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RESEARCH ARTICLE

Drivers of food choice in three urban communities in South Africa

Nazeeia Sayed[a*] and **Elizabeth Catherina Swart**[a,b]

[a]*School of Public Health, University of the Western Cape, Bellville, South Africa*
[b]*Department of Dietetics and Nutrition, University of the Western Cape, Bellville, South Africa*
**Correspondence: nasayed@uwc.ac.za*

Background: With South Africa's high burden of disease, increasing attention has been given to improving food environments to facilitate healthier food access. An understanding of the main drivers of food choice and barriers in consuming healthier foods can assist in the formulation of nudge strategies to improve the quality of diets consumed.
Objectives: To explore the drivers of food choice among adults in three urban communities in South Africa.
Design: Qualitative descriptive phenomenological study using focus-group discussions.
Setting: Three urban sites in the Eastern Cape, KwaZulu Natal, and Western Cape provinces in South Africa.
Subjects: Adults (male and female, 21 to 59 years of age).
Outcome measures: Self-administered sociodemographic questionnaire and focus-group discussions.
Findings: Nine focus groups with 68 participants were completed. Financial considerations, household/family factors, and shop/food retail factors were the key drivers of food choice identified. Health considerations were present, but not prevalent. Enablers of healthy food consumption included: cost, recognised health/nutrition benefits, and good taste. Barriers were unavailability, unknown preparation, beliefs, and disliked taste.
Conclusions: This study found that financial considerations, household/family factors, and the retail food environment were key influences on food choice in three urban South African communities. The research contributes to qualitative evidence on consumer perspectives in urban contexts. Recommendations include exploring retail interventions and pricing strategies to improve access to healthy foods. The study limitations include limited transferability beyond the study sites, but findings remain valuable for guiding future research and public health nutrition policy.

Keywords: barriers, enablers, food choice, healthy food, South Africa

Introduction

The food environment can be regarded as the interface between acquiring food and the broader food system that affects food consumption.[1] With South Africa's high triple burden of malnutrition, increasing attention has been given to actions to ensure a food environment that facilitates healthier food access for all citizens. To date policy action has included an excise tax on sugar-sweetened beverages,[2] regulations to reduce the sodium content of packaged foods and draft food-labelling regulations, which include proposed front-of-pack warning labels.[3] While improving the food environment is crucial, understanding consumer behaviour and drivers of food choice is also important. Blake et al.[4] define the 'science of food choice' as 'generating knowledge about causal drivers of food choice decision making processes and behavior within immediate food and social environments'. Understanding the main drivers of food choice and the barriers faced in accessing and consuming healthier foods can assist in shaping policies to create more enabling food environments.

The decision a person makes on which food to purchase, prepare, and consume is undoubtedly complex. Some of the factors that have been identified to drive food choice and dietary behaviour in urban woman in Africa encompass individual/personal factors, social/network factors, physical environment/setting factors, and macro-level environment/policy factors.[1] Food choices ultimately affect our nutrient intake, and food choices in Africa are strongly influenced by macro-level food price changes.[1] A study of Malawian mothers[5] found that, in addition to cost, taste preferences, food freshness, and healthiness were the strongest factors influencing what foods were purchased. However, emotion played a role in the decision on buying snacks for their children.[5] A study on women from Kenyan urban informal settlements found that purchasing power was the leading factor driving food choice (even trumping taste preferences).[6] However, trade-offs were often made on food affordability and other considerations, including nutrition, as purchasing a 'larger amount' of food for family consumption was more important.[6]

The objective of this study was to explore the drivers of food choice among adults in three urban communities in South Africa. A recent systematic mapping exercise identified sub-Saharan Africa as the foremost studied region globally on drivers of food choice, with quantitative studies being used in the majority of drivers of food choice studies globally.[7] Karanja et al.[7] highlighted the need for probing on food choice of specific foods instead of food as a single category, as will be done in this study. Qualitative research is recommended to inform studies on the drivers of dietary behaviour in the social environment.[1] The qualitative information in this study complements the quantitative questions on drivers of food choice in the 2022 National Dietary Intake Survey (unpublished).

