

## **An investigation of Victorian municipal public health plans for strategies that alleviate food insecurity- a qualitative case study**

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### **Abstract**

Access to safe nutritious food is vital for health, however many Victorians are food insecure. This study aims to explore whether Victorian Municipal Public Health Plan (MPHP) documents include strategies to reduce food insecurity and to understand how the process of local government planning may impact on the inclusion of strategies within these high level plans. A case study of three Municipal Councils in Victoria, Australia employed two data gathering methods: (1) MPHP documents were critiqued to assess decisions made regarding the inclusion of FI within the MPH plans; (2) Qualitative interviews with Local Government Authority (LGA) staff were conducted to establish what the barriers and enablers for the inclusion of strategies to support food security were. LG organisational culture, structures and planning processes, workforce capacity and access and utilisation of evidence all impacted on whether strategies to reduce food insecurity were included in MPHP plans. The findings indicated that greater direction is needed from state government regarding strategic planning approaches that build a more cohesive planning environment. Interventions that focus on organisational culture and capacity to support evidence informed, integrated MPH planning are required to enable strategies that promote food security at local government level.

### **Keywords:**

Food insecurity, health planning, healthy public policy, public health, local government, evidence informed decision making

## Introduction

Regular access to safe nutritious food is vital for health, however as many as 300,000 Victorians are regularly at risk of being food insecure (McCaughey Centre for Community Wellbeing, 2014). The term food insecurity (FI) can be described as not having regular or certain access to safe, nutritionally adequate and culturally appropriate foods (Burns, Jones, Frongillo, 2010; Vichealth 2005). FI is associated with poorer physical health outcomes, particularly in both children and elderly populations (Ramsey, Giskes, Turrell & Gallegos, 2012) and can increase the risk of conditions such as cardiovascular disease, obesity and diabetes (Gowda, Hadley & Aiello, 2012; Pan, Sherry, Njai, Blanck, 2012; Seligman, Jacobs, Lopez & Tschann, 2012). In addition, FI can impede the successful management of these chronic illnesses (Bengle, Sinnett, Johnson, Johnson, Brown & Lee, 2010; Seligman, Jacobs, Lopez & Tschann, 2012), augment the risk of mental ill health and may compromise psychosocial functioning (Hamelin, Beaudry and Habicht, 2002). These potential negative health and social impacts can result in a significant burden not only on individuals and families, but also across the wider community.

The definition of FI implies individuals should not have to rely on acquisition of food through socially unacceptable means such as food banks or other Emergency Food Relief (EFR) services. However, EFR programs are common approaches used to support individuals and families experiencing FI (Furber, Quine, Jackson, Laws & Kirkwood, 2010). In Australia, the demand for EFR services is rapidly increasing, with over 500 such community food programs (CFPs) currently operating in Victoria alone (FareShare, SecondBite & VicRelief, 2011). A recent study found that Victorian CFPs were able to provide only 66 per cent of the food required to meet the demands of their local communities (FareShare, SecondBite & VicRelief, 2011). Whilst CFPs can provide positive health and social benefits to clients (Furber, Quine, Jackson, Laws & Kirkwood, 2010), they are largely reliant upon a voluntary workforce and food donations. Thus, EFR programs do not provide a sustainable solution to this public health issue (Wood, 2012). To develop strategic answers to this complex situation, the current reliance on EFR needs to be strengthened by policy and food system planning to not only improve EFR coordination, but to create supportive environments that enable individuals to obtain a regular supply of fresh healthy foods in more socially acceptable ways (Burns et al., 2010; ).

Understanding and acting on the number of underlying social determinants of FI is important to enable the development of environments where nutritious food is readily accessible and affordable for all community members. Social determinants that have been identified as barriers to food security include poverty, inadequate housing and transportation access and other forms of social disadvantage (Foley, Ward, Carter, Coveney, Tsortos & Taylor, 2009; Walker, Keane and Burke 2010). In Victoria, the financial barriers to healthy food that are experienced by many vulnerable groups have worsened in recent years. For example, increasing food prices coupled with rising housing prices (Australian Housing and Urban Research Institute (AHURI), 2011), pharmaceuticals and utility costs (Australian Competition and Consumer Commission, 2011) in combination with reduced social safety nets (Phillip & Nepal 2012) have made it difficult for low socio economic status (SES) groups to readily access nutritious food. This was emphasised by a recent study which found that the cost of a healthy meal plan equated to 47 per cent of disposable income for welfare dependant families compared to only 16 per cent for average income families (Landrigan & Pollard 2011).

