ENGAGING AND EMPOWERING HEALTHCARE PROFESSIONALS THROUGH NUTRITION COMMUNICATION

A SOCIAL RETURN ON INVESTMENT ANALYSIS

HTANALYSTS

mla
MEAT & LIVESTOCK AUSTRALIA

SOCIAL VALUE INTERNATIONAL

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Engaging and Empowering Healthcare Professionals Through Nutrition Communication – A Social Return on Investment Analysis

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This report is authored by Irene Deltetto, Lucy Rutherford, and Ingrid Joun at **HT**ANALYSTS on behalf of Meat & Livestock Australia Ltd.

We thank all those who generously contributed their time and energy to help us develop this report, including dietitians, general practitioners, and primary care nurses. We hope this report provides useful insight that will help the investment in better resources for healthcare professionals in the nutrition field.

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FOREWORD BY **HT**ANALYSTS

HTANALYSTS has been providing best-in-market strategic impact measurement services for over 20 years.

Our purpose is to have a powerful impact on the health of society by connecting people with the best treatments in the fastest amount of time.

This report details the rationale and methodology used to understand the social and economic impact of the *Make Every Bite Count* program in engaging and empowering health professionals to educate their clients about healthy eating and food waste reduction in line with Australian Dietary Guidelines. In preparing this report we listened to many people who have experience with nutrition communication, all of whom had unique but equally important perspectives. In the following pages we have synthesised those experiences using the Social Return on Investment methodology to tell the story of how is a communication framework and collection of resources that provide practical information about enjoying balanced meals with no food waste, comprising information and tips to support smart shopping, nutritious choices, balanced meals and leftovers impacts the ability of healthcare professionals to empower their clients to make easier healthy eating choices.

We thank all those who generously contributed their time to help us develop this report, including dietitians, general practitioners, and primary care nurses.

GLOSSARY

AI	Artificial intelligence
APNA	Australian Primary Health Care Nurses Association
CAL	Centre for Advanced Learning
DA	Dietitians Australia
GP	General practitioner
MEBC	Make Every Bite Count
MLA	Meat & Livestock Australia
NFP	Not-for-profit
NPV	Net present value
RACGP	The Royal Australian College of General Practitioners
SROI	Social return on investment

EXECUTIVE SUMMARY

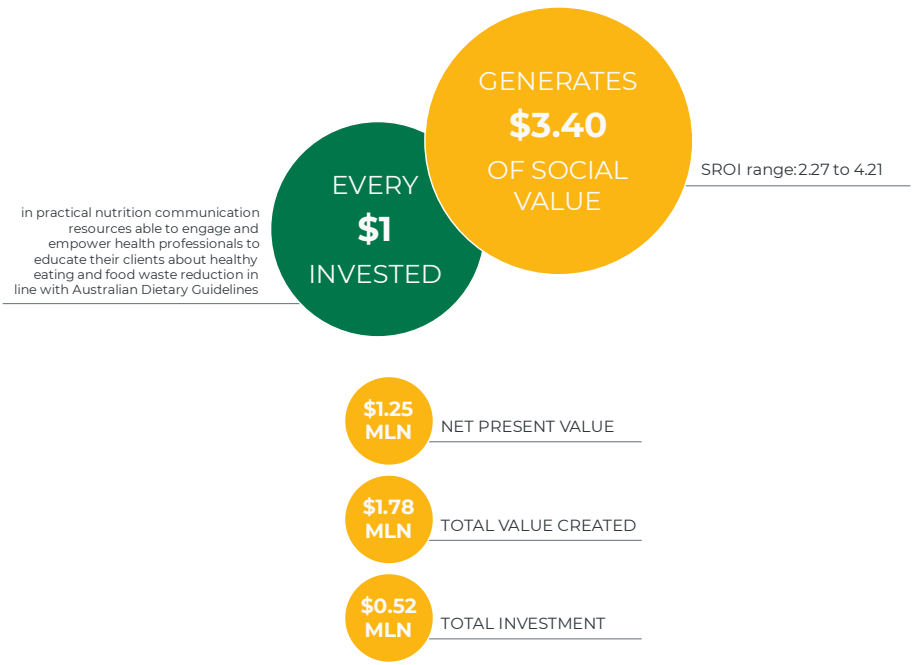
This project is a forecast Social Return on Investment (SROI) analysis, aimed at predicting the broader societal impact that could be achieved through investing in practical nutrition communication resources able to engage and empower health professionals to educate their clients about healthy eating and food waste reduction, in line with Australian Dietary Guidelines. This analysis focuses on dietitians (including clinical and community dietitians, culinary nutrition communicators, and research dietitians), general practitioners (GPs), and primary care nurses, over a one-year period.

To capture this value, interviews were conducted with dietitians, GPs and primary care nurses. Broader societal impacts for these stakeholder groups were evaluated, including those not usually considered in traditional cost-effectiveness analyses. The SROI revealed wide-ranging impacts experienced by stakeholders, including job satisfaction, improved job efficiency and opportunities, and improved reputation.

In the base case, the SROI ratio was estimated to be 3.40, indicating that for every $1 invested into an intervention to provide practical nutrition communication resources to healthcare practitioners, $3.4040 worth of social value is created. The value created was shared between dietitians (46%), primary care nurses (26%), and GPs (28%). All the value created was non-economic in nature, and thus would not be captured in a traditional cost-benefit analysis. Sensitivity analyses showed that the intervention would continue to generate positive social value, even under a range of highly conservative assumptions (SROI ratio range: 2.27 to 4.21).

This analysis was subject to some limitations, particularly related to its forecast nature. As this analysis was a forecast of expected value from the program, rather than a retrospective evaluation, stakeholders may have had a limited accuracy in quantifying expected value creation. Further research in this space should aim to verify the results through retrospective analysis once the program has been running consistently for a few years.

This analysis demonstrates how relatively inexpensive programs to support healthcare professionals in the nutrition space could create significant value, empowering them to educate their clients about healthy eating and food waste reduction in line with Australian Dietary Guidelines, which is ultimately the end goal of nutrition programs.



INTRODUCTION

BACKGROUND

Studies have shown that adequate food and nutrition literacy makes healthy products more enjoyable and, as a result, increases adherence to a healthy diet in both adults and children, reducing the risk of obesity. Consumers with a higher degree of food and nutrition literacy can better estimate portions and cook more spontaneously using what is left in the refrigerator, a practice that takes time, culinary knowledge, and skills [1, 2]. These same skills are also thought to lead to reduced food waste, as consumers engage in greater meal planning, portion control, appropriate food storage and making use of leftovers.

Meat & Livestock Australia (MLA) is the representative body for the red meat industry in Australia with the purpose of fostering the long-term prosperity of the Australian red meat and livestock industry by investing in research and marketing activities. MLA's *Make Every Bite Count* (MEBC) program is a communication framework and collection of resources that provide practical information about enjoying balanced meals with no food waste, comprising information and tips to support smart shopping, nutritious choices, balanced meals and leftovers.

The MEBC is designed to promote sustainable and healthy eating habits, particularly focusing on the consumption of Australian red meat. It emphasises the importance of incorporating red meat into a balanced diet in an environmentally sustainable way, offering practical tips for smart shopping, nutritious choices, and reducing food waste. The program provides guidance on portion sizes, recommending red meat consumption in line with the Australian Dietary Guidelines. The MEBC program incorporates strategies similar to other Australian food waste campaigns to educate about food waste reduction, although it uniquely combines this messaging with healthy eating promotion. For instance, the program uses portion size recommendations not only to reduce waste but also to create nutritious and balanced meals. The MEBC program also supplies educational resources for healthcare professionals to help them communicate practical information about sustainable eating. Additionally, the program aims to engage consumers by providing actionable insights and practical information to make buying, preparing, and serving red meat in a sustainable manner easy and addresses common barriers to sustainable eating, such as cost and convenience.

The insights provided as part of the MEBC program indicate: 1) practical tips about enjoying balanced meals is an easier way to explain dietary recommendations, including portion sizes and, nutrition choices; 2) no food waste strategies provide opportunities to address cost of living barriers and at the same time, is important for the environment and 3) culinary nutrition skills are engaging and empowering for all life stages. In practice, these resources have been developed in various formats for use across different clinical and educational settings. The **social media tiles** are small, visually engaging graphics paired with concise text, designed for quick sharing on platforms like Instagram. They are engaging for promoting healthy eating tips and lifestyle changes in an eye-catching way, often serving as conversation starters or reminders about nutrition goals. The **20-page brochure**, titled *Make Every Bite Count Tips*, is a PDF resource that can be shared digitally or printed. It provides practical guidance on incorporating red meat into a healthy diet, promoting balanced eating, and reducing food waste. Using large graphics and clear text, the tool can be used in clinics, or community events to educate individuals on the four key tips described. The **fact sheets** are concise, one-page documents summarising key nutrition facts and tips, making them ideal for quick reference in busy settings such as healthcare clinics or during consultations. Lastly, the **culinary nutrition video series** offers an engaging and visual demonstrations of nutrition concepts. Hosted by Nutrition Scientist and Culinary Nutrition Professional Joanna McMillan, the series explains the *Make Every Bite Count* tips, focusing on promoting balanced meals and minimizing food waste. The five videos cover each of the four key tips, with the final video featuring Joanna and Mary Jane Morse, editor of *Rare Medium*, exploring exciting food trends. Together, these resources cater to diverse learning preferences, from quick visuals to in-depth reading and engaging multimedia presentations.

These resources differ from other nutrition resources because they are uniquely designed to deliver simple, actionable messages that are visually engaging and easy to understand. In contrast, many other nutrition resources dietitians use—such as national dietary guidelines or technical reports which are more comprehensive, complex and less tailored to specific practical applications. These traditional guidelines are valuable for evidence-based practice but are not always user-friendly for individuals who are time-poor or overwhelmed by extensive information. These resources bridge that gap by being focused, visually appealing, and easy to implement. They complement the more detailed tools dietitians rely on, such as dietary assessments and meal-planning guides, by providing relatable, practical advice that clients can engage with quickly and effectively. This targeted, audience-specific design makes them uniquely valuable for promoting healthy eating in real-world contexts.

The value of practical resources for health professionals is often overlooked, as the primary focus of nutrition programs tends to be direct to patient information and education. However, empowering relevant healthcare professionals with robust, practical tools and resources is an important avenue leading to improved nutrition literacy. When health professionals are confident and well-equipped to advise their clients regarding nutrition, they can more effectively educate their clients, leading to meaningful behaviour changes.

RATIONALE FOR THE STUDY

The impacts created by the MEBC program and the potential benefits of engaging and empowering health professionals to communicate with their clients about healthy eating and food waste are multifaceted. Although cost-effectiveness analyses provide a standardised way of evaluating the value created by nutrition education, they often focus on preventing obesity and associated long-term medical costs or on reducing food waste and can fail to capture the broader impacts of the engagement and empowerment of healthcare professionals.

Noting the impact that education has on health professionals, MLA commissioned **HT**ANALYSTS to evaluate the broader social value of the MEBC program. Social value is the broader financial, environmental and wellbeing outcomes created when something changes in a person's life. This research informed the SROI through a process of understanding, measuring, valuing, and reporting the social outcomes of the MEBC program for a variety of health professionals for whom the program is designed.

MLA will use the findings to inform program planning, contribution to public health policy and opportunities to optimise engagement with nutrition communications and, ultimately, increase consumption of healthy foods in the Australian diet.

OBJECTIVES OF THE STUDY

This analysis aims to assess the value of the MEBC program in engaging and empowering health professionals to educate their clients about healthy eating and food waste reduction in line with Australian Dietary Guidelines. Specifically, the analysis will:

- identify the impacts of the MEBC program from the perspective of each identified stakeholder group; and
- quantify the broader value of the MEBC program across Australia for each stakeholder group.

TYPE OF ANALYSIS

This analysis is a forecast SROI designed to measure the social impact of investing in a nutrition communication program to engage and empower health professionals to educate their clients about healthy eating and food waste reduction. When the analysis was being conducted, Meat & Livestock Australia were developing the MEBC program. As there were no nutrition communication programs available with the same objective and scope of content, a retrospective evaluation was not possible. As such, a forecast SROI was conducted to capture the hypothetical benefits of such a program for health professionals.

A one-year time horizon was chosen to capture the short-term changes in social impacts expected to arise from providing the nutrition communication resources to health professionals. A one-year time horizon is considered reasonable to capture the impact of engaging and empowering health professionals to educate their clients, while limiting the uncertainty associated with extrapolating outcomes over a longer time period. The SROI analysis was conducted between March 2024 and November 2024.

SROI FRAMEWORK

PRINCIPLES AND FRAMEWORK

A forecast SROI analysis was conducted to assess the impact created by investing in practical nutrition communication resources for healthcare professionals.

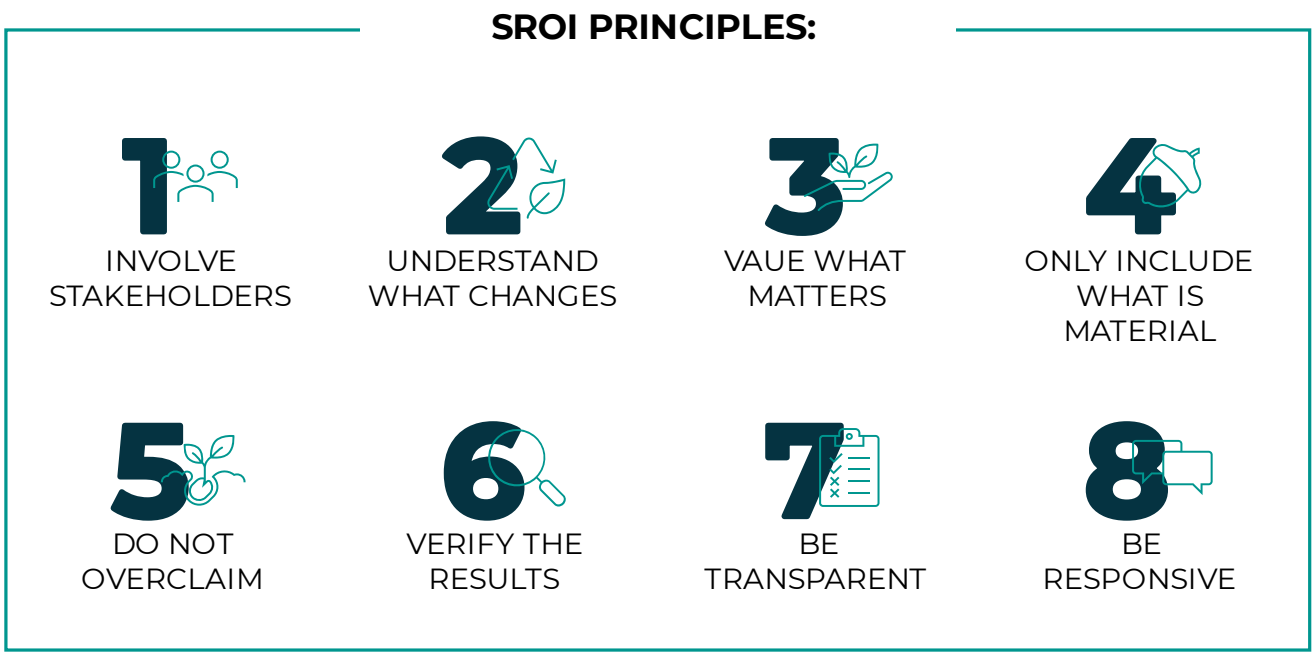
The SROI methodology is based on identifying key outcomes of an intervention, as informed by direct reporting of lived experiences from stakeholders. As such, stakeholder engagement is essential in understanding changes which result from an activity and the value of these changes. Consultation with stakeholders also avoids self-referential thinking and incorrect assessment of impact.

The relationship between inputs, outputs, and outcomes is captured in the "Theory of Change". The Theory of Change visually maps how impact is created from the perspective of stakeholders, providing a chain of events towards each final outcome. In the case of this analysis, final outcomes are assigned a monetary value, representing the result of an investment into practical nutrition communication resources for healthcare professionals (see Appendix IV).

The SROI framework produces both a quantitative and qualitative evaluation of outcomes. Whilst the investment required to provide practical nutrition communication resources has a market price, the financial valuation of those outcomes that do not have a financial nature can represent a challenge. The SROI framework estimates the social value of investing in practical nutrition communication resources by assigning a financial proxy to each outcome for each stakeholder. The framework also considers adjustments to the social value based on estimations of deadweight (what would have occurred anyway), attribution (what other organisations contributed to the outcomes), displacement (what activities were displaced by the intervention), and drop off (whether the outcomes experienced decline over time).

This process generates a story that fuses evidence, economics, and real-world experiences, to assess how investing in practical nutrition communication resources affect healthcare professionals. Comparing the value of the investment with the value of the economic and social value created allows a SROI ratio to be calculated. This ratio shows the social value generated by each dollar invested.

Figure 1 Eight Principles of SROI

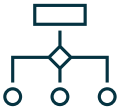


Guided by the above principles, there are six main steps involved in calculating the SROI (see Figure 2) These stages involve identifying and measuring outcomes and, where appropriate, applying financial proxies to valuate those outcomes. The overall value created is calculated and then compared to the investment required to generate it, to obtain the SROI ratio.

Figure 2 Six main steps in a SROI

ESTABLISHING THE SCOPE AND IDENTIFYING STAKEHOLDERS

The scope of the analysis is clearly delineated through a roadmap to ensure a streamlined SROI development process. Stakeholders to be involved are identified as well as the key SROI structural elements, with a particular focus on the research question.



MAPPING OUTCOMES (THEORY OF CHANGE)

This step articulates the program logic, mapping resources (inputs) that would be used to deliver activities (measured as outputs), and how these activities may result in outcomes for stakeholders.

EVIDENCING AND VALUING IMPACT

Data is gathered through qualitative and quantitative methods to evidence and measure the extent to which outcomes are being achieved and how long they last.