Methods

Study sites

The three urban study sites described below were conveniently selected as the researchers had current projects under way, or had community contacts in these sites. The sites were:

Site 1: Worcester, Western Cape;

Site 2: Cenyu Village (outside Stutterheim), Eastern Cape; and

Site 3: Esikhawini, KwaZulu Natal.

Urban areas in this study refer to geographical and economic conditions. The study sites were all non-metro urban areas with mixed housing (informal and formal), mixed employment, and varying levels of access to services and markets.

Fieldworkers

The study employed and trained three fieldworkers, one for each study site. They were all university graduates with previous research fieldwork experience, and could conduct the research in the local language. Fieldworkers facilitated local permissions, recruited participants, made the arrangements for data collection, and completed data transcriptions verbatim and translations into English (if required).

Study participants

Sampling of participants was purposive. Fieldworkers recruited study participants through local community centres, schools, and places of worship. Adults (male and female, 21 years to 59 years of age) were invited to participate in the study. Community members who expressed interest to participate were screened and given a study information sheet. Study documents were available in Afrikaans, Xhosa, and Zulu. Inclusion criteria for study participants were that they were: living in a household with at least one other person, living in the area for at least one year, involved in food purchase, food preparation or food budget for the household, and that they had no major chronic illness or acute problem affecting their current food intake. Exclusion criteria were that a potential participant was: living alone, living in the area for less than one year, was not involved in food purchase, food preparation or the food budget of the household, and had an illness affecting their food intake.

Informed consent and ethical considerations

Participants were given information on the study and what was required from them during recruitment. The study was explained to participants again on the day of the focus-group discussion, and they were asked to read and sign the consent and confidentiality agreement form. In terms of the requirements of the Protection of Personal Information Act (Act 4 of 2013), participants gave their specific permission on personal information collected, i.e. the audio recording. No participants were identifiable in any research data collected.

Study design

The study was a qualitative descriptive phenomenological design using focus-group discussions. This design allowed for participants to share their experiences, which were then analysed as they related to the study objective, A minimum of three focus-group discussions were planned for each site with a minimum of four and a maximum of eight participants per group.[8] Participant recruitment continued until no new information emerged, indicating data saturation after nine focus groups. Trustworthiness was ensured through credibility, dependability, transferability, conformability, and reflexivity as proposed by Thomas and Magilvy.[9] A detailed description of the recruitment and data collection process is provided in this article to enhance the dependability of the data. Conformability and reflexivity were ensured by fieldworkers conducting a critical self-assessment and noting their feelings and attitudes after the discussions. Triangulation of data was achieved through fieldworker reflections and debriefing sessions with the lead researcher. To enhance credibility, the study findings were also shared with the fieldworkers to ensure alignment with their overall impressions of participants' perspectives. Potential bias was minimised through bracketing: the lead researcher did not participate in the focus-group discussions, and the fieldworkers were unfamiliar with the study's focus on drivers of food choice.

Sociodemographic questionnaire

Participants completed a sociodemographic questionnaire before the focus-group discussion. This sociodemographic profile facilitates transferability.

Focus-group discussion guide

A focus-group discussion guide available in Afrikaans, Xhosa, and Zulu facilitated the discussion. The focus-group discussion guide included open-ended questions and was developed to probe around food choice and stimulate response and discussion. Specific prompts that were included, e.g. on the price of foods, were from published literature on the main drivers of food choice. The discussion was recorded and use was made of food pictures to engage the audience during the discussion on the barriers and enablers to consuming specific foods.

Ethics approval

The Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology, and ethics of the research project (Reference number: HS22/9/3).

Pilot study

A pilot was conducted in the KwaZulu Natal site. Pilot data were pooled with the other data as no changes were made.

A token of thanks

As a token of appreciation for their time and cost of travel, each participant received a R100 (one hundred South African rand) grocery shopping voucher.