Whilst levels of community FI continue to rise in Victoria, Local Government Authorities (LGAs) are well placed to create opportunities to develop better food access. In doing so, LGAs need to consider what strategies can be established and incorporated in the development of MPHPs to alleviate FI at a local government level. This requires a systematic approach whereby strategies to support food security at the individual-level are employed in conjunction with those

aimed at improving community capacity and upstream policy and environmental interventions (Pomerleau, Lock, Knai & McKee 2005; Slade, 2009). Local government sits in an opportune position to implement this systems approach and combine top-down policy interventions with integrated, locally relevant, individual-level interventions, influencing the determinants of food access and availability (Sacks, Swinburn, Lawrence, 2009; Yeatman, 2009). The close links that exist between local governments, local stakeholders and the community, as well their legislative authority and obligations to develop and implement locally applicable policies and plans, provides potential for a coordinated approach to food security.

Although Australian local governments are becoming increasingly involved in food and nutrition activities, the degree of involvement remains highly varied (Yeatman, 2009). Strategies have traditionally focused on supporting short-term relief activities such as food banks and soup kitchens or individual capacity building strategies involving community education and training strategies (Slade, 2005; Lawton, 2011; Montague, 2011). There is opportunity for action given the community level in which local governments operate, however current involvement through planning and policy development, to support the redesign of local food supply or determinants of food access, appears to be limited (Lawton, 2009; Allendar, Gleeson, Crammond, Sacks, Lawrence, Peeters, Loff & Swinburn 2012). Understanding why this is so, is important in order to achieve future changes in local food systems, hence investigation of process regarding consideration of FI at local government level is necessary.

### **Victorian policy and planning context**

Victorian local governments have been required to develop Municipal Public Health Plans (MPHPs) since 1988 with the *Public Health and Wellbeing Act* in 2008 formalising the responsibility of local governments to apply a public health approach in their planning. This revision mandates that council “seek to protect, improve and promote public health and wellbeing within the municipal district’ (*Public Health and Wellbeing Act 2008*). This new legislation identified a need for LGAs to not only protect the population from infectious disease but also promote the conditions in which persons can be healthy through supportive built, social, economic and natural environments (*Public Health and Wellbeing Act 2008*).

The revised act strengthened the requirements of local government public health planning through the inclusion of new key principles, which include utilisation of evidence, community consultation and evaluation (*Public Health and Wellbeing Act 2008*). The act also specifies clear functions of council for improving and promoting public health, including creating environments supportive of good health, managing public health planning at the local level and facilitating and supporting local agencies whose work influences public health and wellbeing (*Public Health and Wellbeing Act 2008*).

As a result under the new act each LGA must develop a MPHP within the period of 12 months after each local government general election. In doing so LGA plans must demonstrate examination of data about the community health status and their determinants, provide opportunities for involvement of people in the local community during development, implementation and evaluation of the plan, as well as specify how the council will work in partnership with the Department of Health and other agencies to implement initiatives, projects and programs to accomplish the objectives of the plan. When developing the MPHP documents, LGAs are required to use the *Environments for Health* framework, which is underpinned by a social determinants approach. As such, MPHPs provide an ideal mechanism for strategic actions to be developed and principles incorporated into local government policy and planning schemes to ultimately improve local food access and availability (Allendar et al. 2012).

Development of MPHPs is a relatively new task for many local councils, with staff facing challenges in prioritisation, planning and implementing interventions within a climate of increasingly scarce resources (Brackertz, 2013; Pricewaterhousecoopers 2006). Although capacity for strategic planning has been growing in local government across Australia (Prior & Herriman, 2010), staff required to formulate MPHP documents face difficulties such as inexperience, competing values, rationalities and access to evidence during the complex development process (Howlett, 2007; McDougall, 2007).

Currently there is little known in regard to how well Victorian local governments have incorporated strategies within their MPHPs to improve access and availability of healthy foods within their local community. Furthermore, there is little information on the process undertaken by local government organisations when developing their MPHPs and how this influences the inclusion of various strategies and objectives that may impact upon FI. Therefore, the aims of this paper are to 1) identify the degree in which the MPHP documents include food insecurity as an issue and set out key objectives and priorities to reduce community food insecurity, and 2) give insight into why objectives or strategies to support a reduction in FI were or were not included within MPHPs.