ESTABLISHING IMPACT

The extent to which activities contribute to the impact achieves is determined by placing the intervention in context and understanding what would represent material and valuable changes resulting from an intervention, testing the Theory of Change.

CALCULATING SROI AND WRITING THE REPORT

In this stage, the data that has been gathered is expressed in the form of an SROI ratio, ascribing a monetary value to the material outcomes identified through the research phase.

REPORTING, USING AND EMBEDDING

The SROI report includes qualitative, quantitative and financial findings, to tell the story of change and to provide the reader with information on the social value that could be/has been created by the intervention.

METHOD

ESTABLISHING THE SCOPE

HTANALYSTS developed the scope of this analysis in collaboration with MLA. The scoping phase aimed to gain a top-level understanding of the objectives/potential impacts of the intervention. During the scoping phase, the potential stakeholders who might be impacted by the investment in practical nutrition communication resources were identified and the scope of the SROI analysis was defined (see Table 1).

Table 1 Scope of the SROI

Question	Scope
Organisation?	Meat & Livestock Australia
What is the activity being analysed?	An investment into the Make Every Bite (MEBC) program, which aims to provide practical nutrition communication resources.
How does the activity lead to the desired impact?	By providing practical nutrition resources to healthcare professionals, the intervention supports them in improving their job efficiency, satisfaction and reputation.
What decisions will be influenced by this analysis?	By demonstrating the social impact of investing in practical nutrition resources to healthcare professionals, this analysis will be used to guide the investment in the next steps of the program.
What is the duration of the activity?	A 1-year time horizon was considered appropriate to capture the impacts of the program and to reduce uncertainty. The impact of the program is expected to continue as long as the program is still operational.
Is this analysis a forecast or retrospective evaluation?	This analysis is a forecast as the full suite of MEBC materials had not been disseminated yet for utilisation to healthcare professionals at the time of the analysis. As such, no individuals have experience with the proposed activity. A forecast SROI was therefore considered most appropriate.

Abbreviations: MEBC, Make Every Bite Count; SROI, Social Return on Investment

STAKEHOLDER ENGAGEMENT

The direct involvement of stakeholders is one element that distinguishes the SROI methodology from a cost-effectiveness or cost–benefit analysis. Involving stakeholders allows the social value of a particular intervention to be measured and valued. Stakeholder engagement is vital to understand the importance of changes created and to identify how to quantify changes, based on how stakeholders value each outcome.

The stakeholder engagement process used for this analysis can be divided into four major stages:

- Stakeholder groups identification
- Participant recruitment
- Stakeholder interviews – to identify key outcomes and refine the Theory of Change
- Stakeholder survey – to validate and value outcomes

STAKEHOLDER GROUPS IDENTIFICATION

All groups that may affect or be affected by investment in the MEBC nutrition communication program, whether the effect is intentional or unintentional, and whether that change is positive or negative, were comprehensively considered.

A preliminary list of stakeholders was developed by **HT**ANALYSTS and MLA. Table 2 identifies the stakeholders considered and the rationale for including or excluding them from the SROI analysis.

Table 2 List of stakeholders considered for the analysis

Stakeholders	Included/excluded	Rationale
MLA Nutrition, Sustainability and Communications teams	Excluded	MLA Nutrition, Sustainability and Communications teams are responsible for communicating with and disseminating information to external stakeholders about MLA Research and Development activities. The MEBC program has been developed using insights gained from previous R&D activities. It was expected that the MEBC nutrition communication materials may be used to demonstrate positive outcomes from the R&D activities, which may lead to improved relationships with industry partners and increased certainty in securing funding. Preliminary consultation with the MLA teams revealed that MEBC materials were not likely to be used by MLA teams (other than for distribution to healthcare professionals). Therefore, the MEBC program was not expected to have a material impact on MLA teams.
Medical media suppliers	Excluded	Scoping interviews were conducted with all of the medical media suppliers employed by MLA to promote awareness of the MEBC materials. It was initially hypothesised that medical media suppliers would face financial and reputational impacts due to increased demand for evidence based and practical nutrition resources. That is through an increased demand for nutrition resources simplifying the Australian dietary guidelines and broaden the target audience for resources to include dietitians, general practitioners, nurses, and other allied health professionals who play a role in patient nutrition education. During consultations with medical media suppliers, it became apparent that the MEBC nutrition communication program would not have a significant impact on their professional reputation or their ability to increase their business and/or profit, as it was initially thought. Therefore, the MEBC program was not expected to have a material impact on medical media suppliers.
General practitioners (GPs)	Included	The MEBC nutrition communication program has been designed for use by healthcare professionals in the primary care setting. GPs are expected to be directly impacted by the availability of the MEBC program materials by providing them with clarity on current Australian dietary recommendations and providing a tool that they can use to improve efficiency in their consultations with patients where nutrition communication is a relevant topic. It is expected that having a set of resources available to enhance their communication of nutrition information to their patients may also lead to improved job satisfaction through seeing the positive impacts on their patients. GPs were therefore included as stakeholders in the SROI analysis.
Primary care nurses	Included	The MEBC nutrition communication program has been designed for use by healthcare professionals in the primary care setting. Primary care nurses are expected to be directly impacted by the availability of the MEBC program materials by providing them with clarity on current Australian dietary recommendations and providing a tool that they can use to improve efficiency in their consultations with patients where nutrition communication is a relevant topic. It is expected that having a set of resources available to enhance their communication of nutrition information to their patients may also lead to improved job satisfaction through seeing the positive impacts on their patients. Primary care nurses were therefore included as stakeholders in the SROI analysis.
Dietitians	Included	The MEBC nutrition communication program has been designed for use by healthcare professionals in the primary

Stakeholders	Included/excluded	Rationale
		care setting. Dietitians are expected to be directly impacted by the availability of the MEBC program materials by providing a tool that they can use to improve communication and efficiency in their consultations with clients. It is expected that having a set of resources available to enhance their communication of nutrition information to their patients may also lead to improved job satisfaction through seeing the positive impacts on their patients. Dietitians were therefore included as stakeholders in the SROI analysis.
Patients attending primary care consultations	Excluded	After consultation with MLA, it became clear that the MEBC program has been designed with healthcare professionals as the target audience. The aim of the program is to improve healthcare professionals' communication of nutrition information to their patients. It is expected that improved communication by healthcare professionals may result in indirect impacts on patients, in terms of improved nutrition knowledge and understanding, which may then result in healthier eating choices and improved clinical outcomes. The indirect effects on patients were not considered material to the SROI since the intervention is being disseminated to healthcare professionals only. Given the indirect nature of the link between the program and potential patient impacts, patients were not considered a stakeholder in the analysis.
The environment	Excluded	A key aspect of the nutrition information communicated in the MEBC program focuses on strategies to reduce food waste. Although reduced food waste would be expected to have environmental impacts, the nature of the link is indirect as the MEBC program is not designed to target consumers. Rather, the program has been designed as a tool to improve healthcare professional communication about healthy eating with less food waste. Given the indirect nature of the link between the program and potential environmental impact, the environment was not considered a stakeholder in the analysis.
Department of Health	Excluded	Although diet quality influences the health system via overall healthcare spending, the impacts to this stakeholder were not considered material given the indirect nature of the link between the MEBC materials intended to enhance healthcare professional communication and improved patient health. Therefore, the MEBC program was not expected to have a material impact on the Department of Health.
Meat & Livestock Australia	Excluded	MLA funds the MEBC program and as such provides the investment. After initial consultation with members of the MLA team, it was revealed that the organisation does not experience material outcomes from the MEBC materials. As such, it is not included in the analysis beyond its investment.

Abbreviations: MEBC, Make Every Bite Count; MLA, Meat & Livestock Australia; SROI, social return on investment

PARTICIPANT RECRUITMENT

Healthcare professionals, including dietitians (n=4), GPs (n=4), and primary care nurses (n=4) were recruited for video call interviews through a third-party recruitment agency. Healthcare professionals provided their basic demographic data such as age, gender, and geographic location prior to the interview. This information was collected to discern whether there were any differences in the use of the program that are affected by these factors. The 12 healthcare professionals recruited via the third-party recruitment agency were reimbursed for their time spent being interviewed.

Dietitians specialising in the field of culinary nutrition (n=7) were recruited for video call interviews by **HT**ANALYSTS, with introductions facilitated by MLA. All of these dietitians had previously attended a MEBC launch event during the month prior to the interviews.

Representatives from four medical media suppliers (n=6) who work with MLA to promote and distribute the MEBC program materials were recruited for video call interviews by **HT**ANALYSTS, facilitated by MLA.

Prior to all interviews with stakeholders (dietitians, GPs, primary care nurses, medical media suppliers), the MEBC backgrounder (see Appendix I) was shared with all participants during the recruitment process. The backgrounder provided participants with a summary of the MEBC program and hyperlinks to view the online materials prior to their interview.

These interviews were used for qualitative purposes only, with the results used to develop the follow-up questionnaire that was later distributed to a wider audience.

PRIVACY AND CONSENT

Written consent was obtained from all interviewees prior to each consultation, and consent to record was re-confirmed verbally prior to commencing each interview.

The consent forms outlined the purpose of the project, what would be required during the interview, how the findings would be used, and any privacy and ethical implications for participants.

In accordance with the National Statement on Ethical Conduct in Human Research (2007), this research was considered Negligible Risk, with the only foreseeable risk being inconvenience, hence obtaining ethics approval was not deemed necessary.

STAKEHOLDER INTERVIEWS

Stakeholder interviews were conducted by video call via Microsoft Teams from June to August 2024. Interview guides were developed by **HT**ANALYSTS (Appendix II).

After explaining the purpose of the interview and confirming consent to record, participants were provided with a verbal and visual reminder of the resources that comprise the MEBC program via screen sharing on the video call. In advance of their interview, all participants had been asked to review a one-page summary of the MEBC program, containing hyperlinks to electronic copies of the materials. Questions were intended to be broad and open-ended, to avoid biasing of participant responses. Further questions were used to probe on key outcomes from the draft theory of change, and any additional outcomes that had been mentioned in prior interviews, including any potential negative outcomes.

No member of the MLA team was present during the interviews, and all interview findings were kept confidential by **HT**ANALYSTS, with the MLA team not receiving access to recordings or transcripts from the interviews. This approach ensured that interviewees felt comfortable sharing their experience or anticipated experience without any perceived risk.

Eleven dietitians were interviewed; five were interviewed during individual half-hour calls and six of the dietitians were interviewed during one-hour focus group calls comprising three participants. Three of the dietitians were male and eight females. There was a range of geographic location represented by the eleven dietitians interviewed, with dietitians based in New South Wales (NSW), South Australia (SA), Queensland (QLD) and Victoria (VIC) across metropolitan and regional areas and a mixture of private and public practice settings.

Four GPs were recruited to conduct a half-hour individual video call interview regarding their anticipated use of the MEBC program materials. The four GPs interviewed were male and worked in private practice clinics; two were based in NSW and two in QLD. One GP was based in a metropolitan area, two in regional areas and one in a rural setting. One of the GPs was less than 50 years of age while the other three GPs were at least 50 years old.

Four nurses who work within general practice clinics were recruited to conduct a half-hour, individual video call interview in the same manner as described for GPs. Of the four primary care nurses, all were female; one nurse was less than 50 years of age while the other three nurses were at least 50 years old. Two of the nurses were based in NSW, one in Western Australia (WA) and one in SA. Three of the nurses worked in metropolitan areas and one in a regional area of Australia. Three of the nurses worked in private practice clinics and one in a public health/community clinic.

Table 3 Initial stakeholder interviews conducted

Stakeholder	Number of unique interviewees
Dietitians	11
GPs	4
Primary care nurses	4
Total	**19**

STAKEHOLDER SURVEYS

The objective of the surveys was to verify the findings of the stakeholder interviews and provide quantitative data to inform SROI filters for healthcare professionals using the MEBC materials. Specifically, the surveys included questions to inform proportion, attribution and importance. The questions were produced once thematic saturation had been reached in the interviews. The surveys were designed by **HT**ANALYSTS (Appendix III) and administered online via Voxco for the GPs and nurses, and via Qualtrics for dietitians. The stakeholders did not express any significant negative changes.

While no negative outcomes were identified during the interviews, additional open-ended questions were included in the survey to identify any potential impacts that did not emerge during the interview stage. This was considered particularly important to identify any negative outcomes, in order to ensure that these potentially material outcomes were not excluded from the analysis. To further reduce the risk of overclaiming and to account for potential negative outcomes, if any participants indicated that key indicators would worsen, that proportion of participants was subtracted from the total proportion reported to experience improvement (see Appendix V for further details).

The hyperlink to complete the dietitian survey was included with an e-newsletter that Dietitian Connection mailed to their member database on 25 August 2024. Dietitian Connection is an Australian-based, global professional network for dietitians, which offers resources, job opportunities and professional development tools. The advertisement was displayed for 2 weeks from the 25th of August in the Dietitian Connection e-newsletter; the content of which is included in Appendix I. An incentive of a cookbook giveaway was included as incentive for completion of the survey; 10 prize winners were randomly drawn after the survey closed. The prize was a copy of the Nagi Maehashi '*Dinner*' Cookbook.

The survey closed after a 2-week period and with a total of 327 surveys completed by dietitians in Australia. The majority of dietitian survey respondents were aged between 25-33 years (44%) and 35-44 years (30%). Most dietitians worked in hospital settings (40%), followed by private practice (29%), public practice (14%), corporate (7%), and other settings (10%) which included aged care and non-profit organisations. Most respondents self-identified as clinical dietitians (57%) and community dietitians (32%), with the remainder working as culinary nutrition communicators (7%) and research dietitians (4%).

Recruitment of GPs and primary care nurses for survey completion was performed by a third-party recruitment agency. Financial reimbursement was provided to each participant for the assumed time spent completing the survey (5 minutes). This reimbursement is not expected to have skewed the analysis, as all responses were anonymous. These amounts were not included in the inputs as they were part of the SROI evaluation process and not of the MEBC program development costs, and this forecast SROI is not responsible for the materials changes measured in the analysis.

A total of 100 GPs and 70 nurses completed the survey. GP and primary care nurse demographics were categorised by state of practice, rural, regional, or metro location, setting, age, and gender. Most GP respondents were based in NSW (36%), QLD (24%), and VIC (19%). The majority practiced in metropolitan areas (84%) and regional areas (11%), with most working in private practice (98%). Most GPs were over 55 years old (51%), followed by those aged 45-54 (31%) and 35-44 (15%). There was a nearly equal distribution between male (53%) and female (47%) GPs.

Primary care nurse respondents were primarily based in VIC (47%), SA (31%), and NSW (14%). Most worked in metropolitan areas (64%) and regional areas (24%), with the majority employed in private practice (91%). There was a balanced distribution across age groups: 24-35 years (23%), 34-44 years (20%), 45-54 years (24%), and 55+ years (27%). Nearly all primary care nurses were female (97%).

Table 4 Stakeholder surveys

Stakeholder	Number of unique survey responses
Dietitians	327
GPs	100
Primary care nurses	70
Total	**497**

SUMMARY OF STAKEHOLDER ENGAGEMENT

A summary of stakeholder engagement throughout the SROI process is provided in Table 5. While the number of stakeholders directly engaged for the surveys was relatively low, findings were verified using survey data from a larger cohort of dietitians, GPs and nurses. Interviews were continued until thematic saturation was reach, but there is nevertheless the possibility that the experiences represented by the stakeholders are not representative of the entire ranges of outcomes experienced. Future research should aim to speak to a larger number of dietitians, GPs and nurses following the implementation of the MEBC program, as a retrospective analysis with a larger sample size may reveal potential unidentified outcomes, as well as subgroups not apparent in the current research.

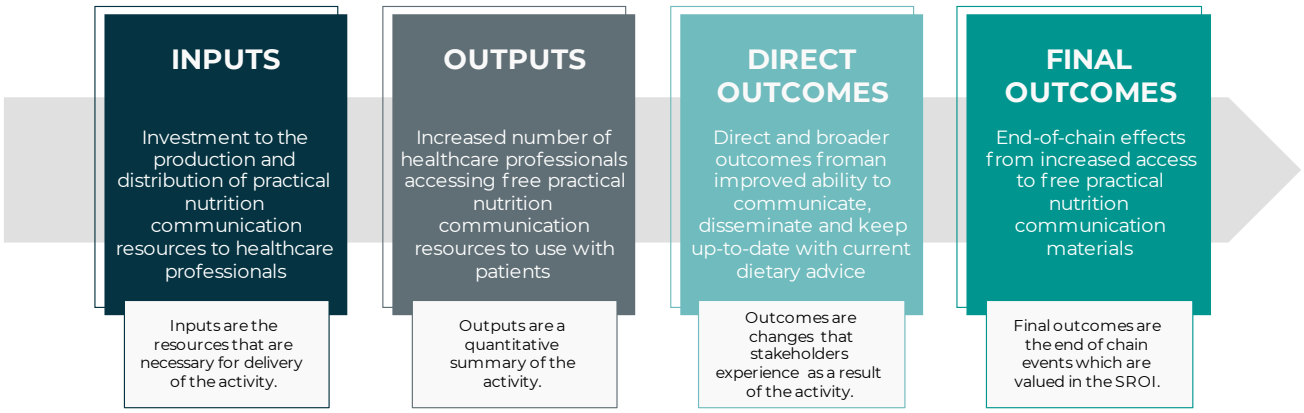
Table 5 Summary of stakeholder engagement throughout the SROI process

Stakeholder	Number of stakeholders uniquely engaged	Mode of engagement
Dietitians	338	• Interviews (n=11) • Surveys (n=327)
GPs	104	• Interviews (n=4) • Surveys (n=100)
Primary care nurses	74	• Interviews (n=4) • Surveys (n=70)

Note: the anonymous survey was also sent to the individuals interviewed during the qualitative phase of the analysis, meaning that some individuals may have completed both an interview and survey.