Data entry and analysis

For the qualitative data: a Microsoft (MS) Excel template (Microsoft Corp, Redmond, WA, USA) was created for verbatim transcription and translations into English. The entries were rechecked by fieldworkers to ensure credibility. The lead researcher checked and collated information. Transcripts were reread and MS Excel was used for the coding and thematic analysis. This was done following a step-wise approach proposed by Creswell,[10] along with guidance from Braun and Clarke[11] and Lester et al.[12] The coding and themes were rechecked by, and discussed with, the second researcher, who is experienced in qualitative research. This was done to ensure credibility. Codes and themes were finalised by consensus. A table with the codes is shared as a supplementary table for transparency. Direct quotes from participants were used in this research report to further enhance credibility and validity. For the quantitative data, descriptive statistics was used to describe the sociodemographic information of participants.

Data storage

Files were backed up to a University Google Drive folder. The study data will be archived in the university repository after analysis and article publication. Paperwork will be stored at the university and shredded after 5 years (December 2027).

Results

Nine focus-group discussions with a total of 68 participants were concluded. This included 22 participants in the Eastern Cape, 22 in Kwa-Zulu Natal, and 24 in the Western Cape. Group sizes ranged from six to eight. One group of nine was allowed.

Sociodemographic characteristics of the sample

The sociodemographic characteristics of the study participants are available in the supplementary file. This information provides the context of the study findings. Participants ranged in age from 21 to 60 years old (mean age: 38.6, SD: 10.7). The majority of participants were female (92.6%), 61.2% indicated they had no employment, over half (55.9%) were single, and about a third (35.3%) had completed high school. Household size ranged from 2 to 17 (mean: 5.7, SD 2.8), with 65 of the 68 households reporting children in the household (mean 2.7, SD 1.6). Around two-thirds (66.1%) of households had a monthly household income of less than R7 500 a month. The amount spent monthly on food ranged from R300 to R6 000 (mean R1 881.40, SD R1 056.67). Only 14 participants (20.6%) reported not receiving any social grant. The vast majority of participants (86.6%) made specific mention of one of the top five food retailers in South Africa as a place they purchased food from. Shoprite, Checkers, Pick n Pay, Boxers, and Spar were mentioned. Eleven participants made specific mention of the local spaza shop/tuck shop. Where a shop was given a local name, it was categorised as 'Other'. Just over half of the participants (52.9%) made use of these 'other' retailers for purchasing food.

Drivers of food choice

Participant experiences revealed rich personal detail on the various factors that affected their food choices. The 89 codes used in the analysis are available in the supplementary file. The codes were categorised into three themes: finances, household/family factors, and shop/food retail factors. The themes are not distinct and some codes align with more than one theme; however, this classification assists the presentation of the results. Figure 1 summarises the drivers of food choice found in this study. These factors include individual factors as well as food environment factors. The alpha-numeric name in brackets within quotes refers to the participant in a specific focus group.

Theme 1: finances as a driver of food choice

Participant responses revealed that the limited money they had and the cost of food was top-of-mind in their purchase and consumption decisions.

> 'In our household, we do not just buy food. Rather we check the price of each food item first to see how much it costs.' (P1_K3)

Food was not the only expense they had; they had competing financial demands for their limited disposable income.

> 'There is no money. The social grant is very small, we are dependent on it so that is why you limit yourself in buying certain things. The children also want clothes on the same social grant money.' (P2_E1)

The high and increasing food prices was acknowledged by participants, and could be limiting the types of food being purchased for consumption.

> 'Prices of food … food is expensive, expensive—as it is, you can buy big stuff like rice, mealie meal, sugar and then you are unable to buy small food.' (P1_E3)

Group responses revealed extremely price-conscious consumers who are persuaded by the adverts and specials from food retailers. Advertising and special offers from retailers are seen as a smart way to shop and participants saw it as a way to extend their budgets.

