Being the instigator is not good business

Food retail managers’ attitude towards health interventions and suggestions for health interventions targeting immigrants

Amanda Järpemo

Supervisor: Meena Daivadanam
Title: Being the instigator is not good business
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Author: Amanda Järpemo

Abstract

Background: Diet-related Non-Communicable diseases are increasing. The prevalence and risk of type 2 diabetes (T2D) are higher among immigrants than Sweden-born population partly due to dietary changes following migration. Health interventions in food retail stores could be a possible cost-effective means of supporting healthier dietary behaviour, and a possible way of supporting immigrants in achieving a healthy transition following migration. Purpose: To explore food retail managers’ attitudes towards health interventions in food retail stores and perceived opportunities and limitations for health interventions targeting immigrants in food retail stores. Method: Qualitative in-depth interviews with food retail managers were used. A total of nine interviews were conducted with six store managers and three dietitians in the food retail sector (health managers). Thematic analysis was used in the data analysis and later discussed through Carroll’s three intersecting circles of CSR.

Results: Three themes were created. 1) Provide more information in different settings 2) It is not our responsibility to be the instigator and 3) Working towards a healthy business enterprise driven by personal motivation. Conclusion: Food retail managers perceive other actors being responsible instigating further health interventions. Opportunities for successful health interventions targeting immigrants are more diverse ways to convey information about healthy eating together with motivated managers as the considerable driving force. The limitations would be incomplete direct economic, legal and ethical motives, from both managers and customers, preventing managers to start voluntary actions in greater extent today.

Keywords: Type 2 diabetes, Immigrants, Health interventions, Food Retail Store, CSR, Green keyhole.
Table of Contents

Abstract.............................................................................................................................................3
Definitions..........................................................................................................................................5
Background .........................................................................................................................................6
Methodology ......................................................................................................................................13
  Method design ............................................................................................................................13
  Study Setting ..............................................................................................................................13
  Study participants .....................................................................................................................13
  Sample selection .......................................................................................................................14
  Inclusion and exclusion criteria ..............................................................................................14
  Ethical considerations ...............................................................................................................15
  Data collection ..........................................................................................................................16
  Data analysis .............................................................................................................................16
  Validity and reliability ...............................................................................................................17
Results ...............................................................................................................................................18
  Provide more information in different settings ......................................................................19
  It is not our responsibility to be the instigator.........................................................................21
  Working towards a healthy business enterprise driven by personal motivation ..................25
Discussion ..........................................................................................................................................27
  Health interventions as a CSR activity - Intersecting circles of CSR ...................................27
  Implications - Simplifying and justifying a complex problem ..............................................31
  Methodological considerations ...............................................................................................32
  Future Research .........................................................................................................................34
  Conclusion ...................................................................................................................................34
Acknowledgements .......................................................................................................................35
References ..........................................................................................................................................36
Appendix 1: Följebrev ....................................................................................................................42
Appendix 2: Forskningspersonsinformation & samtyckesformulär ........................................43
Appendix 3: Intervjuguide butikschefer .......................................................................................47
Appendix 4: Intervjuguide Hälsochefer .........................................................................................49
Definitions

**Health interventions:** Actions in food retail stores which attempt to influence healthier purchase and/or diet pattern.

**Immigrants:** Refers to individuals born in another country and now living in Sweden, also known as foreign-born. The immigration can both be voluntary, or forced because of unsafety in home-country (Swedish Institute, 2015). In this study it means all individuals who intends to stay in Sweden for at least one year (SCB, 2017).

**The Green Keyhole:** The Keyhole is a food label that identifies healthier food products within a product group. The criteria are specified by the National Food agencies in Sweden, Denmark, Norway and Iceland and follow Nordic Nutrition Recommendations (National Food Agency, 2015).

**Corporate Social Responsibility:** The European Commission’s definitions of CSR is being used in this study, as the responsibility of enterprises for their impact on society (European Comission, 2018).

**Diet-related NCDs:** Refers to Non-communicable disease such as cancer, cardiovascular disease and type 2 diabetes, which can be related to dietary intake (World Health Organisation, 2017).
Background

Non-communicable diseases
The prevalence of non-communicable diseases (NCDs) such as type-2 diabetes, all forms of cancer, musculoskeletal disorders and cardiovascular disease are increasing throughout the world (World Health Organisation, 2017). These diseases are causing 60 % of all deaths worldwide and can partly be attributed to lifestyle (World Health Organisation, 2017). The four behavioural risk factors for non-communicable diseases are tobacco use, unhealthy diet, insufficient physical activity and harmful use of alcohol, with diet and physical activity being the most important. In order to stem this negative development, there is a great need for societal level support, whereby regular physical activity and healthy dietary practices are made both affordable and easily accessible for everyone (World Health Organisation, 2017).

Food retail store environment
A review by Cohen and Babey (2012) argues the food retail store environment to be one of the big risk factors of our poor dietary behaviour and suggests that it should be changed to improve public health. The authors conclude that saliency and presentation which influences automatic responses are key factors influencing the purchase, rather than knowledge and awareness (Cohen & Babey, 2012). Food marketers use different strategies in order to increase sales such as price strategies, placement of products and food labelling. Food items have become more accessible, cheaper, larger in size and more calorie-dense and this appears to be influencing our diet-related health problems (Chandon & Wansink, 2012). Food retail stores are the environment where most of our food is purchased and in-store marketing greatly influences consumer behaviour at the point of purchase (Chandon, Hutchinson, Bradlow, & Young, 2009). The rising problems of diet-related NCDs seem to be contributed by factors over and above individual knowledge, skills and, motivation and environmental and policy intervention are being emphasised to be more effective. A review of environmental contexts and conditions influencing eating practices conclude the necessity of making healthful food choices available, identifiable, and affordable for people of all races and income levels, in all different geographic locations (Story, Kaphingst, Robinson-O'Brien, & Glanz, 2008). Therefore, research from other countries, mostly the United States, has conducted interventions in food retail stores in order to affect healthier food and diet purchase.
Two systematic reviews of in-store healthy food interventions have demonstrated increased purchase of healthy foods (Escaron, Meinen, Nitzke, & Martinez-Donate, 2013), (Abdulfatah & Jørgen, 2016). The interventions mostly consisted of awareness raising through food labelling, promotions, campaigns, etcetera, and increasing availability of healthy foods such as fruits and vegetables. Escaron et.al (2013) concluded it to be effective to combine culturally sensitive demand- and supply side strategies for healthier purchase pattern and Abdulfatah and Jørgen (2016) highlighted storeowners’ attitude and level of cooperation as a critical factor for intervention success (Abdulfatah & Jørgen, 2016). They also concluded nutrition programs targeting low-income or minority groups combined with affordability (price adjustments) were more likely to affect healthy food purchase than nutrition knowledge itself. The interventions in the reviews had many different characteristics, one occurring were interventions in deprived neighbourhoods targeting low-income ethnic minority groups since it is known that diet-related NCD’s are directly related to food environment and this group is of particular risk of living in poor food environments (Gittelsohn, 2009).

**Immigrants and non-communicable diseases**

A review by Pickett and Pearl showed the neighbourhood to directly influence health-risk behaviour or indirectly by the availability of and access to healthy foods, normative attitudes towards health behaviour, and social support (Pickett & Pearl, 2001). It is also known that the living area has an important influence on risk factors for NCDs were deprived neighbourhoods are associated with higher prevalence of NCDs (Kawachi & Berkman, 2003). A Swedish study showed a higher prevalence of T2D of people living in a deprived neighbourhood than rest of the country. It was associated with the risk factors of developing T2D such as obesity, sedentary lifestyle, psychosocial risk factors and low socioeconomic status which tend to accumulate amongst immigrants (Bennet, o.a., 2011).