THEORY OF CHANGE

In a SROI, the Theory of Change maps the sequence of events resulting in impact for a stakeholder group. The Theory of Change is informed and guided by stakeholders, and aims to identify the relationship between the inputs, outputs, and outcomes of an intervention to capture the real-world experience of those affected. To avoid overclaiming and overvaluation, only final outcomes were valued to assess the social return of investing in practical nutrition communication resources for healthcare professionals.



Theory of Change maps outline how inputs and outputs are linked, providing a chain of events towards each final outcome [3]. The following Theory of Change maps outline the sequence of events forecast to occur as a result of investing in practical nutrition communication resources.

Outcome indicators for dietitians and culinary nutrition professionals, GPs and practice nurses were derived from consultations with these groups through 1:1 and group interviews.

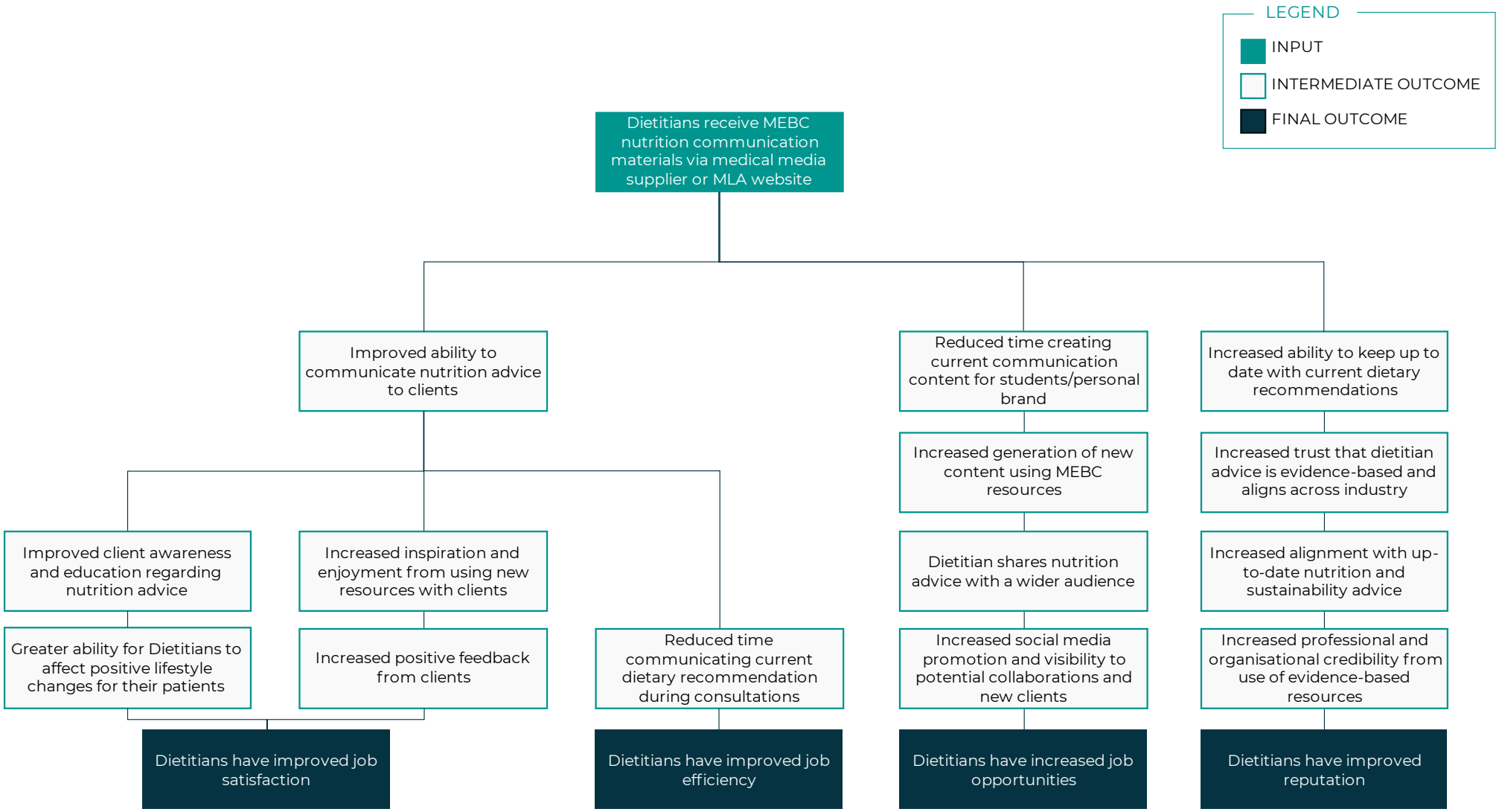
When constructing the Theory of Change maps, the authors considered the inputs, outputs, direct and final outcomes of investing in practical nutrition communication resources for healthcare professionals. The inputs considered were a monetary investment into the intervention, which comes from the total program cost including production of resources, printing, salary of a program manager responsible for overseeing a range of research and development of the MEBC program, and sponsorship via e-newsletters and webinars. The investment also includes the masterclass events conducted for culinary nutrition communicators and dietitians (see for 0 for further detail).

The outputs of the intervention refer to a quantitative summary of the activity. For the purposes of this SROI, the output considered was the number of healthcare professionals that have access to free resources to educate their clients about healthy eating and food waste reduction in line with Australian Dietary Guidelines.

The direct outcomes of the intervention are those that stakeholders experience as a result of the intervention. These are the proximal outcomes which directly result from the increased number of healthcare professionals that receive MEBC practical nutrition communication resources, such as time efficiency during consult with patients or confidence in explaining nutrition advice to patients.

The final outcomes, which are valued in this SROI, are the end of the chain of events that result from the direct outcomes. Final outcomes should be material and exclusive, i.e. there should not be overlap between final outcomes in order to avoid double counting. The final outcomes included in this SROI are described in more detail below.

THEORY OF CHANGE FOR DIETITIANS



FINAL OUTCOMES FOR DIETITIANS

Improved job satisfaction

During the interviews, dietitians shared that practical nutrition communication resources for patient interactions can lead to changes in job satisfaction through an improved ability to have a positive impact on their clients' diets and having increased sources of inspiration to deliver improved care for their clients.

"I talk about food all day, but I do get a bit stale in my own day to day practice or my own day to day cooking. So just even for me to, to sort of get inspired again, thinking about different ways of using leftovers, managing food waste to share with clients."

They highlighted how changes can be experienced both subjectively and objectively through their motivation, patient outcomes, and relationships with colleagues and clients (see Table 6). Experiencing improvements in these indicators was believed by them lead to a change in job satisfaction. This outcome was described qualitatively via stakeholder consultation, and change was quantitatively measured through survey questions on key indicators of improved job satisfaction anticipated if the MEBC resources were available to them.

"I think the two aspects of this material will be the clarifying of information. And just simplifying nutrition as before just people come in super confused or very polarized. So if it is something that is endorsed by the Dietitians Australia and is presented in a sort of a factual way, that's giving them sound advice. I think that will help shape the clients perspective."

Job satisfaction for dietitians is influenced by various factors, such as job performance, improved patient outcomes, and relationships with colleagues and clients. Dietitians who communicate nutrition information effectively to their clients often feel more inspired when they see a positive impact on their patients and/or client's lives. Furthermore, dietitians who feel they are making a positive impact on their clients gain valuable insight through feedback they receive leading to improved job satisfaction. Other factors like higher education, professional expertise, competitive remuneration, a supportive work environment, and opportunities for professional growth contribute to job satisfaction. Additionally, workload management, role clarity, and time availability are crucial in healthcare settings.

Improved job satisfaction is considered a final outcome as it directly affects dietitians' well-being, retention, and overall productivity. When dietitians experience higher job satisfaction, they are more likely to stay in their positions, reducing turnover rates and associated recruitment and training costs. Satisfied dietitians are also more engaged and motivated, leading to better client interactions and higher quality of care.

Improved job efficiency

During the interviews, dietitians shared that providing them with practical nutrition communication resources for patient interactions can lead to changes in their job efficiency through an improved ability to communicate effectively with their clients. A change in job efficiency can be subjectively or objectively experienced by the stakeholder group through reported time to create new and high-quality communication content, as well as self-reported ability to keep up to date with dietary recommendations, and changes in consult time (see Table 6).

"These tools could be used by dietitians—not just communicators—in their own practices to help upskill them. This could help dietitians to provide better support to their clients in overcoming barriers to food provision or healthy eating."

This outcome was described qualitatively via stakeholder consultation, and change was quantitatively measured through survey questions on key indicators of improved job efficiency anticipated if the MEBC resources were available to them.

"Yeah, it would, particularly in the outpatient setting. I think it's great to have a resource that covers things in a simple format that you can give out and refer to."

"I've had to do my own sort of research to find out. Ok. What's helpful for these clients? And it's actually going back to looking at studies [...] as a clinician, we should be able to have access to resources to ease pressure."

Job efficiency is primarily measured using time as a key indicator of productivity. This includes both the time spent in client consultations and time dedicated to administrative tasks, preparation and development of resources for translating scientific information into comprehensible information for the public. Dietitians that have improve communication skills for dietary advice experience a greater ability to communicate dietary advice in consult under time-pressures. For nutrition communicators, job efficiency can be impacted by staying current with the latest nutritional research and evidence-based practices and translating complex scientific information into accessible language for the public.

Improved job efficiency is considered a final outcome as it directly impacts the productivity and effectiveness of dietitians in their roles. Enhanced job efficiency means dietitians can manage their time and resources more effectively, leading to quicker and more accurate client assessments, streamlined administrative tasks, and better overall service delivery. This outcome is distinct because it focuses on the operational aspect of a dietitian's work, emphasizing the ability to achieve more with less effort and time. Improved efficiency can result in higher client throughput, reduced burnout, and the ability to take on more clients or projects without compromising quality. It also contributes to cost savings for employers and better utilisation of healthcare resources, ultimately benefiting both the dietitians and the organisations or clinics they work for. This outcome highlights the practical and logistical improvements in a dietitian's daily work life, setting it apart from other outcomes like job satisfaction or reputation.

Increased job opportunities

During the interviews, dietitians shared that practical nutrition communication resources can lead to changes in job opportunities through inspiration for other content generation and personal brand. A change in job opportunities can be subjectively or objectively experienced by the stakeholder group through a change in revenue, career growth and professional development (see Table 6).

"That's another way that they would also utilise those resources to inspire and let them help them gain confidence within their career."

"And even if they're not directly using the resources, they could still internalise the messages and communicate them in their own way—whether through creating their own social media content, videos, or other methods of sharing the same overarching messages."

This outcome was described qualitatively via stakeholder consultation, and change was quantitatively measured through survey questions on key indicators of improved job opportunities anticipated if the MEBC resources were available to them.

"We place great value on entrepreneurship in dietetic practice these days [...] I often upload information to my website, use it during cooking demos, or feature it in blog posts and social media content. Having access to resources would be a great motivator to use them in these spaces, as they can enhance patient engagement and attract more clients to our services."

Increased job opportunities in dietetics traditionally refers to an increased number of clients in private practice engaging with dietetic services or finding more employment options in non-traditional settings, such as government, public health and the food industry. When dietitians spend less time creating nutrition communication materials for their practice or business, they can focus on developing more personalised nutrition programs. This can also help dietitians attract a broader audience and explore potential business collaborations within their specific dietetics-related niche.

Increased job opportunities for dietitians were considered important and a final outcome as it impacts their career progression and development. With a growing focus on personalised nutrition, dietitians also have entrepreneurial opportunities to build their own brands in niche markets.

Furthermore, as preventive care becomes more important and research on sustainable diets advances, there is increasing recognition of the crucial role dietitians play in managing Australians' health. One of the most significant trends affecting the job market for dietitians is the shift toward preventative care. This highlights the role of dietitians in creating dietary plans that promote health and prevent disease before chronic conditions develop. Dietitians are playing an expanding role in public health endeavours, including policy development, community education, and food security programs aimed at preventing health issues at a population level.

Increased job opportunities is considered a final outcome because it separates a dietitian's efforts to adapt their skills, expand their expertise, and align with emerging trends in healthcare and nutrition. Increased job opportunities reflect their ability to attract and retain clients while evolving to meet changing demands in the field. The outcome of increased job opportunities pertains to the quantitative aspect of employment prospects. This outcome is about the actual availability of more job positions for dietitians, whether through the creation of new roles, expansion of existing services, or diversification into new areas such as corporate wellness programs, telehealth, or specialised nutrition services. It directly impacts the employment rate and career growth potential for dietitians.

Improved reputation

During the interviews, dietitians shared that practical nutrition communication resources can lead to changes reputation through alignment with up-to-date and evidence-based dietary recommendations. A change in job opportunities can be subjectively or objectively experienced by the stakeholder group through their perceived credibility and alignment with reputable organisations and other dietitians (see Table 6).

"Healthy balanced meals with no food waste is something really unique that I think dietitians can own"

This outcome was described qualitatively via stakeholder consultation, and change was quantitatively measured through survey questions on key indicators of improved reputation anticipated if the MEBC resources were available to them.

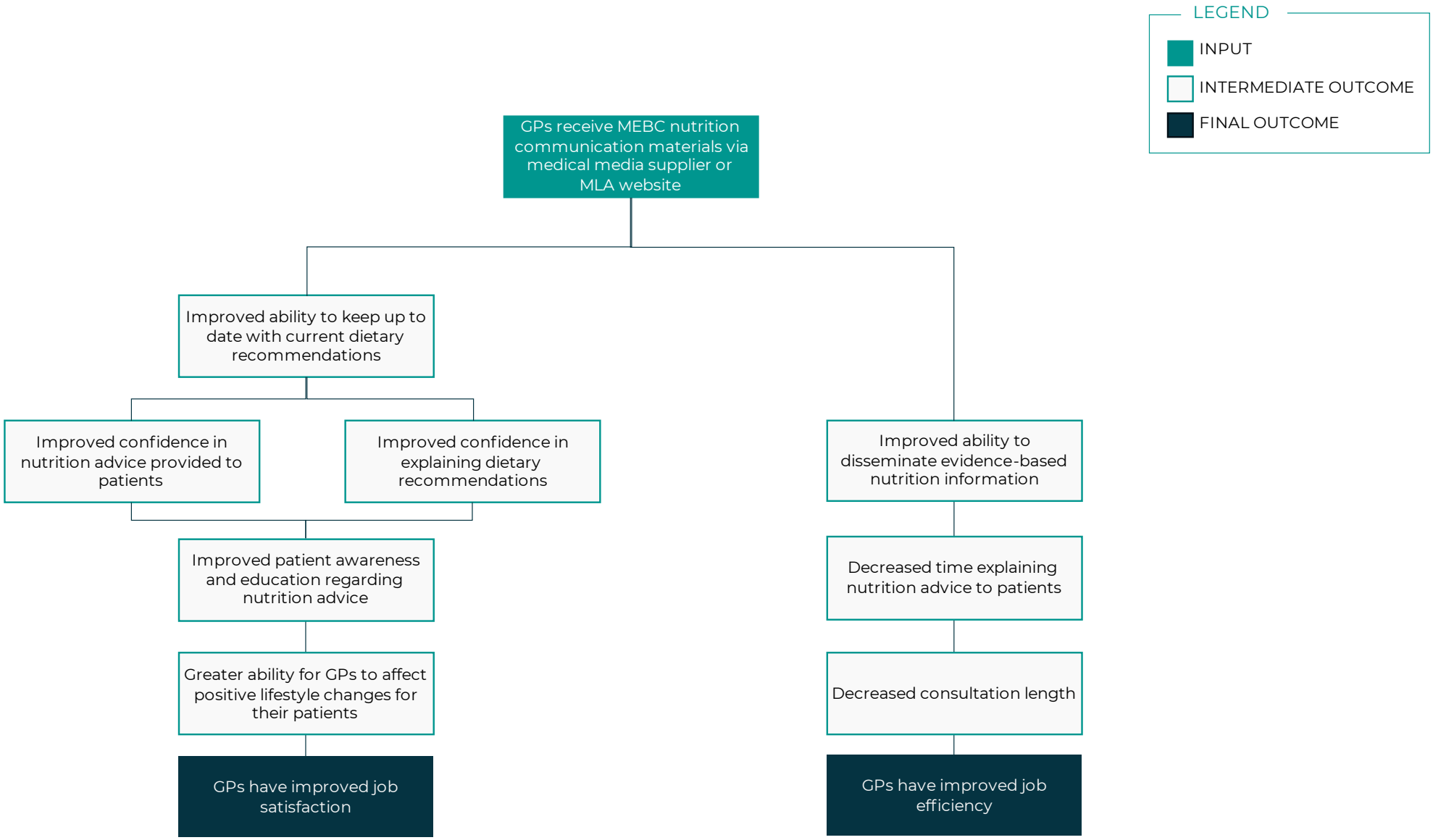
"I'm able to pass to patients some evidence-based information rather than rely on something on YouTube that may not be necessary robust in terms of fact checking. This will be handy to support the patient because it is all driven by the patient's need."

Job reputation for dietitians refers to the perception that colleagues or clients hold about an organisation or individual in a professional context. It is shaped by past actions, behaviours, and interactions in terms of reliability, ethics, and competence. Dietitians experience improved reputation when they can stay up to date with current nutrition research, leading to stronger professional alignment with colleagues and enhanced organisational credibility through prioritisation of evidence-based practice with patients.

Dietetics is an evidence-based profession where peer-reviewed, scientific research underpins practice. Improved reputation in the context of dietitians and nutrition communicators is closely linked to their ability to build trust with clients and wider audiences. This is particularly the case as there has been a shift away from traditional hospital dietitian roles towards more private practice and multidisciplinary areas such as culinary nutrition. Graduates and dietitians advanced in their career need skills beyond just nutrition knowledge, including business skills and counselling abilities, to improve their reputation.