> 'We watch the specials, we live on specials, Boxer's is that, Shoprite's is that. We compare it monthly or weekly depending on what our income is.' (P1_W1)

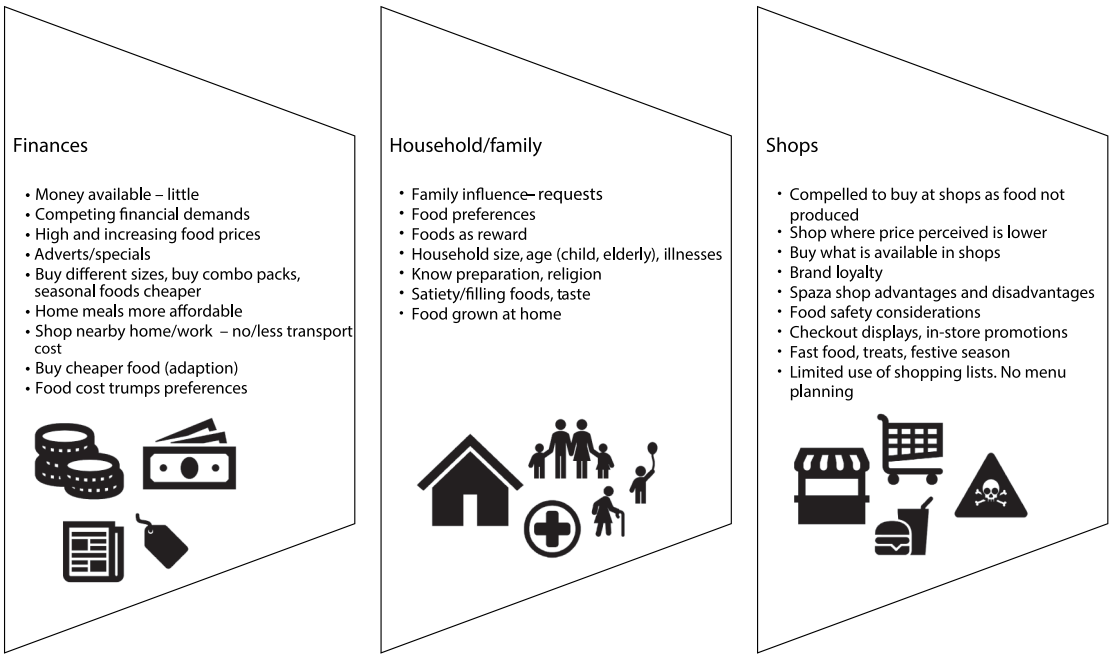

Figure 1: Drivers of food choice in three urban sites in South Africa.

Participants adapted to their limited food budget by buying smaller sizes/quantities of food they needed, and by buying combo packs of food items (which were seen as better value). Foods in season were recognised as being cheaper.

> 'Sometimes you cannot even buy the 10 kg instead you buy 5 kg because of lack of money.' (P3_E1)

Participants also indicated that they adjusted to higher food prices by choosing a cheaper or alternate food to purchase.

> 'Sometimes we buy cow tripe and intestines, chicken feet and liver because it is the cheapest food compared to red meat (beef).' (P3_K2)

Home-prepared foods were acknowledged as more affordable than buying ready-to-eat foods.

> 'In this time that is waste. For an example, I have potatoes at home, I go and buy potato chips in town—that is waste of money.' (P1_E2)

Shopping for food took place in retail stores close to home/work. This behaviour also saved money, as there was savings on transport costs.

> 'But the problem is we only have a Shoprite here and you know that going to town is another cost. So even though its cheap there in town you still have to pay for transport.' (P3_W2)

The cost of food trumped the preference for food.

> 'Sometimes I find myself consuming the food I do not like. I enjoy poultry and beef, but due to financial challenges, I eat what I can get hold of. I live with children, and I cannot afford most of the foodstuffs, and they end up eating food that I am not happy with.' (P2_K2)

Treats/snack foods were considered unaffordable, and purchasing other food (necessities) was seen as the priority.

> 'I do think about yoghurt but I cannot buy them because there is this flour that I have to buy.' (P3_E2)

Theme 2: household/family as a driver of food choice

The family and their specific food preferences have an influence on the foods purchased, prepared, and consumed in the household. One participant also mentioned religious beliefs as an influence on food choice.

> 'We do encounter such … we take turns in buying each other's preferred food items.' (P1_K3)

> 'We don't like to throw away food so you must compromise, so sometimes I don't cook the things I know they're not going to eat because maybe after two days I'll have to throw it away. That's why I don't buy it.' (P8_W2)

There were also indications of food being used as a reward for oneself or other family members.