Immigrants have long been found to have a higher risk of developing diet-related NCDs such as type 2 diabetes (T2D) and cardiovascular disease (Wandel, Raberg, Kumar, & Holmboe-Ottesen, 2008). For example, the prevalence of T2D among non-European immigrants in Sweden is 14,6 %, which is twice as high as it is among Swedish-born subjects (Wåndell, Wajngot, de Faire, & Hellénius, 2007). Non-European immigrants develop T2D earlier than the general population and have a higher risk of not reaching treatment goals (Nationella
Diabetesregistret, 2016). It is also known that foreign-born diabetes patients have a higher risk of diabetic complications and experiencing bad health than Swedish-born population (Wändell P., 1999). One study showed the NCDs among immigrants are positively associated with a number of factors, one of which is poor dietary habits. The study compared the dietary pattern of people living in Iran with immigrants from Iran living in Sweden and concluded the transition to be of unfavourable impact of the risk of NCDs (Koochek, o.a., 2011). It has been hypothesized that the higher prevalence of NCD’s among immigrants can be an effect of an unhealthy dietary transition when moving from home-country to host-country (Sai, 2017).

In Sweden, 18% of the population is born in another country (SCB, 2017), and 2014 was a year of immigration record in Sweden, this creates a debate on how to provide immigrants same opportunity than rest of the population (Swedish Institute, 2015). A recent study conducted in Sweden with the aim of understanding food choices and dietary change among migrants in host countries concluded that there is a need for cost-effective interventions in the food environment to encourage a healthy transition following migration. It was also highlighted that it should be explored how to implement support and navigation promoting a healthy lifestyle in real-life settings (Sai, 2017). As suggested by a recently released report from the Swedish Public Health Authority and National Food Agency (2017), health interventions in food retail stores could be a possible cost-effective method for the target population.

Today, no such intervention has been conducted in Sweden, but the report includes a literature review of health interventions targeting ethnic minority groups in other countries. It demonstrated a positive effect of culturally adjusted support for this target group in actions attempted to improve healthy diet (Public Health Authority & National Food Agency, 2017). Cultural adaptions include cultural sensitivity incorporated into the design, delivery and evaluation of targeted health promotion material and programs. Cultural sensitivity means taking populations’ characteristics, values, and behavioural patterns together with environmental and social forces in regard (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999). The review also showed that although individual educational support has an effect, this can increase health inequality, since the effect is greater among individuals
with higher socioeconomic status. On the contrary, changes in the environment showed no effect on health inequalities (Public Health Authority & National Food Agency, 2017). The need to support a healthy dietary transition for immigrants are also highlighted in a systematic mapping review with the aim of understanding dietary behaviour to promote healthier diet among ethnic minority groups. The review identified clusters with certain factors influencing dietary behaviour among ethnic minority groups by reviewing and synthesizing both qualitative and quantitative studies published between 1999 and 2004. The identified clusters were social and cultural environment (16 factors), food beliefs and perceptions (11 factors), accessibility of food (10 factors), psychosocial (9 factors), migration context (7 factors), social and material resources (5 factors), and the body (5 factors) (Osei-Kwasi, o.a., 2016). Many of the factors which immigrants perceive to influence their food choices can be traced in the food retail store environment and it was concluded that there is a need to further explore the mechanisms behind these factors when adapting mainstream interventions (Osei-Kwasi, o.a., 2016).

Health interventions in food retail stores

In 2016, the government asked Public Health Authority and National Food Agency to explore health interventions in the society connected to dietary habits and physical activity (Public Health Authority & National Food Agency, 2017). One area they were assigned to explore was that of voluntary actions taken by the food sector. The literature review identified a number of successful health interventions, including the reformulation of food items, changes in portion sizes and packaging, interventions of product placement and marketing, addition of nutritional information and health symbols on healthy food items, creation of criteria for food procurement such as taxes and price adjustments (Public Health Authority & National Food Agency, 2017). The review concluded that the food sector has an important role in efforts to promote healthier eating habits, but that there is a further need for understanding mechanisms which could benefit or work against healthy behaviour for certain populations and in particular contexts (Public Health Authority & National Food Agency, 2017).

Concerning voluntary actions in the food sector, food companies in Sweden are already taking actions on a higher level to improve healthier dietary consumption. The Swedish Food Retailers Federation and The Swedish Food Federation have developed both guidelines and action programs on how they can improve public health (Public Health Authority & National
Food Agency, 2017). 97% of the food retailers in Sweden are members of the Swedish Food Retailers Federation (Swedish Food Retailer Federation, 2016) and the Swedish Food Federation has around 800 members, which are companies from the food industry (The Swedish Food Federation, u.d.). The action programs are focusing on a healthy assortment of products, labelling, marketing of healthy eating, and provision of information. However, as the federations do not govern over their members, it could not be concluded the company members’ willingness towards voluntary actions for health promotions (Public Health Authority & National Food Agency, 2017).

**Health interventions as a corporate social responsibility activity**

Health interventions in food retail stores can be understood as a corporate social responsibility (CSR) activity and health is described to be one of food retailer’s responsibility areas (ICA Gruppen, 2017) (Coop Sverige AB, 2018). A useful tool for conceptualising CSR is Carroll's three-domain approach for CSR. It is a non-hierarchal model with intersecting circles which includes a company’s three responsibility areas: economic, legal and ethical. Each domain represents different motives for a CSR action and is accepted to embrace all relevant aspects of CSR (Schwartz & Carroll, 2003).

*Economic domain:* includes activities with the intention of direct or indirect positive economic impact, as maximisation of profit and/or share value for the company.

*Legal domain:* Includes three categories, the first, *compliance,* includes passive, restrictive or opportunistic types of compliance with the law. The Second category is *avoidance* which refers to the desire to avoid possible current or future litigations. The last refers to an *anticipation* of changes in legislation.

*Ethical domain:* Contains ethical responsibilities expected by stakeholders and the general population of which influence the motive. These can be of *Conventional, Consequentialist or Deontological standards.* *Conventional standards* mean the motive is in concern of justice or moral rights, and the standards have been accepted as necessary for the proper functioning of the business. Following *Consequentialist standards* is when the action is intended to *doing good* for the society, being the most beneficial for society, comparing to other options. *Deontological standards* refer to the consideration of following one’s duty or obligation. These three domains are featured in a Venn-diagram and are overlapping, which creates seven categories for how CSR can be conceptualised, analysed and illustrated (See figure 1).
The Three-Domain Model of Corporate Social Responsibility

![Diagram of the Three-Domain Model of Corporate Social Responsibility](image)

*Figure 1 (Schwartz & Carroll, 2003)*

This model is very useful when exploring business motives of a CSR activity since it is a useful scheme when conceptualizing its component domains (Schwartz & Carroll, 2003). One important aspect of a company’s CSR activity is how business practitioners make sense of the values it should represent. Rahbek Pedersen argues that not capturing the mind-sets of business practitioners about social responsibility would make it difficult to understand and predict how firms respond to societal demands (Rahbek Pedersen, 2010). How managers actually perceive the role of business in society in everyday decision making is a precondition for bridging the gap between firm behaviour and stakeholder expectations (Rahbek Pedersen, 2010).

With the need to explore cost-effective interventions targeting immigrants in Sweden (Sai, 2017) (Public Health Authority & National Food Agency, 2017), together with the support of motivated store managers for successful health interventions in food retail stores (Abdulfatah & Jørgen, 2016), and the lack of store managers’ perspective on ongoing voluntary actions among food retailers in Sweden (Public Health Authority & National Food Agency, 2017) leads to the purpose of the study.
Rationale
Health interventions in food retail stores could be a possible cost-effective means of supporting immigrants in achieving a healthy transition following migration, food retail managers could provide extended knowledge for further work with this.