## **Methods**

A qualitative embedded case study approach provided a framework in which to investigate the MPHP development process of three LGAs in Victoria and how process and decision-making contributed to, or prevented strategic action on food access and availability to be incorporated into MPHP documents. An embedded design, was selected as opposed to a single case study, as it allows subunits of analyses may be incorporated so that a more complex design is developed (Yin 2003).

The case study also involved a two-stage process. In stage one, MPHP documents were reviewed to identify if they included statements of issue identification, as well as any objectives or strategies relating to FI. Stage two involved qualitative interviews with staff from the three LGAs to develop an understanding of the influences surrounding the inclusion or omission of FI objectives or strategic actions.

The MPHP documents were accessed from each LGA website and were imported into the qualitative analysis NVivo9® software to facilitate document analysis. This involved looking for content that identified food insecurity as an issue, as well as any content relating to objectives, strategies or actions to reduce community food insecurity.

To understand the process of MPH plan development within each LGA, three qualitative semi-structured interviews were conducted in 2011, with Key Informants (KI) from differing Victorian LGAs. The data from the three sites; interview and document findings make up this case study example.

Ethical approval to conduct the research was provided by Deakin University Human Research Ethics committee. KIs were recruited through the local government Chief Executive Officers who were asked to provide organisational consent for participation in the study. To be eligible to participate in the interviews, individuals had to have played a significant role during the process of developing the councils' most recent MPHP, such as social planners or strategic planners. In order to meet ethical standards set by Deakin University, anonymity of participants was provided. This was to prevent any potential participants recruited into the study feeling coerced to participate, or to mitigate any risk to the participants in regard to the data they provided

influencing their existing workplace relationships. Hence, the names of the local government sites are not provided to protect confidentiality of participants.

The face-to-face interviews were audio-recorded and conducted in a safe, neutral location, nominated by the participant. All interviews were transcribed verbatim and were presented to participants who then had an opportunity to review and reflect upon the interview content, to ensure accuracy and enhance validity (Green, Willis, Hughes, Small, Welch, Gibbs & Daly, 2007; Mays and Pope, 2000). As part of the analysis process, the audio files were listened to and the revised transcripts were reread to allow greater familiarisation with and immersion in the data (Morse, Barrett, Mayan, Olsen, Spiers, 2002). Transcripts were then inductively analysed using NVivo9® software. This involved reducing content through a process of coding, categorisation and identification of themes (Creswell 2007; Green et al. 2007). Data gathering and analysis was conducted in a concurrent and iterative manner, whereby initial interpretations from stage one were utilised to inform the subsequent data collection and analysis phases. This inductive approach was considered appropriate given the studies exploratory nature and the case study method employed (Blignault & Ritchie, 2009; Stake, 2000). In addition, it is important to note that an interpretivist perspective was used throughout this process, whereby the examination of people's lived experiences and perceptions of reality appreciates the context (Denzin & Lincoln, 2011). This is also shaped by the researchers experience and worldview (Denzin & Lincoln, 2011).

### **Case selection**

The time and resource allocations of the project limited the research to three LGA cases studies. Ensuring balance and variety of cases was pertinent, for 'natural generalisability'; to give the greatest opportunity for learning (Stake, 2000). As such, a purposive sampling method, based on key demographic characteristics was used to select three LGAs. The initial pool of municipalities was based on evidence of moderate to high demand for food relief, which was ascertained through the Victorian based food relief agency SecondBite (Lindberg, R. 2011, oral communication, 2 June 2011). From this initial group, LGAs were selected to ensure adequate diversity of demographic characteristics such as total population, age distribution, cultural diversity and socio-economic disadvantage.

Local Government Area one (LG1) was a suburban municipality with a large population and with a high demand for community food relief (Lindberg, R. 2011, oral communication, 2 June 2011). This largely reflected the heightened social disadvantage experienced within the locality. LGA two (LG2) was a large peri-urban municipality experiencing significant regional population growth. LG2 rated better than LG1 in terms of overall social disadvantage according to national datasets. The final case, (LG3) was a small suburban population with significantly higher average wealth and less social disadvantage. LG2 and LG3 also had reportedly high demand for community food relief (Lindberg, R. 2011, oral communication, 2 June). The municipalities had similar median ages, with LG3 being slightly older (median age of 40 years) than LGA 1 and LG2 (median age of 35 years). LG2 had significantly high levels of multiculturalism with 56 per cent of the population born outside Australia compared to LG1 and LG3 which had rates of 22 and 18 respectively. Table one provides a summary of the characteristics for all the LGAs selected for inclusion.