> 'Sometimes … even if there's no money you just tell yourself that I work hard for this money.' (P1_W2)

One participant mentioned household size as an influence on the food purchased. The age of household members, and illnesses affecting family members influenced the food purchased and food preparation.

> 'Yes … we buy specific stuff like for creche like yoghurt to take to school.' (P1_W3)

> 'Yes, for an example people who drink pills for hypertension and diabetes they have to eat healthy when you buy grocery you have to think about them.' (P1_E1)

Foods that were known/familiar were an important consideration in food selection and preparation. Satiety/filling foods were also an important influencer, as well as the taste of foods.

> 'I choose food based on taste. I do not care much about the nutritional value. I buy and eat food because it is tasty.' (P1_K3)

Households that grew food indicated that these foods contributed to the family diet.

> 'My family eat from the garden.' (P2_E3)

Theme 3: the shop (food retailer) as a driver of food choice

When food was not being produced at home, participants mentioned that food purchase from food retailers became necessary. There was also mention that many foods have a short shelf life so regular shop visits were required.

> 'Some people do not have garden so it is forceful for them to go and buy vegetables, some people do not even have land to grow crops.' (P5_E1)

Participants indicated that they shopped where the perceived price of food was lower.

> 'I buy at Shoprite Hyper because it is affordable.' (P4_E3)

The availability of foods in close proximity affected consumption and what was available was purchased.

> 'It does have an effect because we do not have a shopping centre in our township … . We eat vetkoek because there is no food at home.' (P3_K1)

There appeared to be some brand loyalty among participants, which affected what they purchased.

> 'You need to be honest about the type of brand you are buying because of promotion. For example, an Ace maize meal can be on sale, but the fact is it is not of good quality.' (P3_K1)

Spaza shops had their advantages and disadvantages. They were close by and convenient, and offered items on credit. However, participants reported that they often stocked food that was 'not fresh' or 'expired'.

> 'For an example I have a credit book in Somalian shops, I have a child, I have to buy napkins so I buy Somalian food

even if it has expired because they give me on credit.' (P6_E1)

Food safety was considered in the purchasing of food.

'I care about food safety, especially the expiry date on food items … . It is probably cheaper because it has expired, and they are discarding it.' (P1_K1)

Checkout displays and in-store promotion of food items also affected food purchase.

'Sometimes, when at the till point and I happen to see cheaper items that I had not expected … my plans get distorted … .' (P2_K2)

'Yes, it does affect what you buy because if you are with a child, and they request a specific item, you end up leaving out other items in the list that you came to buy to give a child what they want because if not, they will throw tantrums.' (P2_K3)

The end-of-year festive season was noted as affecting foods purchased.

'We change the food in festive season.' (P3_E2)

There was mixed use of shopping lists and limited menu planning.

'I also write down because I usually have low budget, so I buy exactly what I need.' (P4_K1)

'Not with load-shedding [no menu planning].' (P4_W1)

Health was not a key driver of food choice

Health considerations were not foremost in the consideration of food choice in this study. These findings are still included here as this information would be of interest to readers of a nutrition journal. Health aspects were considered by some participants, and there were indications of eating certain foods to prevent illness/keep healthy, preparing food in healthier ways, and making the effort to buy fewer foods identified as unhealthy. However, other participants indicated that price and taste considerations were favoured in their food selection over health considerations.

'We mostly eat fast foods compared to foods preferred by elders.' (P3_K3)

There were differing opinions on the affordability of healthy food, with some participants mentioning that unhealthy food was cheap.

'We do not buy it that much, things that make us to buy food that is unhealthy it is because it is cheap.' (P1_E1)

Other benefits of unhealthy food mentioned were convenience, taste, and reliance on this during periods of load-shedding.