Improved reputation is considered a final outcome because improvements in reputation reflect a dietitian's competence and trustworthiness in their profession, which can be demonstrated through their use of evidence-based practice with clients and alignment with other professionals their field. Increased reputation can be indicated by things such as credibility from using high-quality resources which is distinct from how other final outcomes were described through stakeholder interviews. This outcome can lead to greater trust and credibility, which may result in higher demand for their services, improved client satisfaction, and potentially higher earnings. It reflects the qualitative aspect of their professional standing and the respect they garner in their field.

THEORY OF CHANGE FOR GENERAL PRACTITIONERS



FINAL OUTCOMES FOR GENERAL PRACTITIONERS

Improved job satisfaction

During the interviews, GPs shared that providing them with practical nutrition communication resources for patient interactions can lead to changes in job satisfaction through an improved ability to communicate nutrition advice to patients. A change in job satisfaction can be subjectively experienced by the stakeholder group through increased confidence and ability to disseminate nutrition information to contribute to overall patient awareness and health (see Table 6).

""It becomes easier when you open the discussion with the patient and then provide them with a brochure that reinforces the same message. It's about repeating the message and helping the patient change their eating habits and behaviour. It's not an easy task, but it's necessary, and it needs to start—often during a medical consultation or when patients are visiting a GP practice. This is a good opportunity to make that change."

This outcome was described qualitatively via stakeholder consultation, and change was quantitatively measured through survey questions on key indicators of improved job satisfaction anticipated if the MEBC resources were available to them.

Job satisfaction for GPs can be driven by an increased ability to provide quality patient care and better outcomes for their patients.[4] GPs who are confident in the nutrition information they are sharing with their patients, and have an effective way to disseminate that information, experience improved job satisfaction through affecting positive change on their patients' health.

"I think it would probably be a positive impact because more education to the community about, what healthy eating is and, you know, while this program should target not only doctors but also, the way the community and should be emphasised by all health professionals."

This outcome is considered a final outcome as it reflects the fulfillment GPs derive from their ability to deliver quality care and achieve positive patient outcomes. Job satisfaction is a distinct outcome because it is directly tied to their personal fulfillment in providing quality care and achieving positive patient outcomes. GPs who feel confident in delivering nutrition advice and have effective resources to communicate this information experience greater job satisfaction. This outcome stems from the emotional and professional rewards GPs gain when they see improvements in their patients' health, which fosters a sense of accomplishment. Overall, stakeholder consultations highlighted job satisfaction is a distinct outcome driven by increased confidence, improving patient and community awareness, and the ability to make a meaningful impact on their patients' health.

Improved job efficiency

During the interviews, GPs shared that providing them with practical nutrition communication resources for patient interactions can lead to changes in job efficiency through an improved ability to disseminate evidence-based nutrition advice to patients. A change in job efficiency can be objectively or subjectively experienced by the stakeholder group through consult time efficiency and ability to keep up with recommended dietary requirements (see Table 6).

"I believe the more awareness we have about these organisations providing these materials, the more likely we are to consider using them to help us."

"As general practitioners, we often work within short time frames, covering not just diet but also other lifestyle factors. Even when focusing on diet, it's not just about meat and protein. We assess how motivated patients are for change, and based on where they're most motivated, we direct our efforts accordingly. For example, if diet is a focus, resources like this can be briefly discussed and then given to the patient, allowing them to explore the information at their own pace. Hopefully, this approach helps motivate change."

This outcome was described qualitatively via stakeholder consultation, and change was quantitatively measured through survey questions on key indicators of improved job efficiency anticipated if the MEBC resources were available to them.

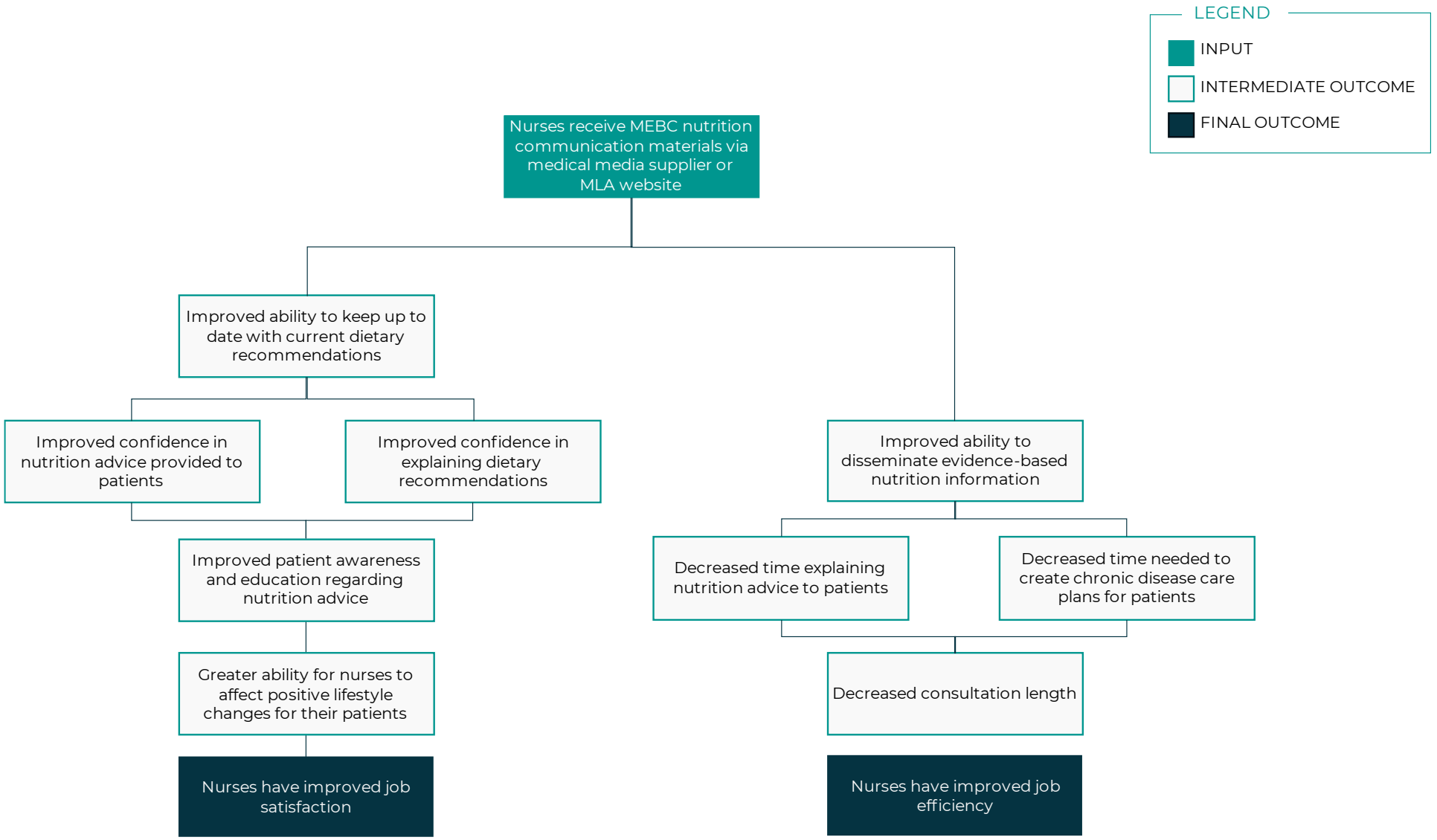
"Most doctors have very limited training in nutritional advice. In medical school, we learn mostly on the go, and over six years of training, we might only have half a day focused on diet. Most of our time is spent learning about diseases, medications, surgical techniques, and other medical aspects. As a result, while people often expect us to have extensive knowledge about nutrition, we actually don't. Referring patients to a dietitian can be costly or inconvenient, which makes it challenging."

"There's lots of patients who can't afford to see the dietitian and so we end up doing everything. So, it saves us time in terms of having to go through everything in detail. We can hand them the information and they can have a look at it"

Job efficiency for GPs means focusing on optimising their time and resources while maintaining high-quality patient care. GPs who possess good communicative skills and have access to tools that improve their communication with patients can improve their efficiency, especially during time constraints often faced by GPs. Integrating technology, continual professional development and having adequate patient resources were found to be important to improving job efficiency.

This outcome is considered a final outcome because it reflects GPs' efforts to manage their time effectively while still providing quality care. Stakeholder consultations highlighted job efficiency as a unique outcome, driven by the integration of practical resources, and improved access to patient information. These factors allow GPs to navigate time constraints more effectively and focus more on patient care, leading to better overall efficiency in their practices.

THEORY OF CHANGE FOR PRIMARY CARE NURSES



FINAL OUTCOMES FOR PRIMARY CARE NURSES

Improved job satisfaction

During the interviews, nurses shared that providing them with practical nutrition communication resources for patient interactions can lead to changes in job satisfaction through an improved ability to communicate nutrition advice to patients. A change in job satisfaction was subjectively experienced by the stakeholder group through increased confidence and ability to disseminate nutrition information to contribute to overall patient awareness and health (see Table 6).

"I think that when I help a patient and they find the advice helpful, they often share it with their relatives. and this way, they can spread the knowledge and create healthier meals for their families. We also get good feedback"

"It would make me feel more confident discussing nutrition with them. It's reassuring to have a physical resource to back up what I'm saying, rather than just sharing my opinion."

"Having specific good resources would make help my motivation at work. Anything that makes my job easier, like having more resources, would definitely help. It would make my work more manageable and keep me motivated."

This outcome was described qualitatively via stakeholder consultation, and change was quantitatively measured through survey questions on key indicators of improved job satisfaction anticipated if the MEBC resources were available to them.

Job satisfaction for primary care nurses is driven by an increased ability to provide quality patient care and better outcomes for their patients. Primary care nurses who are confident in the nutrition information they are sharing with their patients, and have an effective way to disseminate that information, experience improved job satisfaction through affecting positive change on their patients' health. Access to continuing education and opportunities for career progression are also significant factors contributing to primary care nurses' satisfaction; the ability to develop specific skills for primary practice contributes to their sense of growth and fulfillment.

This outcome is considered a final outcome because it captures primary care nurses' job satisfaction derived from their ability to provide quality care. During stakeholder consultations, job satisfaction was specifically identified through different indicators of change, such as improved confidence and nutrition advice they are disseminating, enabling nurses to achieve better patient outcomes and feel fulfilled in their roles.

Improved job efficiency

During the interviews, nurses shared that providing them with practical nutrition communication resources for patient interactions can lead to changes in job efficiency through an improved ability to disseminate up to date evidence-based nutrition advice to patients.

"I've seen a lot of documents that we use for our patients, but when you check the date, they're from 2019 or 2020, so the information isn't up-to-date. It's important to provide patients with the most current information. I'm hoping this resource will be regularly updated so we can continue to use it."

A change in job efficiency was objectively or subjectively experienced by the stakeholder group through time efficiency during consult time and in creating care plans for patients (see Table 6). This outcome was described qualitatively via stakeholder consultation, and change was quantitatively measured through survey questions on key indicators of improved job efficiency anticipated if the MEBC resources were available to them.

"I think it would save time because sometimes there's only a limited amount of time to explain things to the patient, and they can only absorb so much information. Giving them a resource to take home that reinforces what I've said would be helpful. Plus, it would save me time on Googling and trying to find reliable sources."

“In terms of communication, it would really help, especially with patients whose first language isn’t English. The visuals and graphics make it much easier to understand, so it would make communication a lot smoother for me."

Job efficiency for primary care nurses means focusing on optimising their time and organisation while maintaining high-quality patient care. Primary care nurses who possess good communicative skills and have access to tools that improve their communication with patients can improve their efficiency. Nurses who are up to date with current dietary recommendations and can communicate that information effectively with their patients will experience improved job efficiency and reduced consultation time, particularly when creating detailed care plans for patients with chronic conditions.

This outcome is considered a final outcome because it reflects primary care nurses’ ability to perform their roles more effectively. During stakeholder consultations, job efficiency was specifically identified through different indicators of change, such as streamlined nutrition communication and improved time management, enabling primary are nurses to deliver care more efficiently and effectively.

OUTCOME INDICATORS FOR EACH FINAL OUTCOME

Outcome indicators for dietitians and culinary nutrition professionals, GPs and practice nurses were derived from consultation. Indicators were defined as the way in which stakeholders know that a change had occurred. These could be either objective or subjective, and for the purposes of this analysis they were based on direct stakeholder consultation and self-reported expected change.

A summary of indicators for stakeholder outcomes is provided in Table 6. The table includes the indicators used in this SROI, as well as proposed outcome indicators that could be used in an ideal situation with improved data availability. The indicators used in this SROI were primarily subjective, self-reported measures. Should a retrospective SROI be conducted, the proposed indicators should be measured as part of the delivery of the intervention, to support evaluation.

Given that final outcomes were indicated and verified by multiple sources, it is unlikely that other key material outcomes have not been included in this report. No other outcomes were highlighted during the analysis and not included in the analysis.

Table 6 Indicators of stakeholder outcomes

Stakeholder	Outcome	Indicator used in this SROI	Indicator (proposed for future evaluative SROI)
Dietitians	Improved job satisfaction	• Subjective: self-reported positive feedback from clients • Subjective: self-reported ability to change perceptions around unhealthy/restrictive diets • Subjective: self-reported ability to have a positive impact on clients and/or students • Subjective: self-reported enjoyment from sharing more holistic approaches to nutrition • Subjective: self-reported ability to motivate clients effectively	• Objective: change in client retention • Subjective: proportion of people reporting clients providing positive feedback • Subjective: self-reported improved motivation and inspiration to create materials from the intervention
	Improved job efficiency	• Subjective: self-reported time to create new and high-quality communication content • Subjective: self-reported ability to keep up to date with dietary recommendations • Subjective: self-reported ability to communicate dietary guidelines to clients • Subjective: self-reported efficiency in creating care plans for clients • Subjective: self-reported time efficiency during client consults • Subjective: self-reported availability of practical nutrition advice for clients	• Objective: change in consult time • Objective: change in non-consult time (i.e. care plan development and professional development)
	Increased job opportunities	• Subjective: self-reported revenue streams from increased social media promotion	• Objective: change in engagement on social media platforms

Stakeholder	Outcome	Indicator used in this SROI	Indicator (proposed for future evaluative SROI)
		• Subjective: self-reported reach from effective social media communication	• Objective: change in revenue attributed from social media promotion
	Improved reputation	• Subjective: self-reported credibility from using high-quality resources • Subjective: self-reported reputation when starting out in your career • Subjective: self-reported perception of your organisation's commitment to sustainability targets • Subjective: self-reported alignment across dietitians on key messaging and issues • Subjective: self-reported client perception of quality of care through availability of well-designed resources	• Subjective: self-reported increase in reputation when using the intervention • Objective: change in referrals from other practices • Subjective: self-reported perception of industry alignment when using the intervention to explain healthy eating practices • Objective: change in client feedback or testimonials on quality of care
General practitioners	Improved job satisfaction	• Subjective: self-reported confidence in the nutrition advice provided to patients • Subjective: self-reported ability to disseminate nutrition information • Subjective: self-reported patient awareness and education	• Subjective: self-reported change in confidence when providing nutritional counselling when using the intervention • Subjective: self-reported positive behavioural changes in their patient's awareness of healthy eating practices
	Improved job efficiency	• Subjective: self-reported time efficiency during patient consultations • Subjective: Self-reported ability to keep up to date with current dietary recommendations	• Objective: change in consult time • Objective: change in non-consult time
Primary care nurses	Improved job satisfaction	• Subjective: self-reported confidence in the nutrition advice provided to patients • Subjective: self-reported ability to disseminate nutrition information • Subjective: self-reported patient awareness and education	• Subjective: self-reported increased confidence in providing nutritional counselling when using the intervention • Subjective: self-reported positive behavioural changes in their patient's awareness of healthy eating practices
	Improved job efficiency	• Subjective: self-reported time of consult • Subjective: self-reported efficiency in creating care plans for patients • Subjective: Self-reported ability to keep up to date with current dietary recommendations	• Objective: change in consult time • Objective: change in non-consult time (i.e. care plan development)

MEASURING MATERIAL CHANGE

One of the principles of a SROI is to "only include what is material" [3]. This principle ensures that included information and evidence give a true and fair picture, such that reasonable conclusions about impact can be drawn.

The materiality of an outcome was determined by its relevance and significance to the stakeholder. Relevance means the outcome has a clear impact on stakeholders and stakeholders perceive the outcome as important to them. Significance means the outcome has enough scale to influence decisions and actions, based upon its causality, quantity and duration [3].

As per best practice and previously assured SROI, the materiality of each final outcome was assessed by applying pre-specified thresholds and using the following criteria:

1. **Was the change indicated?**

   Indicators are ways of knowing that change has happened [3]. They are applied to outcomes as a way to measure change. Importantly, indicators are best informed by stakeholders and supported by secondary research or complementary data.

   For this SROI, change was indicated if the final outcome was:

   - Indicated by stakeholders during consultation; and/or

2. **Was the change important?**

   Importance determines the relevance, value and impact of an outcome as perceived by stakeholders.[3]

   For this SROI, the change was considered important if:

   - The weighted average importance of the outcome was at least 50% (unless otherwise justified); or
   - The outcome was already financial in nature, and thus the importance was 100%; or
   - The outcome was considered negative or detrimental to stakeholders.

3. **What caused the change?**

   Change in final outcomes was considered material if:

   - The change was at least moderately the result of the intervention. That is, attribution is greater than or equal to 50% (unless otherwise justified) (see Appendix VIII); and
   - The change 'might' or 'very probably would not' have occurred without the intervention. That is, deadweight is less than or equal to 40%. This translates to the fact that the final outcomes can be influenced by a variety of factors other than the use of the intervention which was considered justifiable for this SROI (see Appendix IX).