**Table 1:** Population characteristics of included Local Government Areas

Municipality	Population Number	Geographical area (sq/kms)	SEIFA index <sup>1</sup>
LG1	90000	25	1060
LG2	125 000	120	900
LG3	200 000	1000	995

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<sup>1</sup> The SEIFA index is a an indicator for Socio-economic Indexes for Areas and is a summary measure of several socio-economic conditions within an area. It Incorporates measures of: relative socio-economic disadvantage, relative socio- economic advantage and disadvantage, economic resources, and education and occupational status ABS. The lower the SEIFA score the more disadvantaged is the community (ABS, 2013)

## Results

### ***Food insecurity content within MPHP documents***

There was a varying degree of strategic action upon FI across the LGAs. Examination of the MPHP from LG1 uncovered content that clearly addressed FI. There was a clear definition of FI and how this issue translates to suboptimal nutritional and health status, as well as providing recent data on the prevalence of FI experienced across the municipality. Furthermore, the document contained a strategic objective to improve the availability and affordability of healthy foods, particularly for disadvantaged populations. It also contained an extensive range of broader goals and strategies or actions, which could support the underlying determinants of FI.

For LG2 healthy nutrition was a priority within the MPHP with a strategy related to enhancing food access through community development, licensing and regulation or land use and urban planning. In addition, the plan contained objectives associated with the enhancement of local fresh food production. However, the MPHP document did not contain any explicit reference to the term FI nor was there any supporting content within the document that recognised other potential underlying factors of poor nutrition, such as low income, limited education and social isolation.

The MPHP from LG3 recognised FI as an issue for a small proportion of residents. LG3's plan included data on the levels experienced within the community, as well as, a statement reporting a funding allocation to a local community organisation which, amongst other material support, provided food vouchers to vulnerable community members (although the percentage of this funding used to support FI strategies remained unclear). The document did not contain any objectives or strategies relating to food access, food availability or affordability.

All the three MPHP's, developed by the LGAs, did have a strong focus on supporting the social inclusion for community members, as well as, listing a number of strategies to improve the built environment in terms of public transport and the use of public space, all of which are determinants of FI. However, there was significant scope within MPHP to draw on affordability and availability of nutritious foods to support the most vulnerable community members, but such areas were not discussed in any of the municipal plans critiqued.

### ***Influences on the inclusion of food insecurity within MPHP documents***

The next section discusses the key themes to emerge from the qualitative interviews with LGA practitioners. Highlighted are the enablers on MPHP decision-making regarding the inclusion of food insecurity strategies to tackle the issue in the local communities.

### ***Access and utilisation of evidence***

Access to local evidence that identified the social health issues within individual municipalities was a pivotal barrier to the effectively examining FI during the planning process. Practitioners relied heavily on general health status data, such as, the Victorian Population Health Survey (VPHS) and Community Indicators Victoria (CIV) data sets.

*More and more we are actually relying on the population health survey data....as you know it was only recently that the Victorian Population Health Survey (VPHS) went down to a local government level, so prior to that we, along with a lot of other local councils, weren't quite sure how the state wide and the south-eastern area data how fit with us... So we have just basically used the data through Community Indicators Victoria.*

*[Key Informant (KI), LG1]*

*We found that we don't really have good local evidence. So that's where we have been working in the last couple of years is to try and get the local evidence.*

*[KI, LG2]*

Evidence from these sources formed the basis of the initial health priority identification process, provided information to support community consultation activities and was used during strategic decision making discussions with councillors. However, such data sets are limited in understanding the nature of complex public health issues. For example, information regarding food security from these data sources is drawn from one question: “Have there been any times in the last 12 months when you ran out of food and could not afford to buy more?” (McCaughy Centre for Community Wellbeing, 2014). Informants suggested that this epidemiological measure did not allow a deep understanding of population groups within their community who are at greater risk. Nor do these measures provide any information on the possible causes or consequences of FI for these individuals. As such, a lack of detail regarding FI creates a significant barrier to prioritising FI, as well as, for identifying appropriate mitigation strategies to include within the MPHPs. This finding supports existing advocacy calling for more comprehensive data collection on both individual and community food security in Australia (Moore 2011; Innes- Hughes, Bowers, King, Chapman, Eden 2010; Budge & Slade 2009). Specifically, a Victorian community data set would be helpful in ascertaining the specific barriers to nutritious food in Victorian municipalities to help identify locally relevant strategies to act upon these.

