MJA
The Medical Journal of Australia

Appendix 1

This appendix was part of the submitted manuscript and has been peer reviewed.
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Appendix to: Elliott T, Trevena H, Sacks G, et al. A systematic interim assessment of the Australian Government's Food and Health Dialogue. *Med J Aust* 2014; 200: 000-000. doi: 10.5694/mja13.11240.

Appendix 1 – The application of the RE-AIM evaluation dimensions to assessment of the Food and Health Dialogue

Dimension	Description	Proposed application to assessment of the Food and Health Dialogue
Reach	Proportion, and representativeness of the target population that participates in the intervention	Fraction of Australian population exposed, as consequence of Dialogue activities, to: • Consumer nutrition education • Foods with better nutritional profile • Foods of standardised portion size
Efficacy	Extent to which the program has delivered outcomes in the target population	Changes in average population levels of: • Knowledge, attitudes and behaviours related to nutrition • Consumption of saturated fat, added sugar, sodium, energy, fibre, wholegrains, fruits and vegetables • Levels of blood lipids, blood pressure, diabetes, obesity • Rates of cardiovascular diseases and cancers
Adoption	The degree to which the necessary settings have been engaged in the program	The proportion of Federal, State and Territory governments and food businesses that, as consequence of Dialogue activities, have been engaged in the development of: • A framework for collaboration • Community-wide nutrition education activities • Target setting and action on the reformulation of foods • Efforts to standardize portion sizes
Implementation	Extent to which the intervention actually has been implemented as intended in the real world	Determined on the basis of evidence of actions implemented as a direct consequence of Dialogue activities: • Number of community-wide nutrition education programs rolled out • Proportion of restaurant and processed foods reformulated to better profiles • Change in average nutritional quality of the food supply • Proportion of restaurant and processed foods conforming to standardized portion sizes
Maintenance	How the program is sustained over time and how it is evaluated at the individual and organizational level	Initiatives, implemented as a direct consequence of Dialogue activities, designed to enforce and sustain the interventions and objectively monitor their effects on proximal and distal outcomes: • Enforcement activities • Monitoring programs • Reporting and evaluation strategies

Additional explanatory notes

Reach - refers to the proportion, and representativeness of the target population that participates in the intervention. In the context of the Dialogue, *reach* has been assessed in terms of the extent to which the Dialogue actions have affected the Australian population as a whole, recognising that every Australian eats some processed or restaurant food, and the great majority have a diet that substantially deviates from the optimum recommended. Assessment of *reach* has been done by examining the scientific literature to define the nature and extent of diet-related ill health in the Australian population, cross-referencing the Dialogue activities and objectives against the main issues identified, and then making a determination as to the extent to which population coverage has been achieved by Dialogue programs. Population exposure to education about diet, foods with standardized portion sizes, and foods reformulated to healthier compositions has been the focus of this aspect of evaluation.

Efficacy – describes the extent to which the program has delivered the intended outcomes in the target population. *Efficacy* is intended to capture both the intended positive effects of the intervention as well as any unintended negative effects (such as intentional stakeholder opposition or unintended adverse outcomes) that can sometimes ensue from a public health policy intervention of this type. Like reach, *efficacy* is an individual level measure and in the context of this assessment of the Dialogue it has been interpreted as the extent to which the population is actually better educated about its diet, consumes reformulated foods with standardized portion sizes, and has modified health outcomes as a consequence.

Adoption – is defined as the proportion of the targeted settings that have engaged in the program. This dimension has been applied to the Dialogue by determining the scope of the work foreshadowed by the Dialogue, the settings that need to be adopted for effective implementation, and the extent to which this has been achieved. *Adoption* of education has been determined by searching for National-, State- or Territory-based education initiatives that have emanated from the work of the Dialogue. For food reformulation and portion size standardization, the emphasis has been upon evaluating the proportion of targeted processed food and restaurant food manufacturers and retailers engaged in each program.

Implementation – means the extent to which the planned intervention has been implemented as intended in the real world, and is also a metric measured at the setting level. Evaluation of the education component has been examined by searching for evidence of implemented education programs. The extent to which food reformulation and standardization of portion sizes has been implemented has been evaluated by seeking evidence that relevant programs have delivered real outcomes in terms of target setting and achievement of the specified targets.

Maintenance – describes the degree to which a program is sustained over time, and is evaluated both at the individual and organizational level. Central to maintenance is a program of work within the initiative that enforces the interventions and monitors the effects on proximal and distal outcomes. Ideally, *maintenance* would also include some method of iterative program development such that the observations made during the maintenance phase can be used to enhance the effectiveness of the intervention. Evaluation of this aspect of the Dialogue has focused upon the reported plans of the Dialogue for enforcing, monitoring and evaluating the program.

For every dimension of the evaluation, consideration has been given to the likely representativeness of the groups impacted alongside an assessment of the likely equity of exposure to the intervention for different population subgroups.

Adapted from Jilcott S, Ammerman A, Sommers J, Glasgow RE. Applying the RE-AIM framework to assess the public health impact of policy change. *Ann Behav Med* 2007; 34: 105-114 and Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *Am J Public Health* 1999; 89: 1322-1327.