Purpose
The aim of this paper is to explore food retail managers’ attitudes towards health interventions in food retail stores using Carroll’s three intersecting circles, and perceived opportunities and limitations for health interventions targeting immigrants in food retail stores. It is formulated through two research questions:

- What are food retail managers’ attitudes towards health interventions in food retail stores?
- What do food retail managers perceive to be the opportunities and limitations for a successful health intervention for the immigrant population?
Methodology

Method design
In order to answer the research question, in-depth interviews were conducted. These enabled the capture of descriptions of the interviewee's lifeworld (food retail environment) of a described phenomenon (health interventions focusing on immigrants) through a planned and flexible interview' (Kvale, 2007). A qualitative interview design is a powerful means by which to produce knowledge of the human situation (Kvale, 2007), making it suitable for the study purpose of exploring managers’ attitudes and opinions about health interventions.

Study Setting
This study was a part of the EU financed SMART2D project, whose aim is to explore strategies to prevent and treat diabetes type-2 through self-management. In Sweden, the project’s target population is Non-European immigrants in Stockholm (Department of Public Health Sciences Karolinska Institutet, 2016), since the prevalence of diabetes is higher among this group than among other population (Wändell, Wajngot, de Faire, & Hellénius, 2007). The study site for the project is comprised of socially vulnerable neighbourhoods characterised by low-income levels, high unemployment rates and a high proportion of immigrants (>30%) (Department of Public Health Sciences Karolinska Institutet, 2016).

Study participants
The study consists of two types of participants: 1) store managers in food retail stores in the selected areas; and 2) dietitians working with health at food retailers and food retail federations, who will be referred to as health managers. Describing the first sample of store managers, it consisted of one woman and five men with experience of working in food retail store between 8 and 26 years. Two of them were younger, around 30 years old and the rest were around 50 years old. One store was classified as a Small independent grocer and five stores were classified as Supermarkets, four stores described their customers being multinational and their assortments adjusted after that, with more foreign food items. The health managers were all educated dietitians and had been working in food retail sector around twenty years, all three women and in their forties.

Why the sample consisted of two types were guided by the intersecting circles of corporate social responsibility which include the economic, ethical and legal responsibilities of a company (Schwartz & Carroll, 2003). For the purposes of this project it was assumed that the
The legal dimension of working with health in food retail stores is more the concern of the head office than the individual food retail store managers. The economic and ethical aspects were captured in both store and health manager interviews.

**Sample selection**
The food retail stores in the chosen socio-economically disadvantaged areas of Stockholm were identified and categorized in descending order by size, using of the EPHOC classification system for food retailers: Supermarket, small independent grocer, convenience store, informal vendor, mobile vendor and market (Chow, o.a., 2010). The classification was made by the researcher by means of using online maps to find food stores in the area and later visiting them in order to get an understanding of their size and what they sell. Supermarkets and small independent stores are described by the researcher as places selling the ingredients necessary to prepare a complete meal, including common grocery products, fresh fruit and vegetables. Convenience stores, informal vendors and mobile vendors are seen as places where snacks, beverages and a limited selection of groceries can be purchased. Markets, commonly in the form of stalls located in neighbourhood squares, sell only fruit and vegetables. Food retail stores located in socio-economically disadvantaged areas as defined by the Smart2D project and classified as supermarkets and small independent grocers by the researcher were included in the sample and the managers of these stores were invited to participate in the study. Convenience stores, informal vendors, mobile vendors and markets were excluded as they did not sell all food products. 25 store managers were contacted directly in the store or through an information letter given to a co-worker. The researcher called the manager a few days later, asking for participation in an interview, six managers consented and a time suggested by the manager was scheduled.

Health managers were identified by contacting the president and coordinator for food and health at the Swedish Food Retail Federation, who shared contact information of the other members of food and health council. All identified members (five) were contacted by the researcher via e-mail, three agreed to participate in the study and a time for the interview was scheduled at their convenience.

**Inclusion and exclusion criteria**
Managers of supermarket or small independent grocers in the identified areas were included in the sample since they include all food products necessary for preparing a common meal.
Convenience stores, informal vendors, mobile vendors and markets were excluded. These criteria were used since health interventions in food retail stores were expected to be of a greater concern for larger food retail stores with larger assortment and economic resources.

**Ethical considerations**

The study obtained ethical approval from the regional ethics review board in Stockholm as a part of the SMART2D project (Ref No 2018/239-32/1). The four main ethical principles - Information, consent, confidentiality and usefulness, were taken into consideration before, during, and after the study (Swedish Research Council, 2002). Participants were informed about the study purpose and the voluntary nature of their participation both orally and in text form (See appendix 1). The participants were asked to read through and sign a letter of consent (See appendix 2) prior to the interview, which included agreement to the discussion being recorded. To ensure confidentiality, the interviews were numbered and no personal names, company names or other possible means of identification were included in the results. Furthermore, all data were protected against unauthorized access. The data were used in the way the participants were informed that it would, following the research purpose.

**Interview guide**

The interview guides (See appendix 3 and 4) were constructed with the aim of answering the research questions pertaining to the managers’ attitude towards health interventions in food retail stores and perceived opportunities and limitations for health interventions focused on immigrants in food retail stores. The questions were open-ended and their order was flexible, driven by how topics came up during the interview. The interview guide differed for the food retail managers and health managers, with the former being asked more questions about the practical implications about health interventions and the latter being asked to focus more on the general implications of working with health.

To ensure that the questions covered all dimensions of health intervention in food retail stores, Carrols’ intersecting circles of a company’s three responsibility areas of Corporate Social Responsibility (CSR) were used as a supportive guideline. The economic, ethical and legal dimensions of a CSR-activity were used as a framework when constructing the questions in the sense that economic and ethical considerations were covered in both of the interview guides and questions about legal issues concerning health were asked of the health managers.
Two pilot interviews were conducted, both lasting around one hour, and these were transcribed verbatim. In response to these discussions, the interview guide was modified in terms of reformulating some questions and changing some words. It was also discovered that the direct questions regarding corporate social responsibility confused the respondents when talking about health interventions, and these were therefore removed. To capture economic and ethical concerns, questions regarding motivation as well as opportunities and limitations of health interventions were asked instead. The pilot interviews were not included in the end results. The interview guide for the store managers can be described as consisting of three different themes: Customer behaviour, Affecting healthy shopping behaviour and, Limitations and Opportunities for affecting healthy shopping behaviour especially for immigrants. The interview guide for health managers consisted of four themes: The Company’s work with health, Legal aspects, Communication, and Health interventions to support Immigrants.

**Data collection**

Data were collected from both store and health managers through in-depth interviews. Nine interviews were conducted, three with people working with health and six with store managers, all of whom represented different store brands. Interviews were conducted in Swedish, audio-recorded and lasted around one hour (42 min-67 min).

**Data analysis**

Thematic analysis was applied, which included identifying, analysing and reporting patterns within data in the form of themes (Braun & Clarke, 2006). It is a flexible and useful research tool in qualitative research and has the potential of providing rich, detailed and complex understandings of data (Braun & Clarke, 2006). A theme can be described as a pattern which captures something important in the data. Braun and Clarke’s (2006) six steps of thematic analysis was used in this work. These are *Familiarizing yourself with your data, Transcribing data, Generating initial codes, Searching for themes, Reviewing themes, Defining and naming themes* and *Producing the report* (Braun & Clarke, 2006). The analysis was cross-checked and discussed with the supervisor who had experience in qualitative analysis.
The interviews were transcribed verbatim. Strong intonations were marked as were long pauses, sighs and laughter in order to get more information about the attitudes in certain questions. All material was read through several times and upcoming thoughts were noted in order to start processing the material. The interviews were later coded in Nvivo12 and all data were given attention, although it did not directly answer the study purpose. All the codes were read through several times and the citations and codes were then transferred to excel and grouped. Codes were condensed to form sub-categories, categories, sub-themes and themes. The final results were organised into twelve subcategories which fed into six categories, three subthemes and finally two themes (See Table 1). The categories and themes were crosschecked by re-reading the codes and corresponding parts of the interview transcripts for validation of the themes.