'Food that is unhealthy is very nice.' (P2_E3)

Identified healthy foods mentioned by participants included: maize meal, samp (maize), starchy food, rice, brown rice, brown bread, wholewheat bread, bran cereal, oats, sorghum porridge, pasta, vegetables, cabbage, potatoes, peppers, carrots, spinach, lettuce, green foods, salads, fruit, apples, oranges, peaches, beans, eggs, meat, lean mince, pilchards, fresh chicken, amasi (fermented milk), water, and coarse sea salt. Unhealthy foods mentioned by participants included: too

Table 1: Specific enablers and barriers of foods

Food item	Enabler	Barrier
Chicken liver	Cost: cheap Health/nutrition: protein content, good for blood, is very healthy Keeps size when cooked Liked/taste: family enjoys, like to buy already cooked	Availability and preparation: Available only in small packs Beliefs: female children do not eat liver
Peanut butter	Health/nutrition: makes children strong Liked/taste: added to green leafy vegetables and maize meal/sorghum porridge Liked/taste: enjoyed by children, used for school lunch	Taste: not liked Beliefs: causes acne Other: nut allergy
Beans	Cost: cheap Liked/taste: family enjoys Other: eaten more in winter, filling (with samp)	Beliefs: only for times when there is less money
Lentils	Cost: cheap Health/nutrition	Other: not used to the food/food is not known
Leafy green vegetables	Health/nutrition: are healthy, contain vitamins and minerals Liked/taste Other: available in the home garden	Availability and preparation: Never cooked at home
Other vegetables and fruit	Liked/taste Health/nutrition	Taste: not liked, is acidic

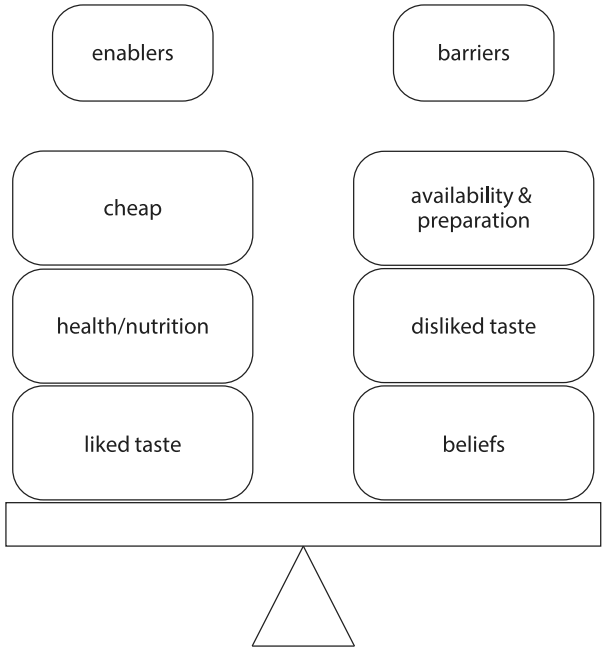

Figure 2: Enablers of and barriers to healthy food consumption.

much fats and oils, too much starchy food, too much salt, white bread, pap, fried food, chips, vetkoek (fried dough with a filling), gas/fizzy drinks, viennas (frankfurters), sausages, processed meats, fast foods, spicy food, curry powder, burgers, polony, white sugar, canned jam, baked beans, tinned food, and soup powder. Foods identified with specific health messages were: cereals, samp (maize), rice, Morvite cereal, Rooibos tea, brown sugar, apples, spinach, broccoli, fish, the Red Bull drink, and foods with the Heart Foundation logo on the packaging.

Enablers of selected healthy food consumption mentioned by participants included: cost (cheap), recognised health/nutrition benefits, and that the taste was good (food was liked). Barriers to healthy food consumption were unavailability and unknown preparation, beliefs about the food, and a disliked taste. Due to wordcount limitations the specific enablers and barriers to the probed foods, i.e. chicken liver, peanut butter, beans, lentils, leafy green vegetables, other vegetables and fruit, are presented in Table 1. Figure 2 synthesises the enablers and barriers to consumption of the probed foods.