It is important to consider the different forms of evidence and application within the planning process. Evidence and how it relates to public health planning has been described using three categories; type 1: descriptions and analysis of determinants of health and disease and their distribution across the population. In Victoria, type 1 evidence primarily used by local government authorities is in the form of the aforementioned VPHS or CIV epidemiological data; type 2, refers to the assessment of intervention options for those most effective in changing health outcomes or risk factors; type 3: Assesses interventions which are best implemented in a given context to achieve the desired effects (Skovgaard, Nielson & Aro 2007).

When asked about the use of evidence or data for strategy development, LGA informants referred only to type 1 evidence in their priority decision-making process, thus, missing information that considers what interventions have been demonstrated to be most effective and for whom. This may have been due to the informants playing a lesser role in the planning for selection and implementation of strategies, hence, tending to focus on the prioritisation process only. Given the lack of discussion of evidence of effectiveness, it remained unclear as to whether only issues with developed and implementable solutions were more likely to be prioritised. Irrespective of the influence on priority setting, given the critical role that intervention selection plays for achieving intended outcomes, this finding is salient and supports continued advocacy for the development and trial of interventions that support the increased use of evidence of effectiveness within the local government setting (Armstrong, Waters, Dobbins, Anderson, Moore, Petticrew, Clark, Pettman, Burns, Moodie, Conning & Swinburn 2013; Armstrong, Prosser, Dobbins & Waters, 2010; Thomas, Hodge & Smith 2009; Pettmann, Armstrong, Pollard, Evans, Stirrat, Scott, Davies-Jackson, Waters 2013; Petticrew, Platt, McCollam, Wilson, Thomas, 2008).

### ***Capacity to apply an integrated planning approach***

Informants also identified that LG organisational culture and structures influenced the extent to which an integrated approach to planning and development of the MPHP was achieved. In particular, barriers to effectively engage stakeholders across the various departments of council were experienced by informants, limiting stakeholder involvement or discussion of the lived experiences of individuals and populations groups within the LGA, regarding FI.

An integrated planning approach was evident when support from organisational leaders meant that departments outside of the community and health directorates were receptive to initial communication and continuing engagement in the decision-making process throughout MPHP development.

*We ran focus groups with the departments across council in the initial phase... to identify priorities... and to set the priorities... and get their buy-in and input. Then personally I went to each of those areas and sat down with them and helped them develop an action plan, I wrote it up, sent it back to them, got them to review it, got them to put in performance indicators and timelines, identify whose responsible... and then from there... we held another focus group to get people to once again have a look at it, to make sure they are aware of the objectives particularly the ones that relate to them... make sure they were still on track and that their actions were still viable... So pretty much all of the team leaders and managers whose work relate to what's in here [referring to the MPHP document] were involved from the very start.*

[KI, LGA 2]

If senior management were not encouraging however, this led to difficulty in gaining input from areas of council integral for tackling the broader issues of food access and availability.

*I invited all departments pretty much... the people who wanted to come, and did come, were your classic Youth Services, Aged Services, Social Services, pretty much, like the Social Development Department...we got less representation from Planning Development and less representation from the City Works which is the waste management, transport and parking development... So of the really the traditionally blokey areas there's less attendance.*

[KI, LG1]

*So I'd like to see maybe a more cohesive approach across council... Whilst the environmental health department are involved, which is fantastic, there's other departments in council that would be really good to be involved in it but I haven't found a way to get there yet.*

[KI, LG3]

Although the above passage demonstrates an important ideological shift in that the practitioner identified the importance of using an *Environments For Health* approach, it does highlight the challenges in implementing this integrated style of planning. Therefore engaging senior management across departments is critical to ensure buy-in from various planning, transport and economic department staff whose work relates directly to food access. This adds to previous research that has highlighted senior management support as critical for achieving interdepartmental collaboration for successful MPHP development (Thomas, Hodge & Smith, 2009; Davey, 2006) and is despite the relatively recent legislative changes that require local governments to use an integrated *Environments For Health* approach to MPH planning. As such legislation in this case may not be enough, but rather, in some cases, strategies are also needed to ensure LG senior management recognise MPHPs as an important tool within council policy and planning and support cross-organisation participation (McBride & Hulme 2001).