**Validity and reliability**

Seven stages of an interview inquiry were followed during the project process, these include Thematising, Designing, Interviewing, Transcribing, Analysing, Verifying and Reporting (Kvale, 2007, s. 35). They were used to ensure scientific conduct for enhancing reliability. Concerning reliability in the analysis, Bryan & Clarke's (2006) six steps to conducting a thematic analysis were followed. To ensure validity, arguments for the research aim and chosen methods were presented in a written paper including theoretical background and chosen methodology together with a philosophical discussion about research design, research problems, and context connected to the research aim. This was followed by a peer debriefing seminar of other disciplines in social science i.e. psychology, sociology, digital media and society who discussed further considerations such as formulation of research questions and approved the chosen methodology. In the data collection phase, which included preparation of the criteria for the study sample, questions in the interview guide and data analysis, the researcher worked in close collaboration with the supervisor in order to achieve validity in data collection and analysis.
Results

The analysis resulted in the emergence of three themes: Provide more information in different settings, It is not our responsibility to be the instigator and, Working towards a healthy business enterprise driven by personal motivation (see table 1).

Table 1. Results Thematic analysis

<table>
<thead>
<tr>
<th>Subcategories</th>
<th>Categories</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target special groups with appropriate tools</td>
<td>It is all about information</td>
<td>Provide more information in different settings</td>
</tr>
<tr>
<td>Interaction through tastings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easy formats conveying information</td>
<td>Barriers to effective interaction with customers</td>
<td></td>
</tr>
<tr>
<td>Assumptions regarding barriers from customers’ perspective</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regulations which limit communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It would be much easier working with regulations</td>
<td>Our hands are tied, it is up to the government and the industry</td>
<td>It is not our responsibility to be the instigator</td>
</tr>
<tr>
<td>Other actors should take responsibility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is the products provided by the industry that cause illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>We follow what the customers are demanding, what they are buying not what they need</td>
<td>It is up to the customers, we follow the financial numbers</td>
<td></td>
</tr>
<tr>
<td>Responsiveness towards future regulations and emerging societal trends</td>
<td>Profiling ourselves as concerned about public health</td>
<td>Working towards a healthy business enterprise driven by personal motivation</td>
</tr>
<tr>
<td>Identifying and working with market trends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal motivation for store manager is key</td>
<td>Individual managers have a significant role</td>
<td></td>
</tr>
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<td></td>
</tr>
</tbody>
</table>
Provide more information in different settings

When the respondents were asked how food retailers could work with health interventions in food stores, a recurring response was the need to inform the consumers about how to eat healthily. When asked how this could be done, a common spontaneous response was the provision of information brochures in some form, perhaps in different language. However, after deliberation or in response to further questions, such a strategy was perceived to be ineffective by store managers as no one read texts when in a food retail store. On further discussion, free tastings were often brought up as another possible health intervention. Store manager were already positive against free tasting since the suppliers pay the costs of the products and it is appreciated by customers. These were suggested as a means by which to start an interaction with customers to provide information. They were also seen as a way to inspire people to try out new healthy products, and so realise that these could be tasty too. Examples were also given from health managers of how the food retail store provided healthy recipes and included health information in their member magazines, also considered to be inspiring communication tools. This stresses the belief that having the right knowledge and tools will encourage actions towards healthier food purchases. One manager described their role as giving the customer the opportunity to be healthy, but then it is up to the customers.

So I think we should provide customers the option to choose, but then, each one of us, individuals, the consumer itself, has to decide its own priority
– Store manager 4

This perceived need for information is reflected in descriptions about immigrants’ perspectives on diet and health which were, in their view, an explanation for this group’s higher risk of type-2 diabetes. Illustrations of this included unhealthy items being mistakenly believed to be healthy and the subsequent need to better communicate the Green keyhole to non-Swedes. For example by providing information about it in different languages in the stores, suggested by one health manager. Although the Green keyhole was brought up as a potential means of communicating about healthy food items in a simple way, store managers were not motivated to work with it given their experience that if was not of interest to customers. It was, however, considered to be of great importance at the higher managerial
level, where its criteria are used as guidelines when developing own branded products, and where it is believed to have great potential use as an information tool.

The myriad examples given on how to convey health information illustrate the perceived thought of consumers lacking such information. Previous examples to offer tastings, recipes and Green keyhole in order to educate about healthy eating can be seen as a belief of a barrier from the customers’ side of resilience to new food habits and not being aware of healthy food options. From the perspective of health managers, another barrier to communication is the health and nutritional legislation (1924/2006) together with the information legislation (1169/2011), whose regulations are seen to limit the food sector in informing the consumer. It is perceived to be impossible describing health benefits so that customers would understand. They believe the purpose of the regulations are good, controlling the information on packaged food products so that it does not mislead the consumer (National Food Agency, 2017), but not created in regard of the customers.

*Something which really is limiting us, is the nutritional health claim regulation, No 1924/2006. Regarding not being able to say anything (about a product’s health benefits), because we are controlled by this EU regulation. We can’t say anything about it, even though it’s good. Because then we have this regulation, which does not allow us to do that.*

– Health manager 2

From the respondents perspective the legislation was not considered to be consumer friendly, as it limited the possibility of providing information in simple and communicative ways. The legislation was concluded to be the biggest hindrance in their efforts to guide consumers on how to eat healthier. The information legislation is also considered to be limiting, because it does not allow the producer to separate naturally occurring sugar from added sugar in the nutritional information. They wanted more open regulations to be able of adapting it to their business. The results of regarding information to be most important in health interventions shown with suggestions to inform in different settings reflect an idea of increased communication will also increase healthier eating. But it also reflects an attitude of the individual to be responsible for its own actions, once being informed, and regulations to be
answerable for the limited communication by food retailers, which resonate with the second theme.

**It is not our responsibility to be the instigator**

The second theme describes an attitude of not being primarily responsible for people’s unhealthy eating habits, instead, other actors should take their responsibility. This is demonstrated by examples of the wish for regulations limiting the amount of salt, sugar and fat in products, or to have general health goals to work with. Health managers expressed a desire for a goal to be set by the government to limit diet-related NCD’s, such as a stated percentage by which obesity should be reduced by a given date. The respondents did not desire concrete guidelines on how this should be operationalised in the food retail sector, since they deemed themselves able to manage it themselves with their internally knowledge and earlier work.

A goal being set by the government was also seen by those working with health as a means to strengthen their argument and thereby motivate others in their sector.

*If the goal was known, it would then be much easier for us informing forward down to the companies, the dietitians could talk with the marketers and inform the goal. Then they can ask, how can we reach that? But now, the others ask why? Why do we have to do that? How will that benefit us? – Health manager 1*

The lack of regulations limits motivation to improve health from the food retailer perspective since it is perceived to be the government that is responsible for such an effort. Also, when asked how immigrants should be supported with health interventions in food retail stores, the response was that it is the migration office’s responsibility to inform them about healthier eating habits. Further questions about cooperation with other actors revealed an accommodating stance, but only if the initiative and resources come from the other party.

Another actor seen as responsible were the National food agency, when it was talked about the Green keyhole, it was seen to have been mistreated and not promoted sufficiently.

*But what is needed, is that someone has to take care of the Swedish key hole. It's really a pity because the national food agency has trouble with that. They're trying, but it's not so easy since you need money for it…To be able to promote the keyhole*
and such. But sadly the sales has decreased in Sweden. Actually, there are other actor's products which reach the guidelines but haven't the keyhole on the package. – Health manager 3

Health managers expressed the belief that it would be beneficial if the National Food Agency could successfully promote the Green Keyhole in order to generate customer demand. This could potentially create a win-win strategy. From a health perspective, it would facilitate communication of which food items are healthy. From a business point of view, sales would increase, since food retailers’ own branded products are leading the way in the use of the symbol.