Discussion

Financial considerations, household/family factors and the shop/food retail factors were the key influences identified in this study as influencing food choice. Health considerations were present, but not prevalent. Income and the price of food was also mentioned in 29 of the 59 models of food choice assessed by Chen and Antonelli[13] in their review on conceptual models of food choice. The SANHANES-1 study (2014)[14] identified the price of food as a key driver of food choice in a national South African sample; health considerations were third, following taste. Two recent South African studies on food choice also found that financial considerations drove food choice.[15,16]

The sociodemographic profile of urban participants in this study paints a dire picture with a high reliance on social grants, high unemployment, and little money to purchase food. Although this study's findings cannot be extrapolated to other communities in South Africa, with food inflation reported at 14% (March 2023)[17] and unemployment at an alarming 32.6%,[18] achieving food and nutrition security for many households in South Africa will be a challenge, and it is likely that financial considerations remain at the forefront in considering foods to purchase and consume. A monthly monitoring report on food prices in South Africa identified the increasing cost of core foods as a concern.[19] These 17 core foods (maize meal, rice, cake flour, white sugar, sugar beans, samp, cooking oil, salt, potatoes, onions, frozen chicken portions, curry powder, stock cubes, soup, tea, and bread[l]) are prioritised by households for purchase, and there is often no money to buy other nutritious foods like vegetables and fruit.[19] Additionally, sugar, vegetables, dairy, eggs, bread, and cereals were identified with the highest year-on-year food inflation.[20]

With regard to barriers to food consumption found in this study (i.e. food unavailability, unknown preparation, beliefs, and the disliked taste of the food), it is plausible that in a resource-constrained situation there may be hesitance and perceived risk in trying new foods that may not be appealing for consumption, thus representing money 'wasted'. Other studies have identified the lack of water and the cost of cooking fuel as barriers to cooking foods such as beans, or vegetables that needed additional rinsing.[6] Understanding these enablers and barriers gives direction to the strategies to follow when promoting the consumption of healthy foods. Practical aspects like recipes and learning how to cook tasty meals (including sampling if possible) are an important consideration. The language we use as health advocates and researchers in our communication when talking about healthy eating choices should resonate with community priorities. We may be more effective if we move away from 'sustainable diets and food systems' messages to 'tasty affordable healthy foods' and 'best value offerings for you, your family (and the planet)'.

The findings of this study support further interventions being explored in two key areas: (1) food retail store interventions that encourage healthier food purchase and consumption, and (2) pricing strategies to make healthy foods more affordable (this is in addition to other food policy actions like VAT-free foods and taxes or front-of-pack labels on food with excessive amounts of nutrients of concern to discourage consumption).

Some 86.8% of participants in this study indicated that they shopped for food at one of the large food retailers in South Africa. The top food retailers make up 80% of total food retail sales in South Africa, with the other sales coming from the informal sector and smaller retailers.[22] Targeting the retail food environment has the potential to affect many South African consumers. An NGO has initiated a campaign calling for price reduction and government subsidy to retailers and manufacturers for the mark-up of 10 foods (eggs, dried beans and lentils, tinned fish, fortified maize meal, peanut butter, rice, amasi (fermented milk), soya mince, 4-in-1 soup mix, and powdered full-cream milk). This has the potential to make these foods more accessible to poorer households.[23] Food retailers and commercial producers could use a portion of their social responsibility funds to 'subsidise' healthier food options—even if only for selected vulnerable people, such as grant holders, to obtain healthier food at a lower price. Unfortunately, a study of food retailers in Cape Town has indicated that food retail managers do not see promotion of healthy food items as their responsibility.[24]

In a 2020 report on a sustainable food system for the European Union,[25] the authors pointed out that in addition to taxes, restrictions, and guidelines, consideration should be given to other effective approaches such as nudging consumers by 'adjusting the architecture of choice'. A paper by Reisch[26] builds the rationale and argument for behaviourally informed food policy to supplement rather than substitute policy instruments such as laws, taxes, or information efforts. A critical component of food choice is the food environment, and consumers do not always make logical decisions when weighing up various criteria. Retailers and food producers yield great power in determining the foods on offer to purchase, and in the influencing tactics used to get consumers to purchase products. For example, it appears that price promotions on unhealthy foods are more common than for healthier foods,[27] and this may persuade consumers to purchase more of these unhealthy foods. A systematic review and meta-analysis of in-store interventions[28] found that consumer purchase was impacted by retail store pricing strategies, and pricing combined with promotion and prompting. Castro et al.[29] highlighted that there is much we in public health can learn from the insights of evidence-based marketing research and in-store customer behaviour. One example they cite is providing samples of healthy food in the produce section to encourage trial and taste, which can then be linked to recipes with products in other aisles. Another study[30] showed how samples encourage the purchase of