4. **What was the quantity of change?**

   For this SROI, quantity of change was assessed using consultation survey data and was considered material if:

   - The proportion who experienced the outcome was at least 50%.

5. **What was the magnitude of change?**

   During consultations, healthcare professionals explained that the intervention would benefit both their work and their patients by incorporating evidence-based nutrition communication resources. This is because it provides them with scientifically supported and easily understandable materials to share with patients. As a result, it saves time during consultations while also increasing confidence in delivering nutritional advice to their patients. Additionally, the quantity of change was informed by the proportion of stakeholders who noticed a change in the outcome if the intervention was available to them. As such, for this SROI, the magnitude of change was considered material if (unless otherwise justified):

   - The magnitude of change >0% (i.e. Any level of change was indicated by the stakeholder group from the use of the intervention with their patients or clients).

6. **What was the duration of change?**

   The duration of change determines how long an outcome lasts after the intervention.[3]

   For this SROI, the duration of change was considered material if:

   - The outcome lasts for the full year if the stakeholder uses the intervention over the period in a manner that is meaningful for their job satisfaction, efficiency, opportunities or reputation.

If the above criteria were met, then a final outcome was considered relevant, significant, and thus material. The assessment of materiality for each stakeholder and outcome included in this SROI is summarised in Table 7. Not all outcomes initially considered for this SROI were found to be material. Some of the initial outcomes were not significant, and, therefore, were excluded from the analysis. This ensured that the analysis aligned with the SROI principle of only including what is material.

As all the assessed outcomes were value alone 20% or more of the investment in the intervention, they were all considered sufficiently valuable to remain in the analysis.

Table 7 Measuring materiality

		Relevance			Significance		
Stakeholder	**Outcome**	**Indicator of change**	**Importance**	**Causality of change**	**Quantity of change**	**Magnitude of change**	**Duration of change**
Dietitians	Job satisfaction	**Yes** – indicated during consultation	**Yes** – stakeholders express that this outcome is important to them	**Yes –** change in the outcome may occur due to the increased use of practical nutrition communication resources	**Yes** – a material proportion of stakeholders are expected to experience this outcome	**Yes** – >0% of change is created from the use of the intervention	**Yes** – this outcome is expected to last at least 12 months
	Job efficiency	**Yes** – indicated during consultation	**Yes** – stakeholders express that this outcome is important to them	**Yes –** change in the outcome may occur due to the increased use of practical nutrition communication resources	**Yes** – a material proportion of stakeholders are expected to experience this outcome	**Yes** – >0% of change is created from the use of the intervention	**Yes** – this outcome is expected to last at least 12 months
	Job opportunities	**Yes** – indicated during consultation	**Yes** – stakeholders express that this outcome is important to them	**Yes –** change in the outcome may occur due to the increased use of practical nutrition communication resources	**Yes** – a material proportion of stakeholders are expected to experience this outcome.	**Yes** – >0% of change is created from the use of the intervention	**Yes** – this outcome is expected to last at least 12 months
	Revenues	**No** – indicated during consultation	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
	Reputation	**Yes** – indicated during consultation	**Yes** – stakeholders express that this outcome is important to them	**Yes –** change in the outcome may occur due to the increased use of practical nutrition communication resources	**Yes** – a material proportion of stakeholders are expected to experience this outcome	**Yes** – >0% of change is created from the use of the intervention	**Yes** – this outcome is expected to last at least 12 months

		Relevance			Significance		
Stakeholder	**Outcome**	**Indicator of change**	**Importance**	**Causality of change**	**Quantity of change**	**Magnitude of change**	**Duration of change**
General practitioners	Job satisfaction	**Yes** – indicated during consultation	**Yes** – stakeholders express that this outcome is important to them	**Yes –** change in the outcome may occur due to the increased use of practical nutrition communication resources	**Yes** – a material proportion of stakeholders are expected to experience this outcome	**Yes** – >0% of change is created from the use of the intervention	**Yes** – this outcome is expected to last at least 12 months
	Job efficiency	**Yes** – indicated during consultation	**Yes** – stakeholders express that this outcome is important to them	**Yes –** change in the outcome may occur due to the increased use of practical nutrition communication resources	**Yes** – a material proportion of stakeholders are expected to experience this outcome	**Yes** – >0% of change is created from the use of the intervention	**Yes** – this outcome is expected to last at least 12 months
	Improved relationship with patients	**No** – indicated during consultation	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Primary care nurses	Job satisfaction	**Yes** – indicated during consultation	**Yes** – stakeholders express that this outcome is important to them	**Yes –** change in the outcome may occur due to the increased use of practical nutrition communication resources	**Yes** – a material proportion of stakeholders are expected to experience this outcome	**Yes** – >0% of change is created from the use of the intervention	**Yes** – this outcome is expected to last at least 12 months
	Job efficiency	**Yes** – indicated during consultation	**Yes** – stakeholders express that this outcome is important to them	**Yes –** change in the outcome may occur due to the increased use of practical nutrition communication resources	**Yes** – a material proportion of stakeholders are expected to experience this outcome	**Yes** – >0% of change is created from the use of the intervention	**Yes** – this outcome is expected to last at least 12 months

HOW MANY PEOPLE ARE IMPACTED

DIETITIANS

The number of dietitians was estimated based on the number of Dietitian Connection members listed in their database. MLA collaborates with Dietitian Connection by promoting its nutrition resources to dietitians through sponsored professional development opportunities and advertisements in e-newsletters (e-news). These efforts aim to increase the use of MLA's practical nutrition resources among health professionals. The breakdown of dietitians (private, public, aged care, community, university, and hospital) was provided by Dietitian Connection through their member analysis and shared via email with MLA.

An e-news containing MEBC resources was sent to the Dietitian Connection database, which is estimated to include approximately 8,500 to 9,000 dietitians in Australia and New Zealand. The open rate of the MLA e-newsletter, as provided via email (e-newsletter results, August 2024), was calculated by dividing the number of unique clicks by the total number of Dietitian Connection members who received the e-newsletter. As a result, the total number of dietitians who opened the MEBC resources was estimated by multiplying the open rate by the total number of dietitians in the Dietitian Connection database (Table 8). This estimate was then used to determine the number of dietitians who would use the MEBC resources.

Table 8 Total dietitian stakeholders

Dietitians	Value	Source
Total DC database	12,440	Email communications with DC, E-newsletter results (August 2024)
Type of dietitians on DC database		
% Private practice	0.18	Email communications with MLA, 2024
% Public health	0.04	Email communications with MLA, 2024
% Aged care, community	0.16	Email communications with MLA, 2024
% University	0.09	Email communications with MLA, 2024
% Hospital	0.22	Email communications with MLA, 2024
Total dietitians on DC database	8,584	Calculation
MLA e-news open rate	0.46	Email communications with DC, E-newsletter results (August 2024)
Total number of dietitians who would use the MEBC resources	**3,948**	

Abbreviations: DC, Dietitian Connection; MLA, Meat & Livestock Australia

GENERAL PRACTITIONERS

MLA partners with three medical media suppliers to distribute their MEBC nutrition resources to GPs: Samples Plus, Tonic Health Media, and AMPCO. Samples Plus directly promotes MLA's practical nutrition resources and promotional activities targeting Australian GP practices. The Samples Plus database served as the basis for the GP stakeholder estimates, as it contained data on past orders of MEBC materials by GPs across Australia.

The total number of unique GP requests, provided by Samples Plus, was divided by the number of years MLA has worked with them, to calculate the average number of unique GP requests per campaign per year. Since MLA could not provide specific GP numbers that MEBC has been used by GPs across Australia per year, it was assumed that through the three medical suppliers there would be full coverage of GPs across Australia. It was assumed that the overlap between other databases collectively cover 100% of Australian GPs, ensuring all GPs would eventually be exposed to the advertising of MEBC materials. Consequently, the reach of Samples Plus was extrapolated by finding the ratio of GPs in Australia to total GPs on Samples Plus database to estimate the total number of GPs covered by their database and the overall number of GPs in

Australia (Table 9). The number of GPs in Australia was obtained from the Department of Health Workforce Data tool.[5]

Table 9 Total general practitioner stakeholders

General practitioners	Value	Source
Number of GPs in Australia	26,599	Health Workforce Data, 2024 [5]
Samples Plus database	20,030	Samples Plus Campaign summary
Time period of database in years	6.0	Samples Plus Campaign summary
Number of GPs requesting MLA resources in defined time period	14,421	Samples Plus Campaign summary
Total unique GP requests per campaign in one year	2,404	Calculation
Ratio of GPs in Australia to total GPs on Samples Plus database	1.33	Calculation
Total number of general practitioners who would use the MEBC resources	**3,192**	

PRIMARY CARE NURSES

It was assumed that the proportion of GPs in Australia exposed to MEBC promotional activities and resources corresponds to the proportion of primary care nurses targeted. To estimate the total number of primary care nurses impacted by MEBC resources, the number of primary care nurses employed in general practice was multiplied by the proportion of GPs targeted across Australia (Table 10). The proportion was calculated via total number of GPs impacted by MEBC resources divided by total GPs in Australia from Table 9. Data on number of primary care nurses employed in general practice settings was obtained from the Australian Institute of Health and Welfare profile of primary health care nurses.[6]

Table 10 Total primary care nurse stakeholders

Primary care nurses	Value	Source
Total primary health care nurses	82,000	Australian Institute of Health and Welfare 2024 [6]
Proportion of primary care nurses employed in general practice	0.68	Australian Institute of Health and Welfare 2024 [6]
Total primary care nurses employed in general practice	55,760	Calculation
Total number of primary care nurses who would use the MEBC resources	**6,691**	

MEAT & LIVESTOCK AUSTRALIA

Meat & Livestock Australia provides funding and support for the MEBC program. Whilst they impact the program through funding, based on feedback from stakeholders they were not identified to have experienced material outcomes from the program and are not included in the total value derived from the program. Meat & Livestock Australia is included in the analysis as a single stakeholder.

VALUING OUTCOMES

Valuing outcomes involves the monetisation of non-financial outcomes by assigning them appropriate financial proxies. Financial proxies reflect the value of change from the perspective of the lived experience of the stakeholder. Given many outcomes are non-financial in nature, stakeholder consultation was used to inform appropriate financial proxies.

There are three main techniques used to value outcomes, however only willingness to pay/accept was used to value outcomes in this SROI:

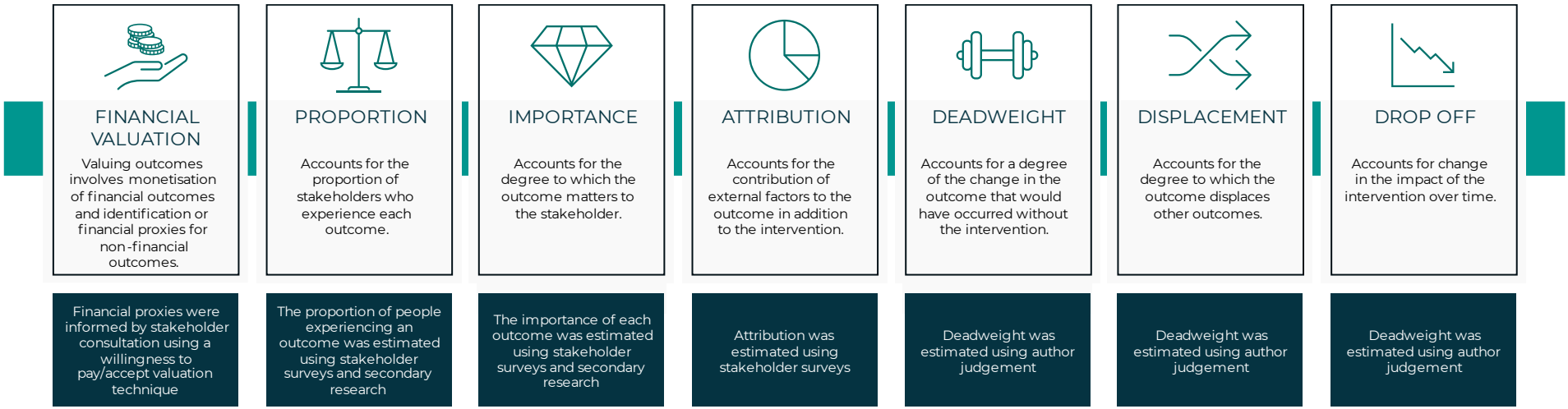
1. **Economic valuation** – the financial value representing the actual savings/cost to the stakeholder
2. **Willingness to pay/accept** – the value of an outcome based on how much stakeholders are willing to pay/accept
3. **Replacement valuation** – the cost of other service(s) and/or good(s) that would achieve the same amount of change

The financial proxies and valuation approach for each outcome of job satisfaction, job efficiency, job opportunities and reputation are detailed in Appendix IV.

CALCULATING THE VALUE

This report aims to quantify the social value created by investing in practical nutrition communication resources for healthcare professionals. Outcomes were derived from stakeholder consultation and secondary research (see sources in Table 19). To calculate the total value, the value of each outcome was calculated by multiplying the financial valuation (Appendix IV) with the importance weighting (Appendix VI), proportion of stakeholders impacted (Appendix V), duration (Appendix VII), and SROI filters, including attribution (Appendix VIII), deadweight (Appendix IX), displacement (Appendix X), and drop off (Appendix XI). As described above, stakeholders were engaged, where possible, to inform the variables used in the calculation process. SROI filters were informed using the authors' judgement in consultation with dietitians, GPs and primary care nurses.

The SROI ratio is calculated by dividing the total value created ($1,890,479) by the total cost of the investment required to create the value ($521,500).



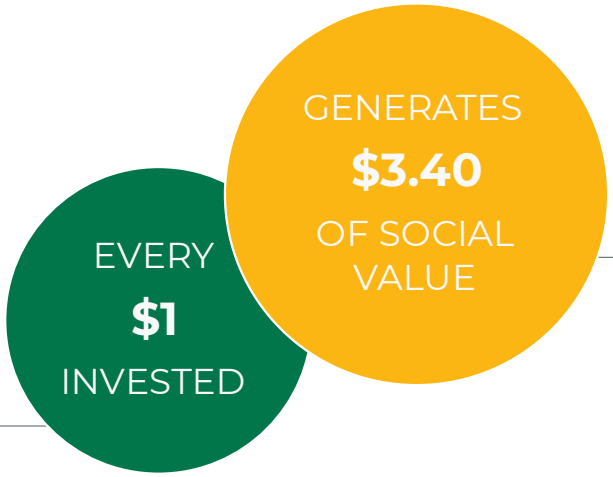
IMPACT OF MEBC NUTRITION COMMUNICATION PROGRAM

$1.25 MLN NET PRESENT VALUE

$1.78 MLN TOTAL VALUE CREATED

$0.52 MLN TOTAL INVESTMENT

in practical nutrition communication resources able to engage and empower health professionals to educate their clients about healthy eating and food waste reduction in line with Australian Dietary Guidelines



SROI range: 2.27 to 4.21

3,948
NUMBER OF DIETITIANS EXPECTED TO BE IMPACTED

3,192
NUMBER OF GPs EXPECTED TO BE IMPACTED

6,691
NUMBER OF PRIMARY CARE NURSES EXPECTED TO BE IMPACTED

THE SOCIAL VALUE CREATED IS SHARED BETWEEN STAKEHOLDERS:

46% Clinical and community dietitians

26% General practitioners

28% Primary care nurses

OUTCOMES GENERATING SOCIAL VALUE FOR STAKEHOLDERS INCLUDE:

- Increased job efficiency
- Increased job satisfaction
- Improved reputation
- Improved job opportunities

INVESTMENT

In a SROI, an input refers to what the stakeholders are contributing in order to make the outputs and outcomes possible [3]. This includes both monetary and 'in-kind' (e.g. time) contributions. MLA is a not-for-profit organisation, primarily funded by transaction levies paid on livestock sales by producers, which supports marketing, research and development activities. A detailed breakdown of the investment required to deliver the intervention is described in 0; a summary is provided below.

The investment required to deliver practical nutrition communication resources for healthcare professionals includes production of resources, distribution, sponsorship, event management and employee salary costs to manage the program. Ongoing funding of the program ensures the resources are up to date with the latest research and dietary guidelines, allowing healthcare professionals to deliver evidence-based advice to their patients effectively. The financial value of the annual investment from MLA into the program and resources was calculated to be $521,500.

Table 11 Total annual input costs

Stakeholders	MEBC component	Financial value of investment for entire stakeholder group	Financial value of investment per healthcare professional
Meat & Livestock Australia	Sponsorship of e-news, webinars, podcasts	$240,000	$17
	Printing and fulfilment of practical resources	$80,000	$6
	Production of practical resources	$40,000	$3
	Masterclass	$70,000	$5
	Program coordinator in NFP annual salary	$91,500	$7
Total annual investment		**$521,500**	**$38**
Total present value investment		**$521,500 over 1 year**	

13,831

NUMBER OF TARGETED HEALTHCARE PROFESSIONALS

$38

ANNUAL INVESTMENT PER HEALTHCARE PROFESSIONAL

$521,500

TOTAL AMOUNT INVESTED OVER 1 YEAR

VALUE CREATED

FINAL OUTCOMES FOR DIETITIANS

JOB SATISFACTION

Providing dietitians with practical nutrition communication resources for patient interactions can lead to changes in job satisfaction through an improved ability to have a positive impact on their clients' diets. These changes can be experienced both subjectively and objectively through their motivation, patient outcomes, and relationships with colleagues and clients. Experiencing improvements in these indicators can lead to a change in job satisfaction. This outcome was described qualitatively via stakeholder consultation, survey data, and secondary research [7]. The change was quantitatively measured through survey questions on key indicators of improved job efficiency anticipated if the MEBC resources were available to them.

"[The MEBC program] is really that practical application of nutrition that has been lacking in the past, and culinary nutrition for me is just beautiful because it brings together nutrition, science with cooking and cheffing and creating this world of fabulous food."