According to store managers, the food industry is another actor responsible for diet-related NCD’s. It was explained that the stores themselves are only retailers of food and that questions related to how to improve food choices, and therefore health interventions, should be more of a concern for the industry that provides the food products. Thus, the industry is believed to have a duty to develop healthier products in order to get people to eat healthier.

Then there is the product development, so we can provide (healthier) options for the customers, to change their behaviour. – Store manager 1

Also expressed was the belief that certain foreign food products, such as "baklava", contribute to diet-related NCD’s, since they are tasty, but also unhealthy. However, certain typical Swedish products are also deemed unhealthy and it was the mix of the two that was thought to be the cause of immigrants’ struggle with a healthy transition. One manager also speculated about gene-modified food as a factor causing obesity.

Like when we talk about organic, then we also can talk about gene-modified food, how is that affecting us? So I, I don't know, I haven't sufficient proof for it but I believe that gene-modified food is certainly a big villain concerning today's obesity problems… I consider it hard to believe that, the fast-growing vegetables, with this protein that make them grow fast, will not stop functioning when being in our bodies. – Store manager 2
Industry’s responsibility was also illustrated in descriptions of the food industry, dubbed "the sugar mafia", as the cause of people eating too much sugar. Sugar was described as a commodity that is bought cheap and sold expensive, with products with high sugar content being sold with a good profit.

The great profitability of unhealthy products was also seen as an explanation for why the food retail store was incapable of doing anything, since their priority was to remain profitable.

*I would say it’s a conflict of interest here. We have, it’s our interest to sell many, unhealthy food items. Partly, some categories. Like, if we talk about candy, which is a very profitable group of products in our business. And then we want to sell more of that because we earn more money on it. Comparing to another option. Like, what would we gain from that in this business? It’s something like that if we provide this item which sells a lot, and we know that if we highlight these in a campaign. Then we know we will attract customers to the stores and sell plenty of this item. Then, why should we change that, when it's a great concept? That is the challenge, why change that, when it works? - Store manager 4*

When it comes to healthy foods, often perceived as nuts, dairy-substitutes and organic products by store managers, the narrow profit margin was said to be a limitation to sales. Being concerned with health was described as being bad for business, due to the differing profitability, i.e. cost price of unhealthy and healthy food categories. It was implied that it should be the responsibility of industry to develop healthy products at low-cost. On the other hand, the food store also has to cater to customer demand and managers explained that unhealthy products have greater appeal. The price of products was often described as the biggest concern for customers and therefore the main influence on their purchases.

*But still, sure you can partly affect the purchase pattern, but the thing is... we still have to supply what the customers want. And that is what it's mainly about. Eh, and a lot comes from what we have in our campaign leaflet. It's where it all starts, customers come and want to buy the cheapest articles for the week. – Store manager 6*
Price was described to be of particular concern in areas such as the study setting since immigrants’ purchasing is even more driven by campaign products and price than it is in the inner-city, due to the difficulty of influencing this group’s purchasing behaviour. The perceived inability to change customers’ behaviour is thus a product of industry refusing to lower prices and customers being unwilling to pay more. Some managers describe attempting to make healthier food items more visible or reducing easy access to unhealthy food items, but with no effect on sales in either case. A reluctance was also expressed about forcing the customers to make particular purchases. The implication of this is that the retail store cannot affect customer behaviour and that it is therefore the customers who are in control of the assortment of goods available. Furthermore, managers describe a good business strategy as reacting to market demands rather than trying to instigate change.

_Actually, I do not feel reliance in raising the customers. We have been trying to do that over the years, to take stand for different things. Which not always has been good for business._ – Store manager 2

The perception of “poor business practice”, reduces the perceived responsibility of food retail stores to be initiators of health interventions and places the responsibility on customers to start the process of creating a healthier society. It was argued that food retail stores already provide a variety of healthy food products, giving customers an opportunity to make healthy food decisions.

_Well, I consider us to be, like we just retail food, to the population so to speak. So, it’s the consumers who are making the choice in the store. They have the opportunity to take the right decision._ – Store manager 3

Customers needing more information and being in control of food retail store activates on the one hand and the expressed need for government regulations and increased industry responsibility on the other, feed into the overall theme that the food retail sector cannot be the instigator of health intervention. However, this does not imply a total lack of motivation on the part of food retail stores or an unwillingness to participate in such efforts.
Working towards a healthy business enterprise driven by personal motivation

The third theme that emerged includes the categories of wanting to be profiled as a health actor and the significant role individual managers have in this work. This highlights concerns about health in the food retail sector and an interest in further incorporating it in their business strategy.

Most apparent were the ongoing work at head office to promote health and the branch agreements concerning health in the food retail sector. Their health interventions was seen as responding to the societal trends of increased obesity and diet-related NCD’s by working to improve own brand products according to Green keyhole guidelines and by inspiring customers by providing healthy recipes and through advice given in magazines, leaflets and social media. The percentage of space that different food segments (i.e. fruit and vegetables versus snacks) were given in campaign leaflets was also of concern and monitoring of this was said to have resulted in less space given to unhealthy items. This reflects an awareness that price is important in customers' decision-making, as expressed earlier by store managers, but also desire to work towards a healthy business enterprise.

Even though health was not perceived to be a big concern for the customers in the respondents’ stores, store managers perceived health to be an ongoing trend in the society. Health managers described an increased health awareness among consumers.

*Also, it has been increasing, health awareness, it has happened a lot. Since I started in 2002, it has really been developing and becoming a great issue, a big consumer issue.* – Health manager 3

Although health awareness has not yet been reflected in regulations or in sales in the respondents’ stores, it is seen as an opportunity for the future. One health manager described health as being a part of their business strategy to influence different divisions throughout the whole company. A health strategy is being put into place to prepare for the expected increase in societal demand in the future. This is also reflected in a voluntary branch project which aims to lower the salt content in food products by help of technical solutions. Health managers expressed the necessity to develop new technical solutions to decrease salt content
without affecting the product’s other properties such as taste or texture since it otherwise would affect consumers’ brand loyalty.

Food retail stores are able to support customers, and immigrants in particular, if the manager is personally motivated to do so. Health managers described health interventions to be occurring, but only in stores where the managers have this motivation. Although store managers consider health interventions to be a way of enhancing their relationship with customers, they also want to cater to the particular needs of those who shop in their store. It was perceived to be possible to conduct profitable projects, but since this is time consuming, it requires that managers are willing to work beyond the scope of their regular routines. Even though it may be economically beneficial to conduct a health intervention, this would still require an enthusiastic store manager.

*You can do it just for a good sake, how to say, a good community effort, or whatever. But, surely you can find a (healthy) product where you also will get a better profit from. If you really are determined enough.* – Store manager 5

Regarding decisions from head office or government, store managers had no problem to follow them, but it needed to consist of personal motivation for it to be successful. First, it needed to be strong driving forces in the head office in order to implement an action, second the store manager had to be motivated in order for it to have the expected effect. It was illustrated when describing earlier projects concerning health or sustainability, i.e. the business’ CSR activities. Altogether, this demonstrates ongoing efforts towards building a healthy business enterprise, but emphasises the significant role of personally motivated managers.
Discussion
This paper aimed to explore store and health managers’ perspectives on health interventions and it was found that store managers did not consider themselves to be responsible for the instigation of such interventions. Instead, they attributed this role to other actors, namely the customers themselves, the government and the food industry. It was thought to be an opportunity informing immigrants more about healthy eating but the insufficient work from the government and industry’s unhealthy and cheap products hindered this. It was also found that health is understood to be a growing trend in society and that capitalising on the trend could result in higher profits for the retail outlets. However, this belief remains a corporate imperative and has been poorly communicated to individual store managers, in the form of either directives or information.

Health interventions as a CSR activity - Intersecting circles of CSR
The results revealed public health to be a part of food retailers’ business, reflected in existing work positions for dietitians within the companies and by ongoing health interventions, although limited in scope. The results are discussed here in the terms of the Intersecting Circles of CSR presented in the background, to explore future implications for health interventions in food retail stores.

