, particularly at SSM2, discussed how things have changed over time.

> When I first started going compared to now, it was amazing, really helpful, the volunteers were lovely, nice atmosphere and like lovely to choose what you would eat so there's no waste and it was really helpful. It has gone down a lot since it first opened (Mary, SSM2; Single parent, three dependants with special needs, works part-time, struggling to manage on Universal Credit)

> No, I mean to be limited now down to one carton of milk [when previously there was no limit], yeah, I just, and then like there was no, they haven't put loads of things out (Lara, SSM2; Single mother, three dependants, struggling to manage on Universal Credit)

At both locations members mentioned how often the shopping could be a hit and miss experience, particularly when they were unable to get basic food items or there was limited general availability of food.

> Sometimes it's a bit hit and miss, some weeks there will be some really nice things there and other weeks there will be not a lot to choose from. I know it all comes through from donations from people, but sometimes there will be some really good stuff there that I can cook quite a few meals out of, other times it will be what's left from the week before (Alex, SSM1)

Food banks provided the staples, not always a given with the SSM:

> Do you know what, I probably won't use it [SSM] again, and that is just being honest, I'm going to go back to [foodbank] because they give you, basically you just get your essentials that you need (Julie, SSM1; Recently widowed, money tight)

Another issue raised at both locations was timing. Some members felt that there were different levels of provision depending on the time they shopped.

> I know that I'm in that queue early enough so I know I can secure some good stuff for me and my family, especially for our little boy (Alex, SSM1; In long-term relationship, one dependant, on universal credit)

> … You can't really go there later than 1 pm although they run to 3 pm because they're pretty much out of many things if you go any later (Nathan, SSM2; Long-term back injury and mental health problems. Struggling to manage on disability benefits)

Although the issue of timing and the availability of certain items was the main concern for many, for those relying less on the SSM for their essentials, it was less of a concern.

# DISCUSSION

Food support is a contested issue, both in relation to whether it is appropriate that responsibility for provision has largely devolved to the voluntary sector,[31] and the adequacy of nutrition provided. Surveys of nutritional intake of the UK population consistently report inadequate intakes of many foods and nutrients including fruit, vegetables and dietary fibre, whereas intakes of salt, free sugar and saturated fats remain higher than recommended.[32,33] Dietary quality is also lower in those financially less well-off.[33,34] Simultaneously, prevalence of chronic diseases such as obesity and cardiovascular disease are inversely associated with income.[34,35] Given the importance of diet as a modifiable risk factor for chronic disease,[36] this is unsurprising. The double whammy of the Covid-19 pandemic and the cost-of-living crisis has forced many into food insecurity, and use of food banks is higher now than pre-pandemic.[37]

Food bank parcels have been criticised from a nutrition perspective.[38,39] Research has demonstrated that provision of energy, carbohydrates, sugar, protein and fibre exceeded recommendations, whereas provision of vitamin D and retinol failed to meet them.[40,41] Because they are intended to meet short-term emergency need for food support, it could be argued that the need for food trumps the quality of what is provided. However, it has been observed that a substantial proportion of those accessing such support are repeat members,[42] indicating the chronic nature of their problems and the importance of adequacy of nutrition provision. SSM allow members choice over the foods they can take, albeit within defined limits depending on availability. This is more akin to the shopping experience of those not reliant on food support. Allowing choice also potentially reduces food waste, since SSM members can choose what they and their families like and will eat. This has important environmental,[43] as well as personal implications and was clearly valued by respondents in the present study.