similar samples; and framing a food sample as healthy primes healthiness and leads to the selection of other healthier food items. An intervention study in Norway found that in-store interventions such as better placement, promoting healthy foods, giving discounts, and placing 'on the go' fruit and vegetable cups at the checkout positively impacted the sales of fruit and vegetables.[31] This promotion of healthy food is very different from what we typically see at checkout or pay-points around the world: a UK report indicated that close to half (43%) of foods and drinks at end-of-aisle displays, stand-alone displays, shop entrances, and pay-points were sugary foods and drinks.[32]

Alongside interventions that encourage healthy food purchase, actions to discourage the more unhealthy food promotion, e.g. price promotions on high-sugar high-fat foods like chocolates, sugar-sweetened beverages, and chips, or linked deals with savings like a pie and sugar-sweetened beverage, need to be discouraged. A UK study found that less healthy categories, such as sugar-sweetened beverages and confectionery, are promoted more frequently, and that price discounts led to stockpiling (which could increase consumption) in the already high consumption households studied.[33] Bundling (i.e. when two or more products are packaged and sold together, often at a discount) was found to be common in fast-food outlets, convenience stores at petrol stations, grocery stores, restaurants, and franchises that pair food with other services in a middle-income and lower income region of the City of Johannesburg, providing an 18% reduction in price, compared with the individual items, and a quarter of these bundles were targeted at children.[34]

This study, and the studies by Magano et al.[15] and Zembe-Mkabile et al.,[16] identify the role of spaza shops in the food economy and the appeal of the food combos offered at perceived discount prices. There is an opportunity for education and guidance of retailers on suggestions for healthier food combo offerings, e.g. removing large sugar packs and processed meat and adding vegetables, eggs, and beans instead. The cost of these interventions and buy-in from retailers needs to be assessed in South Africa. Although favourable business outcomes have been reported for retailers who engage in healthy food retail strategies, the review from Blake et al.[35] calls for the inclusion of community outcomes and retailer perspectives (not just commercial viability and customer perspectives). The retail chain involved in the intervention study in Norway signed an agreement with health authorities to increase sales of healthier products as part of their commitment, and this commitment became part of their business targets.[31]

There are many players in the food system with differing interests and varying powers to act,[25] and unless we start to work together to be innovative, the battle to improve our food system will be made more difficult. It can no longer be 'business as usual' if we want to see healthier food baskets: we need disruption through the promotion of healthier foods and less promotion of unhealthy foods. These retail efforts need to be pursued alongside other public health efforts to improve the food environment for South Africans.

Conclusion

This study found that financial considerations, household/family factors, and the retail food environment were key influences on food choice in three urban South African communities. The research contributes to qualitative evidence on consumer perspectives in urban contexts. Recommendations include exploring retail interventions and pricing strategies to improve access to healthy foods. The study limitations include limited transferability beyond the study sites, but findings remain valuable for guiding future research and public health nutrition policy.

Ethical approval and consent

The study was granted ethical clearance by the Humanities and Social Sciences Research Ethics Committee of the University of the Western Cape (HS22/9/3). The procedures used in this study adhere to the tenets of the Declaration of Helsinki. Informed consent was obtained from all individual participants included in the study.

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Supplementary data – Supplementary data for this article can be accessed online at https://doi.org/10.1080/16070658.2025.2603802.

Note

I. Many of these food items are exempt from the 15% Value-Added Tax (VAT) in South Africa. VAT free items include: brown bread, maize meal, samp (whole maize), mealie rice, rice, dried beans, lentils, legumes, fresh fruit and fresh vegetables, milk powder and dairy powder blends, maas (sour milk), canned pilchards, vegetable cooking oil & brown wheat flour (National Treasury, n.d.).[21]

ORCID

Nazeeia Sayed http://orcid.org/0000-0003-4629-5230
Elizabeth C Swart http://orcid.org/0000-0002-7786-3117

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