Economic domain: The economic domain can be argued to be the biggest motivator of health interventions by the attitude of other to be responsible since it is not good business to be the instigator. Store and health managers were very clear that their focus is on activities concerning their business and that their purpose is mainly to follow market trends and provide what customers demand. Store managers perceived lack of perceived profitability as a barrier of taking any initiative which can be described as lack of direct economic motives. Because the price was a concern for customers in their neighbourhood, there was insufficient customer demand for health interventions because it was perceived to be more expensive buying healthier food items. This result though support price adjustments for low-income ethnic minority groups to have a possible effect on health interventions (Abdulfatah & Jørgen, 2016). Moreover, that businesses should only have the responsibility of making profit has been voiced in previous arguments against CSR, (Carroll & Shabana, 2010).
Some motivation for health interventions was however expressed with descriptions of the desire to profile the company to also be ‘seen’ as responsible for public health. To work with CSR has been shown to strengthening satisfaction and market value from customers’ perspective (Luo & Bhattacharya, 2006) which support it being an indirect economic motive. Also, CSR work within a business has shown to be of importance when attracting new employees (Klimkiewicz, 2017) of which it can be an indirect motive in regards to strengthening their employer branding.

Store managers gave several examples of free tastings in the store as an opportunity for successful health intervention without cost to them because it enhances sales of the products and the suppliers compensate for the free tasting. It is also understood to be very popular among customers. It was described as a potential platform from which information about healthy eating could be delivered, which would, in turn, enhance loyalty from customers. Creating a platform for dialogue could also be a possible way of adapting the intervention to be cultural sensitive which has been shown to be successful for intervention targeting ethnic minority groups (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999), supporting it to be an opportunity. A successful CSR strategy is dependent on trust in order to shape an activity which in turn also enhances the firm's financial performance (Carroll & Shabana, 2010). It has also been demonstrated in an earlier empirical study that providing a social benefit also influenced financial performance by creating brand loyalty (Pivato, Misani, & Tencati, 2008). This support managers’ attitudes of the perceived benefits for free tasting. As the results show some apparent indirect economic motives of health interventions, it suggests an opportunity for future win-win strategies between stakeholders and business according to earlier studies as indirect economic motives are strengthening the full potential of a CSR activity (Carroll & Shabana, 2010).

**Legal domain:** Schwartz and Carroll (2003) described both opportunistic and restrictive compliance under the legal domain and this can also be seen in the manager responses. Regulations were seen as something positive it that they presented a motive to take action. This was illustrated in the description of wanting to have regulations to follow, described as the motive *Opportunistic Compliance*, which entails actively seek out and take advantage of a law. A previous study demonstrated it to be vital for a business to have legislation to follow in order to improve CSR activities (Williamson, Lynch-Wood, & Ramsay, 2006), which
implies a support for managers’ attitude for legislation to be legitimate for future improvement of health interventions. Whether the regulation would provide sufficient motive can only be speculated about, but the health managers seemed to perceive the legislation as an opportunity to strengthen their brand as concerned for health, to create more possibilities of motivating others in the company to work with health. Store managers also explained that legislation makes it easier for them to take action since they are forced to act with *considerations of a law*. Managers also described EU regulations on health claims and nutritional information as restrictive since this legislation decreased their possibilities of implementing more health interventions because it restricts the ability to communicate (Restrictive Compliance). The legislation’s aim is to not mislead consumers about a product’s health benefits (National Food Agency, 2017), in other words, is the effect of the legislation a subject to diverse interpretations.

Under the theme of *Working towards a healthy business enterprise driven by personal motivation*, a possible motive can be to be a preparation for future laws or societal trends (*anticipation of law*). An example of this is their work with the Green keyhole in own branded products. The market is not demanding it now but is expected to do so in the future. The government has started an investigation of the keyhole (Public Health Authority & National Food Agency, 2017), which indicates that regulation may be imposed in the future, in terms of requiring stores to carry a particular percentage of keyhole marked products in their assortment. This is supported by Carroll and Buchholtz (2009) who argue that it is better for CSR activities to be proactive rather than reactive. To anticipate, plan and initiate is less costly than reacting to social problems when they appear (Carroll & Buchholtz, 2009). The government recently tasked Public Health Authority and National Food Agency (2017) to investigate health interventions connected to diet and physical activity in society. In light of the resulting report, it is possible that food retailers anticipate more health regulations for products in the future.

**Ethical domain:** Analysing if a motive has a purely ethical dimension is difficult because one does not know whether legal anticipations and indirect economic benefits are also at play (Schwartz & Carroll, 2003). Ethical motives will, therefore, be discussed with possible implications for other domains. The significant need for personal motivation on the part of store managers was seen as a key factor by respondents for implementation of a successful
health intervention. Earlier studies support these findings by the positive impact of a motivated manager for a successful health intervention (Abdulfatah & Jørgen, 2016) and that implemented CSR activities often correlate with the personal values of the those who arrange them (Serban, 2015). One study has also shown it to have a special impact of the success in the period after the intervention have been conducted (Song, Gittelsohn, & Kim, 2011) which support this belief to be an opportunity for success in future health interventions. No direct examples of ethical motives for health interventions among store managers appear in the results. Schwartz and Carroll (2003) described the ethical domain in terms of deontological standards and consequentialist standards. In our study, none of the managers described health interventions as a food retailers’ duty or obligation (Deontological standards). However, the health managers’ examples of health interventions that had been implemented followed Consequentialist standards, as exemplified by the monitoring and changing of product distribution in campaign leaflets. Since this activity is not regulated and not communicated outwards to customers, the motive does not fit into the legal or economic domain. Health managers are aware that many customers purchase their products based on the campaign pamphlets. This creates the possibility of only focusing on the cost price, but still, they choose to monitor and influence the distribution of healthy and unhealthy food items. Yet, there could be an indirect economic motive in this activity, though quite far-fetched, in wanting to strengthen their Employer branding, entailing health concerned employees.

Wanting to provide information about healthy eating and products, can be seen as an ethical motive following Conventional standards which is codes of conduct accepted in the organisation. The majority of the food retailers in this study have positions known as Health managers in the head office and this illustrates the acceptance of working with health in the company. Store managers did not perceive themselves to be responsible for influence customers to make healthy choices, but it was accepted to be a for industry or higher levels to do that meaning public health concerns are a conventional standard. Yet, there were no conventional standards regarding food retailers’ different ways of enhancing unhealthy food purchase, i.e. affecting unhealthy purchase pattern were not seen as breaking any ethical codes of conduct. It was seen as not being their responsibility since they were left out doing what was needed for profit, lacking economic motives changing that concept of exploiting unhealthy products. Health managers’ interest in informing customers more about the health
benefits of certain products, such as the amount of added sugar, can be seen as an ethical motive following *Consequentialist standards*, that it would be a way of *doing good* for the society to inform this. However, it can also be an expression of the indirect economic motive of wanting to market their own branded products more, since they follow the keyhole criteria to a greater extent than other brands.

**Implications - Simplifying and justifying a complex problem**

The interviews revealed a strong belief on the part of managers that lack of information is the reason for unhealthy habits and that providing information is of great importance to promoting healthier eating. They believed, for example, that immigrants lacked information about how to eat healthily and had many suggestions about different ways in which this information could be communicated. They also placed emphasis on certain products, perceived as unhealthy, as a limiting factor in the healthy diet transition of immigrants.