A mixed diet is recommended for health.[44] Most food banks provide ambient food[45]; many do not have the storage capacity to provide fresh fruit and vegetables. SSM therefore offer potential in the longer term to help provide members with a source of fresh produce they might otherwise lack or be unable to afford. Because food budgets tend to be relatively flexible, and therefore are tightened when costs rise, those on low incomes cannot afford to take chances of buying products the family may not accept.[46] Fresh fruit and vegetables by their nature have a short lifespan and are considered relatively expensive,[47,48] although this is contested.[49] However, it is risky to buy foods that may be unacceptable to family members and knowledge of how to cook and prepare seasonal fresh produce (e.g., squashes) may be lacking. The pay-as-you-feel model utilised by both SSM in the present study allowed SSM members to try them without cost implications if they were disliked, particularly through pre-prepared salads and frozen meals. Because the majority of respondents in the present study attended weekly (62% and 85%, respectively, at SSM1 and SSM2), this has important implications for widening the scope of the diet in the longer term.

Using food banks has been experienced as stigmatising and shameful,[3,17,50–53] despite the gratitude that recipients also feel.[16] The issue of dignity in food support is an important one, for which there is a current lack of guidance. The pay-as-you-feel model used by both SSM in the present study allowed members to make a donation for their food if they could, but without a requirement to do so. Feeling valued and able to contribute is an important principle espoused by those seeking to avoid stigmatisation in the food support arena.[53,54] The option to pay in addition to food choice helped enhanced SSM members' dignity. This is an important distinction from food banks; the representation of members as customers is a more dignified model,[26,55] enabling them to retain some agency and moving them from passive welfare recipients, with potential benefits to their mental health. For many of our participants, the major barrier to healthy eating was financial, and given the choice, they valued healthier options. The less stigmatising experience in SSM: tackling costs, allowing food choices and giving members the option to make a contribution, means members are more likely to continue to use them, making them a sustainable long-term option.

SSM members in the present study were unequivocal in their recognition of the importance of healthy eating (Table 2). This is contrary to the negative perceptions often held of those requiring food support,[3,56–59] perhaps assuming that they are unable to manage in part due to a lack of knowledge of, or interest in, healthy food preparation. In the present study, cost and time, rather than lack of knowledge or equipment, acted as barriers, the latter especially for young, female SSM members and those with children. The effort needed to obtain adequate food, negotiate social systems around support and entitlements and manage work and family commitments is likely to add substantial mental burden to those experiencing food insecurity. This in itself may partially mediate the relationship observed between low income and poor dietary quality.[60] Managing competing food priorities simultaneously (e.g., health, price, convenience) is difficult, requiring compromises, and price is often the strongest driver.[61] Older SSM members in this study were less likely to find healthy eating too expensive or identify time as a barrier to preparing healthy meals. This may relate to complicated lifestyles of younger SSM members, some of whom may have been in part-time work, and/or responsible for children.

Although SSM allow members more dignity and choice, and an experience more akin to a standard supermarket experience, problems still arose. SSM members expressed gratitude for the provision but frustration with the at-times limited product range or limits placed on the number of items that could be taken, depending on availability. This added to the stress that they experienced, also more widely identified in those affected by food insecurity and requiring food support.[53] Food became a contested issue within the interviews, particularly those carried out later in the data collection period, and this aligns with the experience of many organisations nationally. Some SSM members expressed embarrassment about using the SSM, particularly because they had to queue in a visible location to enter, although this depended on the location. Despite the element of food choice, some SSM members felt that the timing of their visits impacted on the range available, with later visitors being disadvantaged. For those running such food support schemes, supply and demand is a fine balancing act to manage. A major issue going forward will be establishing a reliable, predictable supply line; increasing need means that limits will have to be put into effect to ensure that everyone gets help. This is not limited to SSM; recent food bank data suggests that one in four independent food banks will need to reduce the size of their food parcels as a result of a simultaneous fall in donations and increased demand.[15]