This may also be a reflection of broader issues experienced by local governments in terms of resourcing capacity and systems to support high level strategic planning (Tan & Artist 2013). The historical context of local government within the Australian federal polity and recent increase in roles and responsibilities for local government in planning and service provision, which arguably have been unmatched by concomitant increases in financial capacity, may in part explain, this limited workforce capacity and support for integrated strategic planning, even when leadership is supportive (Brackertz, 2013). Therefore, these findings may also indicate the need for interventions to optimise organisational capacity, culture and systems to support integrated planning (Armstrong et al. 2013; Pettmann et al. 2008).

### **Organisational culture**

Organisational culture also influenced how food and nutrition issues were situated politically. For example, a more traditional organisational culture evident at one LG, which considered public health activities to be broader than the local government remit, hindered the inclusion of food access and availability strategies into their MPHP.

*...some of these staff have been here for twenty years and they started working when health was considered quite different. The traditional thought is that health is all about clean water, and of course it is about clean water you can't argue with that but I had to say that it is also the environments for health and it's all interlinked.*  
[KI, LG1]

Another example of this was given when an informant stated that council wanted to “...do the right thing by all of the rate payers” and as a result was careful to consider “...things that that might sit well with [the] community” [KI, LG1] during the strategic decision making process. As such, they emphasised that either senior council staff or the broader community would need to first consider food security as an issue before it could justifiably be included as a priority in future strategic plans:

*... if a councillor got behind it [food security]... if a councillor said “what are we doing about this [be]cause it looks like a real issue” that would probably, that might spark [action]... the issue speaking to people is probably the important thing.* [KI, LG3]

These findings suggest that although food security is becoming increasingly acknowledged as an issue within the Victorian context, more advocacy is needed to increase the community's awareness and to gain councillors and senior executive support for action upon this issue. This is consistent with previous research that found real or perceived community needs are perhaps the strongest drivers of local council policy change (Allendar et al. 2012). Described by de Leeuw (2007) as cultural rationality, this reflection of values, ethics and what is perceived social opinion is argued to be most crucial for priority setting in local government.

### **Networks and partnerships**

Community networks were also vital to enhance MPHP development, for both increasing local council awareness of food security as an issue and by providing resources to local government in regard to how this problem may be mitigated. For example, differences the perception of the severity of FI within the community were evident despite the measured incidence of FI and demand for food relief being similar for the three municipalities.

All key informants acknowledged their regions Primary Care Partnerships (PCPs) or the Food Alliance<sup>2</sup> as being both an important information source and/or a facilitator for the development and implementation of strategies to support food security. Similarly, the Municipal Association Victoria (MAV) and the Victoria Local Government Association (VLGA) were also identified as being important for providing information in regard to FI. Working with food systems stakeholders such as these better-enabled practitioners to identify efficacious food security interventions to suit local contexts and integrate these into the MPHPs. This adds to evidence that encourages local governments to engage with community partnerships and alliances for the enhancement of public health activities (Thomas et al. 2009, de Leeuw 2007).

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<sup>2</sup> The Food Alliance is a partnership network between the local government and various charitable organisations including food rescue and emergency food relief providers, as well as broader community based organisations.

Informants also generally perceived the role of local government as being the facilitator of new and existing community networks and as communication channels across the local community.

*We decided that council itself cannot do a lot of the implementation. It actually has to come from agencies and people who are actually working with the people who are food insecure ... So that [having the food alliance network] has been really good [be]cause it has enabled these people to go off and do these things... to work on those areas.*

[KI, LG3]

Whilst it is important for local governments to work with and enhance networks and partnerships, their involvement at a higher policy level is essential. With the literature suggesting that urban and strategic planning mechanisms have the greatest potential to influence food access, availability and affordability (Montague 2011; Allendar et al. 2012; Enns, Rose, de Vries & Hayes 2008; Pretorius, 2008).