"[the resources] might be really helpful because a common issue I see with patients is the belief that eating healthy is always more expensive [...] It's really hard to encourage them to think outside that, that walled box. I think if the patients actually read that, it would actually have a significant impact on their wellbeing."

JOB EFFICIENCY

Providing dietitians with practical nutrition communication resources for patient interactions can lead to changes in job efficiency through an improved ability to communicate effectively with their clients. A change in job efficiency can be subjectively or objectively experienced by the stakeholder group through changes in consult time. This outcome was described qualitatively via stakeholder consultation, survey data, and secondary research [8]. The change was quantitatively measured through survey questions on key indicators of improved job satisfaction anticipated if the MEBC resources were available to them.

"In a clinical setting, anything that makes it easier for us to convey information or apply practical solutions is a win. If I find a resource that serves as a simple cheat sheet with key points, along with practical tips for patients to implement at home, it creates a much easier opportunity for me to engage my clients effectively."

"People don't realise the time it takes to create good content. It's something that many of us would love to do more of, but don't have time for. Any shortcuts or tools that can help—whether to prepare a presentation or for me to write an engaging article or create social media content. Shortcuts can be great."

JOB OPPORTUNITIES

Providing dietitians with practical nutrition communication resources can lead to changes in job opportunities through inspiration for other content generation and personal brand. A change in job opportunities can be subjectively or objectively experienced by the stakeholder group through a change in revenue, career growth and professional development. This outcome was described qualitatively via stakeholder consultation, survey data, and secondary research [9]. The change was quantitatively measured through survey questions on key indicators of improved job opportunities anticipated if the MEBC resources were available to them.

> *"For the most part, dieticians are going to be generating revenue from their private practice or from working for someone else and they will be doing the socials on the side. Very few of them I think are making any kind of an income from social media [...] we put great value on entrepreneurship these days in dietetic practice [...] And it's the questions I always get from young dieticians and other people trying to get into this world [...] How do I get into media? How do I create content? How do I, so I hope that these kinds of resources can help them, to help them to create these resources until they can and then work out how they integrate it and make it into their own style and then develop their own things along the way. So yes, I would hope it's [the MEBC program] a really positive thing for them."*

REPUTATION

Providing dietitians with practical nutrition communication resources can lead to changes reputation through alignment with up-to-date and evidence-based dietary recommendations. A change in job opportunities can be subjectively or objectively experienced by the stakeholder group through their perceived credibility and alignment with reputable organisations and other dietitians. This outcome was described qualitatively via stakeholder consultation, survey data, and secondary research [10]. The change was quantitatively measured through survey questions on key indicators of improved reputation anticipated if the MEBC resources were available to them.

> *"Having useful resources in your consultation in your practice is quite useful. On behalf of all of those clinicians doing 1:1 care and group education, those resources do come in handy, particularly [...] for someone that does not have your level of reputation maybe just starting in the space."*

> *"I'm able to pass to patients some evidence-based information rather than rely on something on YouTube that may not be necessarily robust in terms of fact checking. This will be handy to support the patient because it is all driven by the patient's need."*

TOTAL VALUE CREATED FOR DIETITIANS

The value of each final outcome for dietitians was calculated. The value created from the provision of free practical nutrition communication resources is outlined in Table 12.

Table 12 Total present value created for dietitians

Stakeholder	Outcomes	Total present value for entire stakeholder group	Total present value created per individual stakeholder
	Job satisfaction	$143,369	$36.31

Stakeholder	Outcomes	Total present value for entire stakeholder group	Total present value created per individual stakeholder
Clinical and community dietitians	Job efficiency	$167,447	$42.41
	Job opportunities	$150,621	$38.15
	Reputation	$360,909	$91.41
	Total present value created	$822,346	

FINAL OUTCOMES FOR GENERAL PRACTITIONERS

JOB SATISFACTION

Providing GPs with practical nutrition communication resources for patient interactions can lead to changes in job satisfaction through an improved ability to communicate nutrition advice to patients. A change in job satisfaction can be subjectively experienced by the stakeholder group through increased confidence and ability to disseminate nutrition information to contribute to overall patient awareness and health. This outcome was described qualitatively via stakeholder consultation, survey data, and secondary research [11]. The change was quantitatively measured through survey questions on key indicators of improved job satisfaction anticipated if the MEBC resources were available to them.

"[The resources] reinforce everything. I try to keep up to date as much as possible, but they help consolidate it all when my mind is full. Sometimes they act as an aid for me, not just for handing out to others. I can go through them to remind myself and explain to others what we're supposed to be doing. So, yes, I think they [the resources] are good."

JOB EFFICIENCY

Providing GPs with practical nutrition communication resources for patient interactions can lead to changes in job efficiency through an improved ability to disseminate evidence-based nutrition advice to patients. A change in job efficiency can be objectively or subjectively experienced by the stakeholder group through consult time efficiency and ability to keep up with recommended dietary requirements. This outcome was described qualitatively via stakeholder consultation, survey data, and secondary research [12]. The change was quantitatively measured through survey questions on key indicators of improved job efficiency anticipated if the MEBC resources were available to them.

"[The resources] saves us time by allowing us to provide patients with information without having to go through every detail. We can hand them the materials, and they can have a look at it [...] patients are more likely to trust the information if their GP provides it, rather than if they simply find it online."

"I feel that my advice in the consultation will be more meaningful value for time and effort, it would be easier and it probably makes me a bit more efficient because I can show them [the resources] and it will be more meaningful for me to go through that article with all that pamphlet with them rather than me, bring up something on my

laptop and say, point to this, click on that, you know - that probably won't mean much to them."

TOTAL VALUE CREATED FOR GENERAL PRACTITIONERS

The value of each final outcome for GPs was calculated. The value created from the provision of free practical nutrition communication resources is outlined in Table 13.

Table 13 Total present value created for general practitioners

Stakeholder	Outcomes	Total present value for entire stakeholder group	Total present value created per individual stakeholder
GPs	Job satisfaction	$315,557	$99
	Job efficiency	$146,861	$46
	Total present value created	$462,418	

Abbreviations: GPs, general practitioners

OUTCOMES FOR PRIMARY CARE NURSES

JOB SATISFACTION

Providing primary care nurses with practical nutrition communication resources for patient interactions can lead to changes in job satisfaction through an improved ability to communicate nutrition advice to patients. A change in job satisfaction was subjectively experienced by the stakeholder group through increased confidence and ability to disseminate nutrition information to contribute to overall patient awareness and health. This outcome was described qualitatively via stakeholder consultation, survey data, and secondary research [13, 14]. The change was quantitatively measured through survey questions on key indicators of improved job satisfaction anticipated if the MEBC resources were available to them.

"It [the resources] would make me feel a bit more confident to discuss nutrition with patient [...] and it's nice to have a sort of physical resource to say this is backing up what I'm telling you rather than me going off track."

JOB EFFICIENCY

Providing primary care nurses with practical nutrition communication resources for patient interactions can lead to changes in job efficiency through an improved ability to disseminate evidence-based nutrition advice to patients. A change in job efficiency was objectively or subjectively experienced by the stakeholder group through time efficiency during consult time and in creating care plans for patients. This outcome was described qualitatively via stakeholder consultation, survey data, and secondary research [15]. The change was quantitatively measured through survey questions on key indicators of improved job efficiency anticipated if the MEBC resources were available to them.

"I do a lot of care planning at work in a GP practice [...] currently I am conducting care plans and health assessments, seeing about eight people a day with various chronic diseases. Many of these patients are always looking for advice on healthy eating [...] a lot of them ask me not to refer them to a dietitian, they are always looking for advice [...] these resources would be helpful."

TOTAL VALUE CREATED FOR PRIMARY CARE NURSES

The value of each final outcome for primary care nurses was calculated. The value created from the provision of free practical nutrition communication resources is outlined in Table 14.

Table 14 Total present value created for primary care nurses

Stakeholder	Outcomes	Total present value for entire stakeholder group	Total present value created per individual stakeholder
Primary care nurses	Job satisfaction	$302,904	$45
	Job efficiency	$187,732	$28
	Total present value created	$490,636	

SENSITIVITY ANALYSIS

A SROI analysis, like all types of economic evaluations, should include sensitivity analyses to assess the impact of certain assumptions on the results. Since the results of this assessment are often based on hypotheses and variables that are based on interviews and surveys, it is important to test plausible ranges of key assumptions to understand how the results would change.

The following variables were tested in the sensitivity analysis:

1. Stakeholder calculations
2. SROI filters
3. Valuation approaches

STAKEHOLDER CALCULATIONS

Estimates of MLA campaign targeting and dietitians who received MLA marketing via medical media suppliers from historical campaigns were used to inform the stakeholder calculations. A sensitivity analysis was conducted to test different open rates of medical media marketing for dietitians. Additionally, the assumption that all GPs and primary care nurses received MLA marketing from a medical media supplier in Australia was tested (Table 15). No sensitivity analysis was conducted on the total number of GPs, primary care nurses and dietitians in Australia as these are published by the Australian institute of Health and Welfare and Department of Health.[5]·[6]

Table 15 Stakeholder calculation sensitivity analysis

Stakeholder group	Scenario	Value	SROI ratio, NPV	% change in SROI ratio	Description
Dietitians	Base case	3,948	1:3.40, $1,253,900	-	Based on DC e-news open rate from survey results analysis (base case of 46%)
	Sensitivity analysis	2,575	1:2.86, $967,866		Assumption of future open rates of DC e-news (lower limit of 30%)
	Sensitivity analysis	5,150	1:3.88, $1,504,179.13		Assumption of future open rates of DC e-news (upper limit of 60%)
GPs	Base case	3,192	1:3.40, $1,253,900	-	Based on assumption of 100% GP reach
	Sensitivity analysis (remove extrapolation)	2,404	1:2.95, $1,018,679		Medical media suppliers may not reach 100% of GPs in Australia, and hence extrapolation of % GP requests were removed.
Primary care nurses	Base case	6,691	1:3.40, $1,253,900	-	Based on assumption of 100% GP reach and hence primary care nurse reach
	Sensitivity analysis (remove extrapolation)	5,039	1:3.17, $1,132,767		Medical media suppliers may not reach 100% of GPs in Australia, and hence extrapolation of % GP requests were removed.

Abbreviations: DC, Dietitians Connection; GP, general practitioners; NPV, net present value; SROI, social return on investment

SROI FILTERS

Estimates of SROI filters, including importance, proportion, and attribution, were informed by stakeholder consultation. Other SROI filters, including deadweight and displacement were informed by secondary research and authors' judgement and were therefore tested in the sensitivity analyses (Table 16) [16].

It is not expected that other nutrition programs would become available over the time horizon of this SROI; something that could impact the deadweight or attribution filters. However, the sensitivity analyses consider the scenario that an alternative range of nutrition communication materials, used for similar purposes, are available for use by the healthcare professionals.

Table 16 Deadweight sensitivity analysis

SROI filter	Stakeholder	Type	Outcomes	Value	SROI ratio, NPV	% change in SROI ratio	Description
Deadweight	All	Base case	All	40%	1:3.40, $1,253,900	-	Based on assumption that the change might have occurred even if the activity had not occurred
		Sensitivity analysis	All	60%	1:2.27, $662,100		Test assumption (upper limit)
	All	Sensitivity analysis	Job efficiency and job satisfaction	20%	1:4.21, $1,675,190		Test assumption (lower limit)
Displacement	All	Base case	All	0%	1:3.40, $1,253,900	-	Based on assumption that MEBC does not displace any other nutrition communication program
		Sensitivity analysis	All	20%	1:2.72, $898,820		Test assumption that outcomes from the intervention have displaced alternative activities (i.e. use of alternative nutrition programs) by 20%

Abbreviations: NPV, net present value; SROI, social return on investment

VALUATION APPROACHES

The valuation approach and financial proxy used for each outcome were informed via stakeholder consultation, providing insight into what healthcare professionals were willing to pay to improve those outcomes. Since the final outcomes are highly personal based on individual, work experience and field of practice, alternative scenarios were used to conduct sensitivity analyses for specified outcomes within each stakeholder group (Table 17).

Table 17Financial proxy sensitivity analysis

Stakeholder	Outcome	Type	Value	SROI ratio, NPV	% change in SROI ratio	Description

Dietitians	Job Opportunities	Base case	$1,360	1:3.40, $1,253,900	-	Using member rate for DA conference.[17]
		Sensitivity analysis	$1,565	1:3.63, $1,370,676		Using non-member rate for DA conference.[17]
		Sensitivity analysis	$1,198	1:3.55, $1,330,021		Based on varying advertising rates and their timeframe on DA.[18]
GPs	Job efficiency	Base case	$684	1:3.40, $1,253,900	-	Base case calculated weighted average across various inputs
		Sensitivity analysis	$20	1:3.13, $1,111,334		Use of lowest value response (alternative nutrition paid resources)
		Sensitivity analysis	$985	1:3.53, $1,318,574		Use of highest value response only (continuous professional development activities)
Primary care nurses	Job efficiency	Base case	$480	1:3.40, $1,253,900	-	Base case calculated weighted average across various inputs
		Sensitivity analysis	$20	1:3.06, $1,073,995		Use of lowest value response (alternative nutrition paid resources)
		Sensitivity analysis	$720	1:3.58, $1,347,930		Use of highest value response only (continuous professional development activities)

Abbreviations: DA, Dietitians Australia; NPV, net present value; SROI, social return on investment

OVERALL IMPACT OF UNCERTAINTY

Sensitivity analyses testing a range of inputs show the impact of various assumptions made throughout this SROI analysis. Due to the forecast nature of this SROI, certain assumptions were made due to the lack of stakeholders with direct experience using the current resources. Since some GPs and dietitians had used previous MLA program materials, some past data were used to project certain variables, such as stakeholder numbers in this SROI. Most assumptions were based on secondary research and stakeholder consultation. However, there is the possibility that the cumulative impact of these assumptions could have influenced the overall result.

One of the assumptions tested in this SROI was the number of stakeholders that would use the MEBC resources. To accurately estimate the number of stakeholders that would receive MLA marketing informing them about the program materials, past MEBC program data, such as GP uptake from medical media suppliers, was utilised. Uptake data for previous MEBC programs over the past six years were available and considered a reliable indicator of future use of the updated program. However, for this SROI, it was assumed that all GPs and primary care nurses are targeted by medical media suppliers and would therefore be exposed to MLA marketing and their resources. Consequently, extrapolations were excluded as part of the sensitivity analysis, reducing MLA reach by approximately 6% across both stakeholder groups. Additionally, various open rates for Dietitians Connection e-news were tested for dietitians, considering the uncertainty of assuming that open rates would directly correlate to use of the resources. Depending on the open rate used in the analysis, a range of between 17% increase and 15% decrease in the SROI ratio was found.

SROI filters were primarily informed by stakeholder consultation. As this was a forecast SROI, it was not feasible to use stakeholder data for all filters, especially those such as deadweight and displacement, as stakeholders often do not have the experience of the counterfactual (i.e. what would have happened if they did not experience using the intervention) and are therefore unable to accurately assess these. As such, an assumption was made for each of these filters and tested through sensitivity analysis. The base case input for deadweight (40%) accounts for the possibility that the change in outcomes might have happened

without the intervention. This serves as a moderately conservative estimate, considering various factors that could influence the final outcomes for healthcare professionals. Therefore, the sensitivity of the result was tested using deadweight of 20% for certain outcomes/stakeholders and 60% for all outcomes. A deadweight of 60% tested the assumption that these outcomes might have likely occurred independently, particularly among more established health professionals; however, this was considered highly uncertain and tested to establish the lower SROI threshold. Conversely, the impact of outcomes such as job efficiency and job satisfaction for all stakeholders (excluding research dietitians) were assessed at a deadweight of 20%. These two outcomes were considered most appropriate to reflect changes that would likely not have occurred without the intervention. This is due to the fact that many healthcare professionals prioritise reducing administrative burdens, addressing health professional burnout, and developing strategies to communicate more effectively with their patients [19]. Access to effective nutrition communication materials can more likely facilitate these outcomes directly.

Sensitivity of the result was examined by adjusting displacement to 20%. However, it is unlikely that MEBC will affect outcomes from another nutrition communication program or similar activity. This is because resources used in consultations or other means would most likely supplement other resources or activities. However, a scenario where displacement might occur was considered, and the lower limit of the result was tested for robustness. The results fall within the upper and lower limits of the threshold sensitivity analysis.

The valuation of some financial proxies was tested based on assumptions made from secondary research. The actual financial proxies were not modified, as they were based on consultation with health professionals on how they would value certain outcomes, but their valuation was tested. Given minor assumptions for each outcome, and relatively inexpensive proxies, the sensitivity analysis conducted did not impact the SROI ratio significantly (<10%), demonstrating the robustness of the valuation method.

Overall, the modelled SROI ratio was most sensitive to the SROI filters of deadweight and displacement. Introducing other nutrition communication materials used by dietitians and healthcare professionals could potentially displace other outcomes or interventions used by health professionals, affecting the SROI ratio. New nutrition communication tools might replace or reduce existing programs or resources used by health professionals. Some may adopt the new materials, while others might stick with their own methods due to perceived organisational bias. This variability could lead to different outcomes across healthcare settings or practitioner groups. However, the extent remains unknown and therefore, the conservative base case was assumed, and displacement was tested accordingly.

Under a range of plausible assumptions, the SROI for the proposed intervention remains above 2 (range 2.27 to 4.21), demonstrating that the intervention is likely to result in positive social value. Overall, the results are robust given the assumptions outlined here. The overall SROI ratio has been tested and lies within a reasonable average of both limits.

VERIFICATION AND DISSEMINATION OF RESULTS

Stakeholders were engaged throughout the SROI process, to ensure the information in the survey, results, and analysis expresses their lived experience. Once thematic saturation was reached in the stakeholder interviews, the draft Theory of Change was developed. Based on the indicators of change and final outcomes in the draft Theory of Change, the stakeholder surveys were developed and deployed. The surveys verified the findings of the stakeholder interviews and provided quantitative data to inform proportion, attribution, importance and financial proxies.