There are many complex factors influencing eating behaviour among ethnic and other minority groups (Osei-Kwasi, o.a., 2016), but respondents did not show much concern of this. The issue of not being responsible could be seen as lack of motivators to change behaviour but also ignorance how environment affect dietary behaviour earlier reviews have shown (Cohen & Babey, 2012) (Osei-Kwasi, o.a., 2016) (Sai , 2017). The managers perceived information to be more influential which shows contradictory results compared to earlier literature. There is evidence of successful health interventions with educational efforts (Public Health Authority & National Food Agency, 2017), but then often in combination with other support. However, some of these have been seen to increase health inequality due to better effect among people with higher socioeconomic status (Lorenc, Petticrew, Welch, & Tugwell, 2013). This shows an implication for the perceived opportunity to maybe not be suitable for this context of immigrants in deprived neighbourhoods. However, it has been argued that health interventions have a greater effect among people with higher socioeconomic status only in the short-term and that the effect will even out over time. The theory of “Diffusion of interventions” explains how ideas are transmitted in the society (Rogers, 2002). Though, the descriptions of immigrants’ special diet and their lack of knowledge as explanations of their higher risk of diseases (type-2 diabetes) reflect a simplified attitude from respondents’ perspective of the complex cause of diet-related NCDs.
Store managers described certain food items that cause diet-related NCD’s and expressed the need for healthier product management. This is supported by a narrative review in which consumption of ultra-processed food items i.e. high calorie, low nutrient dense products seemed to correlate with cardiometabolic outcomes (Poti, Braga, & Qin, 2017). Healthier product development was seen as an opportunity for successful health intervention, but focusing on developing healthier products to improve the health of the target population can be questionable. The voluntary action described by health managers of reducing salt content without affecting the products’ other properties can be an opportunity for health improvement. Reducing salt intake is seen as one of the most cost-effective methods for improving health outcomes in that it can lower the blood pressure and therefore reduce the risk for cardiometabolic disease (World Health Organisation, 2016). However, improving nutrient content in products may only have a marginal effect on health outcomes of the target population since factors influencing ethnic minority group’s dietary behaviour are diverse and complex (Osei-Kwasi, o.a., 2016) and where the choice of products only would be one part.

**Methodological considerations**

The purpose of a sample selection should be to get new insights and understandings for the research question (Backman, 2010). Both the sample selection and the number of respondents must be considered for validation of the conclusion. One aspect is whether individuals who participate have a more positive attitude towards health interventions than those who do not or if they are trying to answer what is perceived as expected by the interviewer. As the results revealed attitudes which often were restrictive to health interventions, and were supported by earlier findings, the conclusion could be seen as a valid answer to the research questions.

Concerning the sample size of nine respondents, it can be discussed whether this is sufficient for a valid conclusion. In qualitative interviews, a valid sample size can be argued to be when saturation occurs within the data, i.e. no new information is revealed in the last interviews (Guest, Bunce, & Johnson, 2006). One previous experimental study demonstrated saturation after twelve interviews, however, if the respondents have similar characteristics, saturation can occur earlier. Since the sample consists of store managers from two classifications of food retail stores and within neighbourhoods of similar socioeconomic status (see method section), and the health managers had similar educational levels and occupational
backgrounds, they can be argued to have similar characteristics. The final interviews with both health managers and store managers did not reveal new information, which indicates data saturation. No systematic check-up was undertaken, which prevents the decision that the data was completely saturated, but this is considered not having a fatal influence on the final conclusion.

Regarding the analysis, Thematic analysis has been criticized as being too flexible in the sense that clear guidelines are lacking and the researcher is left with his or her own interpretation of how to capture themes from the data (Attride-Stirling, 2001). To overcome this, both Braun & Clarke’s six steps of conducting thematic analysis were followed and descriptions of how to conduct a trustworthy thematic analysis (Nowell, Norris, White, & Moules, 2017) were taken into consideration. For example going back and forth within the data and frequently rearrange groups and categories as deeper interpretations emerged. When categories had been named, the quotations behind the codes were double-checked in order to confirm right interpretation.

Using Carroll’s three-domain model of Corporate Social Responsibility in this study was very useful when conceptualising managers’ attitudes towards health interventions since it captures all relevant aspects of CSR (Schwartz & Carroll, 2003). Although, it can have its limitations assuming the three dimensions to be somewhat distinct, which can cause interpretation of a motive to be of pure economic, legal or ethical nature. By declaring the use of the model as a way to conceptualize CSR motives with implications of alternative motivations regarding the ethical domain, this interpretation was avoided.

The gender of the respondents and researcher can be an influencing factor in scientific studies (Chapman, Benedict, & Schiöth, 2018). As the sample consisted of a quite equal distribution of four women and five men, it is seen as gender not being an influencing factor for the conclusion.
Future Research

Health interventions seem to be a growing CSR activity among food retailers and this opens up many possibilities for future research. First, the customers’ perspective regarding ongoing health interventions would be of great value for developing future strategies of health interventions. Quantitative studies of the effect of such interventions would strengthen the evidence base and provide motivation for others if successful. Also, the perspective of store managers who have already conducted health interventions would provide greater insight on motivational factors for successful interventions and provide examples of how to increase awareness of health interventions in food retail stores.

Conclusion

Food retail managers’ attitude towards health interventions in food retail stores, was that the government, industry or the individual were seen as responsible to instigate further actions to improve healthier eating. The existing healthy assortment and described on-going actions in food retail sector were seen as an already active engagement in public health, shifting the role to other actors. The viewed opportunities for successful health interventions targeting immigrants were more diverse ways to convey information about healthy eating, orally through free tastings or through symbols as the Green keyhole. This together with personally motivated managers being the considerable driving force for success. The perceived limitations were incomplete direct economic, legal and ethical motives from both managers and customers, preventing managers to start voluntary actions in greater extent today.
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References


Appendix 1: Följebrev

Vill du vara med i en intervjustudie om att främja hälsosamma matval i butik?


Därmed tillfrågas butikshandelare i ett område med hög andel utlandsfödda att delta i en intervju om hur butiker kan främja hälsosamma matval. Deltagandet är absolut frivilligt och deltagare har rätt att avbryta sitt deltagande utan att ange skäl till varför.

Jag ringer upp dig inom några dagar för att fråga om du är intresserad att delta i en intervju.


Jag som utför intervjun heter Amanda Järpemo och kommer att vara den som även analyserar materialet. Vid eventuella frågor, kontakta mig gärna!

Amanda Järpemo
Epost: amanda_jarpemo@hotmail.com
Telefonnummer: 0768814499
Appendix 2: Forskningspersonsinformation & samtyckesformulär


1. Förfrågan om deltagande


2. Hur går studien till?

Totalt kommer 10-20 personer i Stockholms Läns Landsting från utvalda områden att delta i denna studie. Dessa personer kommer delta i enskilda intervjuer som kommer att vara ca 1 timme långa och kommer att spelas in. Intervjuerna kommer att hållas på en plats som vi gemensamt kommer överens om där det känns tryggt och lugnt. Sedan lyssnar vi i forskningsteamet på intervjuerna och skriver ner exakt vad som sagts under intervjun. När detta är gjort så läser vi igenom den och alla andras intervjuer och analyserar materialet. Vid behov kontaktar vi dig ifall det är något som var oklart. Allt material behandlas konfidentiellt, se nedan.

Vi planerar att undersöka butikschefers och sakkunnigas uppfattningar om att främja hälsosamma matvanor i livsmedelsbutiker, speciellt för utlandsfödda som kan uppleva det svårt med hälsosamma matvanor och som har ökad risk för sjukdomar kopplad till kosten. Under intervjun kommer jag att fråga om din uppfattning och tankar kring Axfooods roll för att främja hälsosamma matvanor och söker även efter tips om vad som
behövs för att det ska lyckas. Målet är att förstå din uppfattning om detta, vilket gör att det inte finns några rätta eller fel svar på frågorna.

3. **Innebär studien några risker och/eller fördelar?**

Eventuellt kan du uppleva obehag när du svarar på frågor som rör dina egna åsikter, dock kommer vi att se till att intervjuerna hålls på en avskild plats så att du kan känna dig så bekväm som möjligt i dessa situationer. Resultaten från studien hoppas vi i framtiden bättre ska kunna hjälpa personer att behålla en god hälsa. Du hjälper till genom att dela med dig av dina egna erfarenheter under intervjun.