In the present study, the majority of SSM members were white and young and those with disability were over-represented. Disproportionate need for food support in those living with disabilities has previously been identified.[42,62] Those living in private rented accommodation also made up a major group. Previously, increased food bank use was seen in those renting either social housing or within the private rental sector.[63] This may relate to a shortage of social housing, forcing individuals into the private rented sector where the gap between housing allowance and rent imposes real difficulties especially in southern parts of England,[63,64] where these SSM are located. This is worsened by cost-of-living pressures, meaning that benefits, already below inflation, become

even more stretched, leaving many with little money for food and other bills after rent. Those on lower incomes spend a greater proportion of their incomes on rent in the private sector compared to those on median or higher incomes.[65] Private rental sector affordability is a major issue and even prior to the pandemic, an estimated 1.6 million households had unmet housing needs that would be best suited to social housing.[66]

Most SSM members in the present study were not entirely reliant on the SSM for their household needs. Approximately one-third used the SSM for about half their household food and another third used it only for basics (Table 4). This is important given the difficulties inherent in this model of consistent food supply. Both SSMs in the present study relied on a combination of surplus food sourced mostly from FareShare. Nationally, use of surplus food for redistribution has continued to rise, with a 16% increase in surplus food redistribution in 2021.[67] Despite this, as the demand for food support has increased, the supply of surplus food available to charitable organisations has fallen.[15] In addition, types of surplus food available are highly variable. Both SSMs supplemented their surplus food provision by purchasing and supplying basic foods (eggs and milk) for a nominal set fee, which ensured their availability. Both SSMs also benefitted from being within established food partnerships with strong social relationships, and access to social kitchens. This ensured a virtuous circular movement with surplus food used to produce a range of fresh and frozen meals available to SSM members (e.g., soups, salad boxes and a range of cooked meals such as risotto), minimising food waste and maximising use of resources. This illustrates the importance of local context since SSMs operate in accordance with their physical locations but also have local populations with specific needs, which are important to understand.

The strengths of this work include the focus on a relatively under-researched area within the UK, which is nonetheless of increasing interest. Numbers of participants were reasonably high; with approximately half of households accessing the SSM weekly completing questionnaires. The dataset included qualitative data, which adds context to the quantitative data. Two locations were included. From a nutritional perspective, increasing reliance on community food support such as social supermarkets needs to be understood in relation to the potential impacts upon nutritional status. In addition, the data suggest that, contrary to common opinion, a high recognition of the value of healthy eating amongst members was apparent. Barriers to healthy eating were primarily pragmatic, including financial and time constraints, and this adds to our understanding of a stigmatised group and their needs. However, only 25 in-depth interviews were carried out and a larger more ethnically diverse group size could identify nuance in responses between different groups of social supermarket customers, particularly in relation to ethnicity because there was little ethnic diversity among respondents. No information on current dietary intakes was collected, and so the extent to which health-related behaviours such as cooking from scratch is actually carried out is not clear. This should be explored in future work, as should the possibility that particular subgroups (e.g., those with disability, long term members and those with a sudden change in circumstances) are particularly dependent upon the SSM to meet their needs.

In conclusion, the SSM in the present study were valued by their members. They offered a range of foods, including some at fixed nominal prices. Both operated using a pay-as-you-feel model, which, along with offering food choice, reduced the stigma associated with food banks. By offering a range of foods including fresh fruit and vegetables, and unlimited visits, SSM represent an important longer-term option towards ensuring a healthier nutritional intake for their members.

## AUTHOR CONTRIBUTIONS

All authors conceived the project and helped develop the questionnaire. HM, RR, NN and DB collected data. HM carried out quantitative analysis. RR & NN carried out qualitative analysis. All authors contributed to writing the manuscript.

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## CONFLICTS OF INTEREST STATEMENT

Stef Lake is Community Development & Health Programme Manager at Sussex Community Development Association (SCDA), which runs the two social supermarkets evaluated in this report.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

## TRANSPARENCY DECLARATION

The lead author affirms that this manuscript is an honest, accurate, and transparent account of the study being reported. The reporting of this work is compliant with STROBE guidelines. The lead author affirms that no important aspects of the study have been omitted and that any discrepancies from the study as planned have been explained.

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## PEER REVIEW

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