Some assumptions were made by the researchers regarding the inputs for the SROI filters, in particular, deadweight and displacement. SROI filters such as attribution and importance were informed by the responses to the stakeholder surveys, which also requested information about financial proxies for each of the final outcomes. The filters of deadweight and displacement and a range of valuation approaches were tested in sensitivity analyses. Under a range of plausible assumptions, the SROI for the proposed intervention remains above 2 (range 2.42 to 4.35), demonstrating that the intervention is likely to result in positive social value. Future research should aim to engage a group of stakeholders to reach consensus or share their range of lived experience relating to these filters.

The results and assumptions of this forecast analysis were discussed with MLA management throughout each stage of the SROI to confirm that the findings were considered plausible. The MLA Senior Manager for Food and Nutrition has extensive experience developing nutrition programs and collaborating with health professional users of the programs.

The results of this analysis will be disseminated to relevant audiences. The dissemination plan is not yet finalised, however, is expected to include:

- A communication report will be developed to be public facing and disseminated among SROI stakeholder groups and red meat peak industry bodies. The report may also be shared with those involved with nutrition policy making in Australia.

IMPLICATIONS AND PROGRAM RECOMMENDATIONS

This report is the first SROI analysis to investigate the value of investing in practical nutrition communication resources to engage and empower health professionals, including dietitians, GPs and primary care nurses, to educate their clients about healthy eating and food waste reduction in line with Australian Dietary Guidelines.

Through qualitative and subsequent quantitative consultation, the SROI revealed wide-ranging impacts experienced by stakeholders, including job satisfaction, improved job efficiency, improved job opportunities, and improved reputation.

This analysis provides robust evidence that for every $1 invested in the MEBC nutrition communication program, $3.40 of social value is generated. All the value created was non-economic in nature, and thus would not be captured in a traditional cost-benefit analysis. Sensitivity analyses showed that the intervention would continue to generate positive social value, even under a range of highly conservative assumption (SROI ratio range: 2.27 to 4.21).

The results of the SROI tell the story of the impact of nutrition communication resources for the healthcare professionals that use them. The value of practical resources for health professionals is often overlooked, as the primary focus of nutrition programs tends to be focussed on direct-to-patient information and education. However, empowering relevant healthcare professionals with robust, practical tools and resources is an important avenue leading to improved nutrition literacy. When health professionals are confident and well-equipped to advise their clients regarding nutrition, they can more effectively educate their clients, leading to meaningful behaviour changes.

During the stakeholder interviews, stakeholders advised which aspects of the MEBC nutrition communication materials were of most value to them, and also provided suggestions for improvement of the resources with a view to use in their own practice. Their suggestions included the following:

1. Some stakeholders expressed a preference for using non-branded and non-industry affiliated nutrition communication materials with their clients. Some stakeholders felt that industry-sponsored materials may be biased in their recommendations.
2. It was noted that the imagery and meal ideas included within the MEBC materials do not reflect the types of cuisine prepared by all of the stakeholders' clients. It was therefore suggested that increased diversity in meal suggestions and imagery to represent a wider range of multicultural cuisine would be of benefit to allow healthcare professionals in helping them to engage with their clients.

This SROI analysis demonstrates the value of investing in practical nutrition communication resources to engage and empower health professionals, including dietitians, GPs and primary care nurses. Based on a robust stakeholder consultation process, the analysis provides evidence that for every $1 invested in the MEBC nutrition communication program, $3.40 of social value is generated. This research serves to illustrate how relatively inexpensive programs to support healthcare professionals in the nutrition space can create significant value, empowering them to educate their clients about healthy eating and food waste reduction in line with Australian Dietary Guidelines, which is ultimately the end goal of nutrition programs.

FUTURE EVALUATIVE SROI RECOMMENDATIONS

Following the roll-out of the full MEBC program, confirmation of findings through retrospective evaluation of outcomes would allow the social impact of the program to be confirmed and allow assessment of the ongoing social value of the program. Key recommendations to achieve robust retrospective evaluation using the SROI methodology are described below.

RESEARCH DESIGN AND SAMPLING

Stakeholder selection: The developer and funder of the MEBC program, MLA, should be considered for inclusion as a stakeholder in the evaluative SROI analysis. Despite no potential outcomes emerging in the forecast SROI, further consideration should be given to whether the MEBC program manager or MLA as a company, or both, are materially impacted by the program and therefore whether they are included as stakeholders in the analysis.

Stakeholder definition: Culinary nutrition is a new and evolving field of practice, meaning that it is difficult to closely define the stakeholders who practice this profession. Additionally, there is overlap between this field and more traditional dietetics practice. Given the challenges in defining the role of a culinary nutrition communicator, there is a possibility that the feedback obtained from the culinary nutrition communicators engaged for this research is not representative of the profession as a whole in Australia. Future research should further scope the granularity of the dietitians' stakeholder group. At the time of the interviews, this was not fully understood; a question regarding the type of dietitian was included in the questionnaire for demographic purposes only, and it was only once the survey results were obtained that potential differences emerged between the subspecialities of dietitians.

Non-financial incentives: The evaluative SROI should aim to avoid providing financial incentive for the stakeholders to participate in the surveys to minimise the risk of bias in the survey findings. Non-financial motivation to participate should be considered and may include access to related resources or more in-depth and repeated engagement with the study and its goals. Repeated administration of the quantitative survey to relevant stakeholders would provide an ongoing indicator of outcome changes resulting from the use of the nutrition communication program.

Defining a baseline: The SROI forecast relied on stakeholders reporting estimates of the magnitude of change (using a 5-point Likert scale) they would anticipate experiencing from the use of the MEBC nutrition communication program. A baseline for pre-intervention status was not collected as part of the forecast, although this will be required for an evaluative SROI analysis. The baseline situation would be pre-intervention, and the end of the activity would be defined as 12 months since receiving the MEBC resources.

CALCULATING VALUE

Indicators: the combination of subjective and objective indicators for an evaluative SROI would strengthen the analysis, providing insights on how change is created. Proposed indicators for future evaluations are summarised in Table 18 Future indicators recommendations.

Table 18 Future indicators recommendations

Stakeholder	Outcome	Indicator (proposed for future evaluative SROI)
Dietitians	Improved job satisfaction	• Objective: change in client retention • Subjective: proportion of people reporting clients providing positive feedback • Subjective: self-reported improved motivation and inspiration to create materials from the intervention
	Improved job efficiency	• Objective: change in consult time • Objective: change in non-consult time (i.e. care plan development and professional development)

Stakeholder	Outcome	Indicator (proposed for future evaluative SROI)
	Increased job opportunities	• Objective: change in engagement on social media platforms • Objective: change in revenue attributed from social media promotion
	Improved reputation	• Subjective: self-reported increase in reputation when using the intervention • Objective: change in referrals from other practices • Subjective: self-reported perception of industry alignment when using the intervention to explain healthy eating practices • Objective: change in client feedback or testimonials on quality of care
General practitioners	Improved job satisfaction	• Subjective: self-reported change in confidence when providing nutritional counselling when using the intervention • Subjective: self-reported positive behavioural changes in their patient's awareness of healthy eating practices
	Improved job efficiency	• Objective: change in consult time • Objective: change in non-consult time
Primary care nurses	Improved job satisfaction	• Subjective: self-reported increased confidence in providing nutritional counselling when using the intervention • Subjective: self-reported positive behavioural changes in their patient's awareness of healthy eating practices
	Improved job efficiency	• Objective: change in consult time • Objective: change in non-consult time (i.e. care plan development)

Outcome valuation: The current analysis relied on revealed preference financial proxies. This approach carries some context-specific limitations, risk of bias or inaccuracies and limited stakeholder engagement. The recommendation for an evaluative SROI is to combine revealed preference proxies with stated preference methods, such as surveys and interviews, to capture a wider range of values and perspectives, and employ a variety of financial proxies to cross-validate results and reduce the risk of bias from any single source. Adopting these approaches, the robustness and credibility of the SROI would be strengthened, providing a more accurate and comprehensive understanding of the social value generated by the MEBC program.

Duration and drop-off: In order to assess whether some outcomes will have a duration beyond the on-year period forecasted in this analysis, an evaluative SROI should be conducted following a minimum of 2-3 years of running MEBC program. For the purposes of duration assessment, the duration of each well-defined outcome should be determined by directly asking stakeholders how long they experienced the outcomes as post to the activity. This approach would leverage the firsthand insights of those who directly experienced the outcomes, providing realistic and accurate estimates. For the purposes of assessing drop-off, stakeholders should be asked to estimate the annual rate of decline for a given outcome on a scale from 0% to 100%. These estimates would then be averaged to calculate the drop-off percentage for each change. Additionally, stakeholders should be encouraged to qualitatively describe their perceptions of the drop-off effect and provide the rationale behind their quantitative estimates. This approach would allow for a comprehensive understanding of both the numerical decline and the contextual factors influencing stakeholders' perceptions of the drop-off.

Discounting: If during the evaluation phase a duration longer than one year will emerge for certain outcomes, the recommended discount rate to be applied would be 7%, with sensitivity analyses at 3% and 10%, consistently with Australian government's recommended for impact assessments.

VERIFICATION

Under- or over-claiming on key elements like deadweight, displacement, drop-off/duration and attribution can significantly distort the findings of an SROI. It is therefore important that these SROI filters be considered closely in the evaluative SROI analysis, and that the assumptions are validated through other methods.

Validate deadweight estimation: The deadweight estimates should be validated during an evaluative SROI by including a specific question in the stakeholder questionnaire asking participants to reflect on whether they would have achieved the same outcomes without the intervention and exploring through interviews whether they are aware of, or use any other nutrition communication tools, and the outcomes associated with those.

Validate displacement assumption: For this SROI, the authors assumed 0% displacement across all outcomes on the basis that the nature of the outcomes do not lend themselves to displacing other outcomes elsewhere. In order to validate this assumption, particularly related to job opportunities, the authors recommend asking participants about any negative consequences experienced elsewhere and monitoring outcomes over a longer period of time as part of an evaluative SROI which would provide an indication of any emerging displacement effects. Secondary research and discussions with stakeholders to investigate other nutrition communication tools would also contribute to informing the displacement assumptions.

APPENDIX I RECRUITMENT MATERIALS

MEBC BACKGROUNDER

Social Return on Investment Analysis of MLA's *Make every bite count* program

Background

- Meat & Livestock Australia (MLA) has commissioned HTANALYSTS to conduct a Social Return on Investment (SROI) analysis to understand how to optimise the impact of nutrition communications about Australian red meat by evaluating the impact of MLA's *Make every bite count* (MEBC) program.
- The program promotes uptake of insights-led resources to help stakeholders promote consumption of 'balanced meals with no food waste' in key settings.
- The resources are designed to improve consumption of healthy foods by providing practical information about buying, preparing and enjoying 'balanced meals with no food waste' in line with Australian Dietary Guidelines.
- HTANALYSTS, an independent agency with expertise in SROI analysis, will interview stakeholders to understand how they would engage with the program, identify opportunities for improvements and quantify the social, economic and environmental value and impacts that could be created from the optimised program.
- The findings will help MLA to develop activities and resources that support adoption by delivering benefits to stakeholders.

Resources

- Brochures and fact sheets for healthcare professionals to help their clients follow dietary recommendations.
- Social media resources, including culinary nutrition videos, tiles and infographics for dietitians to promote culinary nutrition skills that enable Australians to enjoy healthy meals and reduce food waste.
- Guides to help marketers and retailers to promote Australian red meat in 'Balanced Meals with no food waste' (in development).
    - The Guides will explain the type of product information that will help consumers and shoppers to make purchase and consumption decisions in line with Australian Dietary Guidelines.
    - Product information will provide guidance on amounts and types of meat to buy, pairing meat with vegetables and legumes, and food storage tips.
    - Insights about popular meals and practices will be provided to optimise engagement and empower enjoyment of healthy meals.

Activities

Stakeholders	
Healthcare professionals	• Quarterly advertising of brochures and fact sheets through medical media channels targeting GPs and dietitians to raise awareness and facilitate uptake.
Dietitians	• Sponsorship of webinars and podcasts about culinary nutrition and sustainable eating to raise awareness and understanding of the evidence and implications for dietetic practice.

MLA marketing, retailers and dietitians	• MLA-hosted Masterclasses to facilitate adoption of 'Balanced Meals with no food waste' Guides by creating a collaborative environment for identifying opportunities to increase consumption of healthy foods in retail and consumer media channels.

DIETITIAN SURVEY FLYER

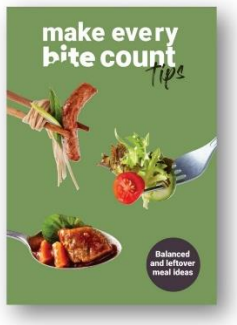
Your feedback for a chance to win!

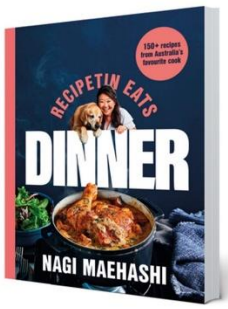
Complete a short, anonymous survey by September 8th for a chance to win one of ten copies of *RecipeTin Eats: Dinner* by Nagi Maehashi.

[Click here to complete the survey]

We invite you to share your thoughts on Meat & Livestock Australia's "Make Every Bite Count" program. The program aims to help dietitians communicate practical information about buying, preparing, and enjoying balanced meals with no food waste. Your feedback will help to inform Meat & Livestock Australia about the social value and impact of investing in the program.

Thank you for your participation!





APPENDIX II INTERVIEW GUIDES

INTERVIEW GUIDE FOR HEALTHCARE PROFESSIONALS

Moderator: Introduce **HT**ANALYSTS team, ask participants to introduce themselves and briefly describe the type of work they do, request permission to record interview.

Thank you very much for taking the time to speak with us. We are conducting research on behalf of MLA that aims to understand the impact of providing insights and resources via the MEBC program. The information we are collecting today will be used to inform a report about the broader impacts of the MEBC program. No personal details will be included and anything you share today will remain anonymous.

MEBC program overview

I believe you received a one-page summary about the MEBC program with links to the materials on the website, but to give you a very quick reminder, the MEBC program promotes uptake of resources that provide practical information about enjoying balanced meals with no food waste, comprising information and tips about smart shopping, nutritious choices, balanced meals and leftovers. The program includes a suite of resources designed to help different professionals to provide guidance on healthy eating and inform purchase and consumption decisions about Australian red meat. These communications are underpinned by insights and scientific research reports generated by research conducted by MLA. All of these are available on the MLA Healthy Meals website.

The **four key messages** communicated throughout the materials provide information and tips about:

1. Smart shopping, which is about buying protein foods in recommended portion sizes:
2. Nutritious choices, which promotes variety with affordable options;
3. Balanced meals, which helps to boost intake of vegetables and legumes;
4. Leftover meals, which provides tips for quick, easy meals and reducing food waste.

These messages are conveyed through a variety of channels including videos, social media resources, brochures and factsheets. In terms of materials, there are two main ones:

1. **Brochures** which provide practical guidance and meal ideas on portion sizes and nutritious choices aligned with the Australian Dietary Guidelines;
2. **Fact sheets** that focus on various aspects from no food waste, Smart Shopping & Nutritious Choices, guide to choosing iron or protein-rich foods, carbohydrates, meals for family and babies and finally a guide for lean cuts; and

I am going to ask questions about the impact of the MEBC program, and specifically the optimal MEBC program on the work you do.

1. If you were to use these resources with your patients, would it have any impact on the work you do as a healthcare professional?
    a. Probe: Would these materials support/ supplement your current resources you share with patients?
    b. Probe: Would using these materials have any impact in your ability to communicate dietary advice with your patients?
    c. Probe: Would these materials have any impact on your motivation to counsel patients on their diet
    d. Probe: Would they have any impact on your ability to keep up to date with current research or nutrition advice? Would it have any impact on your work to have these up to date and research backed nutrition recommendations

2. What outcomes would you expect from using the optimal MEBC materials with your patients? *Alternative: If you were to use these materials with your patients, what would motivate you to do so?*
    a. Probe: Do you think using these materials would impact patient awareness about healthy eating practices? And have any impact on your patients' health?
    b. Probe: Does your practice have measures around the National preventative health strategy and if so, would use of these resources have any impact on meeting those goals?
    c. Probe: Would use of evidence-based resources in the MEBC program have any effect on your relationship with your clients/patients or the amount of trust they have in your advice?
    d. Probe: Ultimately, would this have any effect on your job satisfaction as a healthcare professional?
    e. Probe: Do you think there would be any other positive or negative impacts of the MEBC program on the wider community?

APPENDIX III STAKEHOLDER SURVEYS

SURVEY FOR DIETITIANS

Thank you for volunteering to participate in this brief, anonymous, online survey about the impacts of the *Make Every Bite Count* program. This is being conducted by **HT**ANALYSTS for research supported by Meat & Livestock Australia.

This research is a Social Return on Investment (SROI) study assessing the social, economic and environmental value and impacts that could be created from the *Make Every Bite Count* program.

Insights from this survey will be used to inform a report detailing the value of practical nutrition communication resources for dietitians and other healthcare professionals. These findings will help to inform Meat & Livestock Australia about the social value and impact of investing in the program.

If you have any questions regarding this study, please do not hesitate to contact **HT**ANALYSTS via MEBC_impact@htanalysts.com.au or calling 02 9193 7777.

About the *Make Every Bite Count* program

Meat & Livestock Australia (MLA) has produced a series of resources for dietitians and other healthcare professionals to share practical information with their clients about buying, preparing and enjoying **balanced meals with no food waste.**

Resources include brochures, fact sheets, social media tiles and videos https://www.mlahealthymeals.com.au/resources/carbohydrate-foods-in-a-healthy-diet/published **on MLA's Healthy Meals website**.