4. **Hantering av data och sekretess**


Resultaten från denna studie kommer att publiceras som en eller flera vetenskapliga artiklar. Alla deltagare som är intresserade kan få ta del av resultaten innan publikation.

5. **Försäkring och ersättning**

Standard försäkring gäller.
6. Frivillighet

Ditt deltagande i denna studie är frivilligt. Om du väljer att delta då kommer du att delta i 1 intervju. Om du väljer att avbryta deltagandet av något skäl, behöver du inte uppgöra några anledningar för ditt beslut. Ditt icke-deltagande kommer inte att påverka dig negativt på något sätt.

7. Ansvariga

Meena Daivadanam - Huvudansvarig forskare för SMART2D, Institutionen för folkhälsovetenskap, Karolinska Institutet Tel: 073-712 16 87 E-postadress: Meena.daivadanam@ki.se

Amanda Järpemo – Masterstudent i kostvetenskap, Institutionen för Kostvetenskap, Uppsala Universitet. Tel: 076-8814499 E-postadress: Amanda.Jarpemo.8452@student.uu.se

Helle Mölsted Alvesson – ansvarig för implementering av studien, Institutionen för folkhälsovetenskap, Karolinska Institutet Tel: 076 3297084 E-postadress: helle.molsted-almesson@ki.se
**SAMTYCKESFORUMLÄR för studien**

**Intervjustudie om hälsoinitiativ i butik.**


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Deltagarens namn (textat):

Deltagarens signatur:

Datum:

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Intervjuarens namn (textat):

Intervjuarens signatur:

Datum:
Appendix 3: Intervjuguide butikschefer

Berätta gärna om din bakgrund av att arbeta i butik?

Vad tror du styr kunder när de handlar?

- Hur tänker ni som butik på det? Vad gör ni för att locka till köp?
- Hur beter sig era kunder, finns det några som beter sig olika?
- Upplever ni några trender? Hur tillmötesgår ni det?

En trend som jag har sett i olika affärer är att guida konsumenten att göra hälsosamma livsmedelsval, till exempel genom skyltning och olika aktiviteter om vad som är hälsosamt. Vad tycker du om det?

- Vet du om några exempel på sådana här hälsoaktiviteter?
- Vad för vinster tror du man kan få av att göra sådant?

Hur funkar det med er marknadsföring och produktplacering, bestämmer ni allt själva eller använder ni några mallar uppför? Hur mycket styr ni själva? Skyltning och var produkterna ska stå.

- Om era kunder skulle efterfråga mer hjälp att göra hälsosamma livsmedelsval, hur skulle ni göra då?
- Om du ville ta reda på vad som är nyttigt eller inte, var skulle du söka den informationen?
- Vad skulle du tycka vara svårt med att göra det?

Det finns studier att människor som flyttar till ett nytt land tycker att det är en utmaning att handla livsmedel, hitta varor och förstå vad allt innehåller. Tror du att den här gruppen finns i din kundkrets?

- Hur märker man det?
- Om någon av era kunder inte förstår svenska, vad finns det för svårigheter med det när man ska handla? Hur skulle man kunna hjälpa dem?
- Om någon av era kunder inte känner igen många av era varor och/eller inte hittar varor som känns igen från hemlandet, hur skulle man kunna hjälpa dem?
Säg att ett projekt skulle genomföras där syftet är att hjälpa kunder, särskilt nyinflyttade, att handla mer hälsosam mat. Hur skulle ni göra då?
- Vad skulle krävas för att du skulle börja med ett projekt som guidade dina kunder, särskilt invandrare, att göra mer hälsosamma livsmedelsval?
- Vad ser du för utmaningar med ett sådant här projekt?
- Hur utför man ett sådant projekt så att det blir lönsamt för alla?

Vad för projekt mer konkret skulle funka i er butik?
- Hur gör man ett sådant här projekt långsiktigt? Vad behövs?
- Om ett sådant här projekt skulle införas för att det finns en kundefråga, tror du att några skulle motsätta sig det? Varför/Varför inte?

Om vi skulle vilja utföra någon slags undersökning i eller utanför er butik, kanske även att ni skulle kunna svara på era kunders frågor, hur skulle ni ställa er mot det?
- Skulle ni vara intresserade att vara med på ett möte där olika personer från kommunen skulle diskutera problem kopplade till livsmedelshandling?
- Hur skulle du ställa dig till att sponsra aktiviteter för personer i socialt utsatta områden som behöver ändra sin diet på grund av sjukdom?
- Hur skulle du beskriva att din motivation till det är? Vad tror du påverkar den?

Vad mer skulle du vilja tillägga?
- Vilka tankar och funderingar har du om det vi har pratat om?
Appendix 4: Intervjuguide Hälsochefer

Berätta gärna hur ni startade att arbeta med hälsa och har utvecklats?
- Vad är din roll?
- Vad för projekt har ni arbetat med?
- Vad driver er att arbeta med hälsa?
- Vad har ni för mål med dessa projekt?
- Vad ser ni för vinster med att arbeta med hälsa i livsmedelsbutiker?
- Vilka utmaningar har ni hanterat?
- Vad ser ni för framtidiga utmaningar?
- Vilka drivkrafter finns det i ert CSR-arbete? Skiljer de sig mellan olika delar?
- Vad kännetecknar ett lyckat CSR-arbete?
- Hur kombinerar man lönsamhet med CSR?

Det är väldigt inspirerande att läsa om era hälsoinitiativ, varför gör ni det?
- Hur tänker ni på den ekonomiska aspecten när ni planerar ett projekt?
- Hur arbetar man med folkhälsan på ett lönsamt sätt?
- Finns det några som skulle kunna motsätta sig det? Varför/varför inte?
- Finns det några lagar och regler ni tar i beaktning inom arbetet med folkhälsan?
- Skulle ni vilja ha några lagar och regler inom arbete med folkhälsan?

Hur fungerar er kommunikation av ert arbete med folkhälsan?
- Till butiker?
- Kunder?
- Vad för olika kundgrupper kommunikerar ni mot?
- Hur tror du att olika kundgrupper svarar mot era hälsoinitiativ?
- Sverige blir alltmer multikulturellt, är det en kundgrupp ni försöker fånga in? Hur?
  Varför/varför inte?

Det finns studier att invandrare kan uppleva det svårt att komma till Sverige och börja handla livsmedel, för att de inte förstår språket och har svårt att tolka vad det är för produkter. Tror du ert företag har potentialen att stödja dessa svårigheter? Hur?
Säg att ett projekt skulle genomföras där syftet är att hjälpa konsumenter, särskilt invandrare, att handla mer hälsosam mat. Hur skulle ni göra då?

- Hur utför man ett sådant projekt så att det blir lönsamt för alla?
- Vad finns det för utmaningar med ett sådant här projekt?
- Vad tror du skulle krävas för att ett sådant här projekt skulle införas?
- Hur tror du att dina medarbetare och olika butiker skulle vara motiverade till det?
- Om ett sådant här projekt skulle införas för att det finns en kundefrågan, tror du att några skulle motsätta sig det? Varför/Varför inte?
- Hur gör man ett sådant här projekt långsiktigt? Vad behövs?

Skulle ni vara intresserade av att samarbeta med universitetet eller andra organisationer som vill arbeta för att främja hälsan hos social utsatta grupper i samhället?

- Vad är det som skulle göra det intressant för er att delta?
- Vilka utmaningar skulle det kunna finnas?
- Hur skulle man kunna arbeta med dem?
- Skulle ni kunna tänka er att samarbeta med kommun och vårdcentral i projekt som är inriktat till personer med livsstilssjukdomar?

Vad mer skulle du vilja tillägga?

- Vilka tankar och funderingar har du om det vi har pratat om?