## **Discussion**

This case study demonstrates that there was variation in the identification of FI as an issue within Victorian Local Government Authorities. There was also a discordant degree of inclusion of objectives and strategies to reduce FI across the local government areas included in this embedded case study. To our knowledge, this is the first study to examine Victorian local government Municipal Public Health and Wellbeing Plans for content related to food insecurity. This is also the first study of how the MPHP planning processes influenced inclusion and prioritisation of food insecurity within MPHP planning documents.

The case study illuminated a number of planning process influences' upon MPHP development, which impacted whether FI was included as a priority by the local governments in these strategic documents. These influences were: access and utilisation of evidence, capacity for integrated planning, organisational culture and networks and partnerships. Whilst there are no known studies, specifically focused on local government MPHP planning decision-making and food insecurity, there have been two studies of local government planning or policy within the area of healthy eating more broadly (Allendar et al. 2012, Yeatman, 2003). The findings herein support Yeatman's study (2003), which found evidence and organisational factors as important influences of local food and nutrition policies. The other by Allender and colleagues (2012), found leadership support, political ideology and external groups as the key influences on local policy decision making (although this study looked at both healthy eating and physical activity policy decision-making).

The results do also support a growing body of literature internationally, exploring the influences on various policy development processes (at local, state and national levels) and how these impact upon the inclusion strategies focused on healthy eating or nutrition (Craig, Felix, Walker & Phillips 2010; Freudenberg, 2015; Mosier, 2013; Quinn, Johnson, Krieger, MacDougall, Payne, & Chan, 2015; Ulmer, Rathert, Rose, 2012; Yeatman, 2003). Many of these studies have identified organisational factors (Craig, et al. 2010; Freudenberg, 2015; Mosier, 2013; Quinn, et al. 2015; Ulmer et al., 2012; Yeatman, 2003), access and utilisation of evidence (Quinn, et. al, 2015; Yeatman, 2003;), and the role of networks and partnerships (Freudenberg, 2015; Craig, et al. 2010; Mosier, 2013; Quinn, et al., 2015; Ulmer, et al., 2012) as critical to food and nutrition being included in government policies or plans. These studies also, however, found other factors such as political ideology, personal values and beliefs and issue framing as critical (Craig, et al. 2010; Freudenberg, 2015; Mosier, 2013; Quinn, et al. 2015; Ulmer et al., 2012; Yeatman, 2003).

Therefore, future studies focusing on food insecurity policy or plan development may benefit by exploring the role of such factors in decision-making.

This study has a number of limitations. As a qualitative case study, this research may be questioned in regard to the ability to generalise the findings beyond this context. However, given that the case study context is provided, the learning's outlined herein may be amenable to 'naturalistic generalisation' (Yin, 2014). It must also be acknowledged that data was collected following a time lapse between when the strategic planning process undertaken by those involved was carried out and the conducting the interviews for this case study. This may have resulted in recall bias (Patton, 1999). Furthermore, the study investigated only the content of the MPHPs not the strategies currently being implemented at each council. This is important to consider, given that it has been noted that opportunity exists for enhancement of local government processes not only developing, but also for, delivering these high level plans (Tan & Artist 2013). Furthermore, the study did not look at associations between the inclusions of FI objectives and strategies in MPHP documents and the impact of these on community levels of FI. This was beyond the scope of this study but is recommended that future research be undertaken to examine the association between government strategic priorities and changes at the community level.

A number of strategies were employed to help enhance the reliability of the study, including use of an immersive analytical process (conducted by BC), which involved continuous reflection, and self-conscious data collection, analysis and interpretation (Mays & Pope, 2000). In addition, the use of purposively sampling of interviewees, who were given the opportunity to view transcripts for accuracy, as well as, the studies use of verbatim quotes which allowed direct access to respondents' views, increases the trustworthiness of findings (Hannes, 2011). As such the case study presented provides authentic examples of current Victorian local government MPH planning processes and the implications for strategic action upon FI.

## **5. Conclusion**

This qualitative case study of Victorian MPH planning found numerous underlying factors influenced the ability of local government practitioners to formulate strategic actions upon FI. These included an unmet need for comprehensive and meaningful data on FI, inadequate access to, and utilisation of evidence of effectiveness, as well as organisational culture and systems that limited an integrated approach to plan development. The study provides important insights for policy makers and practitioners working to influence local public health planning in support of food insecurity. In particular, the findings suggest that the development of systems to support access to and utilisation of evidence, as well as to enhance policy networks and partnerships may assist in food insecurity being incorporated into local government MPHP priorities and strategic actions.

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