Insights-led and aligned to Australian Dietary Guidelines, the resources are designed to communicate practical information about:

- Buying meat by recommended portion sizes,
- choosing lean and affordable options,
- boosting intake of vegetables and legumes and
- turning leftovers into quick, easy meals.

Titled **'Make Every Bite Count',** insights indicate the approach is engaging, empowering and accessible to all age groups. A series of resources targeting key life stages is planned, starting with early childhood and building on MLA's popular fact sheet about preparing smooth and lumpy textures and finger foods from the family meal.

To raise awareness about the program and opportunities for dietetic practice, MLA has sponsored healthcare professional **webinars** and **podcasts** about culinary nutrition and sustainable eating. Future topics will consider challenges and opportunities to promote healthy eating in key life stages.

MLA-hosted **Masterclasses** for culinary nutrition dietitians provides a collaborative environment for sharing knowledge, skills and resources about the preparation of popular cuts of red meat in 'balanced meals with no food waste' to suit key life stages.

Free distribution of resources is available to **dietitians and GP practices.**

Please proceed to begin the survey.

Are you based in Australia?

- o Yes

- No *terminates survey

Which one of these best describes your profession?

- Clinical dietitian
- Community dietitian
- Culinary nutrition communicator
- Research dietitian

In what setting is your primary practice?

- Private practice
- Public practice
- Hospital
- Corporate
- Other

What is your age?

- <25 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55+ years

We are now going to ask a few questions to understand whether these resources would be useful to you and whether they could create any positive impacts, and whether those are important to you. When asking about outcomes and impacts, would like to know your whether this is true for you, and whether these things are important. Of course, we may have missed something so we're also keen to get your general feedback at the end.

Please indicate whether you think the following outcomes would be improved, worsened, or no different if you were to have the MEBC nutrition communication materials available to you.

	Worsened	No different	Improved
Credibility from using high-quality resources	○	○	○
Reputation when starting out in your career	○	○	○
Perception of your organisation's commitment to sustainability targets	○	○	○
Alignment across dietitians on key messaging and issues	○	○	○
Client perception of quality of care through availability of well-designed resources	○	○	○
Revenue streams from increased social media promotion	○	○	○

	Worsened	No different	Improved
Reach from effective social media communication	○	○	○
Positive feedback from clients	○	○	○
Ability to change perceptions around unhealthy/restrictive diets	○	○	○
Ability to have a positive impact on clients and/or students	○	○	○
Enjoyment from sharing more holistic approaches to nutrition	○	○	○
Ability to motivate clients effectively	○	○	○
Time to create new and high-quality communication content	○	○	○
Ability to keep up to date with dietary recommendations	○	○	○
Communication of dietary guidelines with clients	○	○	○
Efficiency in creating care plans for clients	○	○	○
Time efficiency during client consults	○	○	○
Availability of practical nutrition advice for clients	○	○	○

Next, we would like to understand how important these outcomes are for you:

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Increased credibility from using high-quality resources	○	○	○	○	○
Improved reputation when starting out in your career	○	○	○	○	○
Improved perception of your organisation's commitment to sustainability targets	○	○	○	○	○
Improved alignment across dietitians on key messaging and issues	○	○	○	○	○
Improved client perception of quality of care through availability of well-designed resources	○	○	○	○	○

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Increased revenue streams from increased social media promotion	○	○	○	○	○
Increased reach from effective social media communication	○	○	○	○	○
Increased positive feedback from clients	○	○	○	○	○
Increased ability to change perceptions around unhealthy/restrictive diets	○	○	○	○	○
Increased ability to have a positive impact on clients and/or students	○	○	○	○	○
Increased enjoyment from sharing more holistic approaches to nutrition	○	○	○	○	○
Improved ability to motivate clients effectively	○	○	○	○	○
Reduced time to create new and high-quality communication content	○	○	○	○	○
Increased ability to keep up to date with dietary recommendations	○	○	○	○	○
Improved communication of dietary guidelines with clients	○	○	○	○	○
Increased efficiency in creating care plans for clients	○	○	○	○	○
Increased time efficiency during client consults	○	○	○	○	○
Increased availability of practical nutrition advice for clients	○	○	○	○	○

If you had the MEBC nutrition communication materials available to you, how much do you think they would contribute to improve this outcome? (table is populated with outcomes that were previously rated to improve)

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Credibility from using high-quality resources	○	○	○	○	○
Reputation when starting out in your career	○	○	○	○	○

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Perception of your organisation's commitment to sustainability targets	○	○	○	○	○
Alignment across dietitians on key messaging and issues	○	○	○	○	○
Client perception of quality of care through availability of well-designed resources	○	○	○	○	○
Revenue streams from increased social media promotion	○	○	○	○	○
Reach from effective social media communication	○	○	○	○	○
Positive feedback from clients	○	○	○	○	○
Ability to change perceptions around unhealthy/restrictive diets	○	○	○	○	○
Ability to have a positive impact on clients and/or students	○	○	○	○	○
Enjoyment from sharing more holistic approaches to nutrition	○	○	○	○	○
Ability to motivate clients effectively	○	○	○	○	○
Time to create new and high-quality communication content	○	○	○	○	○
Ability to keep up to date with dietary recommendations	○	○	○	○	○
Communication of dietary guidelines with clients	○	○	○	○	○
Efficiency in creating care plans for clients	○	○	○	○	○
Time efficiency during client consults	○	○	○	○	○
Availability of practical nutrition advice for clients	○	○	○	○	○

If you had the MEBC nutrition communication materials available to you, how much do you think they would contribute to worsen this outcome? (table is populated with outcomes that were previously rated to worsen)

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Credibility from using high-quality resources	○	○	○	○	○
Reputation when starting out in your career	○	○	○	○	○
Perception of your organisation's commitment to sustainability targets	○	○	○	○	○
Alignment across dietitians on key messaging and issues	○	○	○	○	○
Client perception of quality of care through availability of well-designed resources	○	○	○	○	○
Revenue streams from increased social media promotion	○	○	○	○	○
Reach from effective social media communication	○	○	○	○	○
Positive feedback from clients	○	○	○	○	○
Ability to change perceptions around unhealthy/restrictive diets	○	○	○	○	○
Ability to have a positive impact on clients and/or students	○	○	○	○	○
Enjoyment from sharing more holistic approaches to nutrition	○	○	○	○	○
Ability to motivate clients effectively	○	○	○	○	○
Time to create new and high-quality communication content	○	○	○	○	○
Ability to keep up to date with dietary recommendations	○	○	○	○	○
Communication of dietary guidelines with clients	○	○	○	○	○
Efficiency in creating care plans for clients	○	○	○	○	○
Time efficiency during client consults	○	○	○	○	○

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Availability of practical nutrition advice for clients	○	○	○	○	○

What activities would you participate in or what resources would you purchase to achieve these outcomes?

- Improve your job reputation: [free text field]
- Increase your job opportunities: [free text field]
- Improve your job satisfaction: [free text field]
- Improve your job efficiency: [free text field]

If you had the MEBC nutrition communication materials available to you, do you think you would experience any other outcome (positive or negative) as a dietitian? [free text field]

Thank you for taking the time to complete the survey about the *Make Every Bite Count* program.

Please click below if you would like to enter the draw to win one of ten copies of *RecipeTin Eats: Dinner* by Nagi Maehashi. Your responses to the survey will still remain anonymous.

SURVEY FOR GPS AND PRIMARY CARE NURSES

This survey is intended for GPs/primary care nurses based in Australia. Are you an AHPRA-registered GP/primary care nurses based in Australia?

- Yes
- No *terminates survey

In what location is your primary practice?

- Metropolitan
- Regional
- Rural

In what setting is your primary practice?

- Private practice
- Public practice
- Other [please specify]

What is your age?

- <25 years
- 25-34 years
- 35-44 years
- 45-54 years
- 55+ years

Thank you for volunteering to participate in this brief, anonymous, online survey about the impacts of the *Make Every Bite Count* program. This is being conducted by **HT**ANALYSTS for research supported by Meat & Livestock Australia.

This research is a Social Return on Investment (SROI) study assessing the social, economic and environmental value and impacts that could be created from the *Make Every Bite Count* program.

Insights from this survey will be used to inform a report detailing the value of practical nutrition communication resources for healthcare professionals. These findings will help to inform Meat & Livestock Australia about the social value and impact of investing in the program.

If you have any questions regarding this study, please do not hesitate to contact **HT**ANALYSTS via MEBC_impact@htanalysts.com.au or calling 02 9193 7777.

About the *Make Every Bite Count* program

Please read through the summary of the *Make Every Bite Count* program provided below.

Meat & Livestock Australia (MLA) has produced a series of resources for healthcare professionals to share practical information with their clients about buying, preparing, and enjoying balanced meals with no food waste.

Resources include brochures, fact sheets, social media tiles, and videos published on MLA's Healthy Meals website.

Insights-led and aligned to Australian Dietary Guidelines, the resources are designed to communicate practical information about:

- buying meat by recommended portion sizes,
- choosing lean and affordable options,
- boosting intake of vegetables and legumes, and
- turning leftovers into quick, easy meals.

Titled '*Make Every Bite Count*', insights indicate the approach is engaging, empowering, and accessible to all age groups. A series of resources targeting key life stages are planned, starting with early childhood and building on MLA's popular fact sheet about preparing smooth and lumpy textures and finger foods from the family meal.

Free distribution of resources is available to dietitians and general practice clinics.

Please proceed to begin the survey.

We are now going to ask a few questions to understand whether the *Make Every Bite Count* nutrition communication resources would be useful to you and whether they could create any positive impacts, and whether those are important to you. When asking about outcomes and impacts, would like to know your whether this is true for you, and whether these things are important.

Of course, we may have missed something so we're also keen to get your general feedback at the end.

Please indicate whether you think the following outcomes would be improved, worsened, or no different if you were to have the *Make Every Bite Count* nutrition communication materials available to you.

	Worsened	No different	Improved
Confidence in the nutrition advice provided to your patients	○	○	○
Ability to disseminate nutrition information	○	○	○
Patient awareness and education	○	○	○
Time efficiency during consultations with patients	○	○	○
Efficiency in creating care plans for your patients	○	○	○
Ability to keep up to date with current dietary recommendations	○	○	○

Next, we would like to understand how important these outcomes are for you:

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Increased confidence in the nutrition advice provided to your patients	○	○	○	○	○
Improved ability to disseminate nutrition information	○	○	○	○	○

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Improved patient awareness and education	○	○	○	○	○
Improved time efficiency during consultations with patients i.e. shorter consultation length	○	○	○	○	○
Improved efficiency in creating care plans for your patients	○	○	○	○	○
Improved ability to keep up to date with current dietary recommendations	○	○	○	○	○

If you had the *Make Every Bite Count* nutrition communication materials available to you, how much do you think they would contribute to improve this outcome? (table is populated with outcomes previously scored to improve)

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Confidence in the nutrition advice provided to your patients	○	○	○	○	○
Ability to disseminate nutrition information	○	○	○	○	○
Patient awareness and education	○	○	○	○	○
Time efficiency during consultations with patients	○	○	○	○	○
Efficiency in creating care plans for your patients	○	○	○	○	○
Ability to keep up to date with current dietary recommendations	○	○	○	○	○

If you had the *Make Every Bite Count* nutrition communication materials available to you, how much do you think they would contribute to worsen this outcome? (table is populated with outcomes previously scored to worsen)

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Confidence in the nutrition advice provided to your patients	○	○	○	○	○
Ability to disseminate nutrition information	○	○	○	○	○

	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)
Patient awareness and education	○	○	○	○	○
Time efficiency during consultations with patients	○	○	○	○	○
Efficiency in creating care plans for your patients	○	○	○	○	○
Ability to keep up to date with current dietary recommendations	○	○	○	○	○

More generally, in your role as a GP/primary care nurses, what activities would you participate in or what resources would you purchase to achieve these outcomes?

- Improve your job satisfaction [free text field]
- Improve your work efficiency [free text field]

If you had the *Make Every Bite Count* nutrition communication materials available to you, do you think you would experience any other outcome (positive or negative) as a GP/primary care nurses? [free text field]

Thank you for taking the time to complete the survey about the *Make Every Bite Count* program.

APPENDIX IV FINANCIAL PROXIES

Valuing outcomes involves the monetisation of non-financial outcomes by assigning them appropriate financial proxies. Financial proxies should reflect the value of the change in the outcome from the perspective of the stakeholder experiencing the outcome. However, this financial value does not always correlate directly with the subjective importance of the outcome to the stakeholder. For example, the outcome of increased job opportunities might have a high financial value because it can lead to higher income, more employment options, and economic growth. On the other hand, job satisfaction, while potentially having a lower financial proxy value, might be more important to stakeholders on a personal level. Job satisfaction affects well-being, mental health, and overall happiness, which are crucial aspects of a person's life but are harder to quantify in monetary terms. Stakeholders might prioritise job satisfaction because it directly influences their daily experiences and quality of life, even if its financial proxy is lower. In essence, financial proxies are tools to measure and compare outcomes, but they don't capture the full spectrum of personal and subjective importance that stakeholders place on different outcomes. This distinction is crucial in SROI analysis to ensure that both quantitative and qualitative aspects of value are considered. The importance of each outcome for the individual stakeholder groups are presented in Appendix VI.

Given that many outcomes are non-financial in nature, this process requires the judgement of the authors to decide – based on an understanding of the stakeholders and their experience of the outcomes – what values are appropriate.

One main technique has been used to value outcomes:

- Revealed preference – the value is assessed by looking at people's choices and behaviours in actual markets.

No Australian willingness to pay study for the identified outcomes and stakeholders was identified.

Relying solely on revealed preference proxies for financial proxies in a forecast SROI analysis does carry some risks, including: [1] Bias and inaccuracy: these proxies can be influenced by market imperfections, personal biases, and external factors that do not accurately represent the true value of social outcomes; [2] Context-specific limitations: the applicability of revealed preference proxies can vary significantly across different contexts and populations, leading to potential misestimations when applied universally; [3] Limited stakeholder engagement: sole reliance on these proxies may overlook the perspectives and values of some key stakeholders.

The financial proxies, valuation approach and rationale for each outcome are outlined in Table 19.

Table 19 Financial Proxies

Stakeholder	Outcome	Valuation approach	Value of financial proxy (annual)	Rationale
Dietitians	Job satisfaction	Revealed preference	$348 [20]	During stakeholder consultation, dietitians advised that a yearly subscription to a client management software would improve their job satisfaction. Nutritionist software can automate practice management and client communication, allowing dietitians to streamline administrative tasks. By reducing these tasks, dietitians can dedicate more time to their core responsibilities, such as patient care and professional development, leading to improved job satisfaction. Therefore, the price of a yearly subscription to a client management software for private practice was used as a financial proxy for this outcome.
	Job efficiency	Revealed preference	$516 [21]	During consultation, dietitians advised that AI software could help improve their job efficiency. AI tools can monitor client progress and provide insights, helping dietitians make informed decisions for their clients. It can be used as a complementary tool to improve efficiency in addition to expertise and personalised care services provided. Therefore, the price of a yearly subscription to AI software useful for private practice was used as a financial proxy for this outcome.
	Job opportunities	Revealed preference	$1,360 [22-24]	During stakeholder consultation, dietitians advised that attending conferences, investing in advertising services, and pursuing professional development in digital marketing could enhance their job opportunities. For instance, attending three in-person conferences per year would help dietitians build professional relationships with peers, thereby improving their job prospects. Multiple conferences provide opportunities to network, learn from industry leaders, and be exposed to new career opportunities. DA offers various advertising and promotion options, such as positions vacant, commercial advertisements (including those in the Nutrition & Dietetics journal), event sponsorship, and trade exhibitions. The Nutrition & Dietetics journal accepts advertisements relevant to the field, promoting high-quality products and services from reputable organisations. According to DA, advertising a practice room costs $107 for one month, and this fee was assumed to reflect the cost of promoting services for practices. Completing an online short course on digital marketing each year can help dietitians enhance their business skills. Learning digital marketing techniques helps dietitians create and manage effective websites, social media profiles, and online content, increasing their visibility to potential clients and employers.

Stakeholder	Outcome	Valuation approach	Value of financial proxy (annual)	Rationale
				Therefore, the average price of the three activities (attending three conferences per year, yearly promotion of services on DA website and access to digital marketing courses) was used as a financial proxy for this outcome.
	Reputation	Revealed preference	$1,135 [22]	During stakeholder consultation, dietitians advised that attending conferences could help improve their reputation. Attending a multi-day conference would help dietitians build professional relationships with peers, thereby improving reputation. It was assumed that dietitians typically attend at least one conference annually to enhance their professional reputation and expand their network. The registration fee does not cover additional expenses like travel, accommodation, or time off required for attendance. By participating in such conferences, dietitians can exchange knowledge, build professional connections, showcase their expertise, and present research over a few days to improve their reputation. Therefore, the price of attending a DC advertised annual three-day conference was used as a financial proxy for this outcome.
General practitioners	Job satisfaction	Revealed preference	$985 [25]	During stakeholder consultation, GPs advised that professional development such as courses, events and webinars would improve job satisfaction. Access to such can be done via the RACGP. The RACGP offers a range of courses and events that include face-to-face, online modules, webinars and other learning programs. RACGP members have free access to all RACGP webinars as part of their membership benefits. Therefore, the membership can provide GPs with the tools, support, and professional recognition needed to enhance their career satisfaction and long-term growth. Therefore, the cost of RACGP membership was used as a financial proxy for this outcome.
	Job efficiency	Revealed preference	$684 [25-27]	During stakeholder consultation, GPs advised that a range of tools (access to online and printed patient education materials, professional development and patient management software) would improve their job efficiency. The RACGP membership was used to value the professional development. The RACGP offers a range of courses and events that include face-to-face, online modules, webinars and other learning programs. RACGP members have free access to all RACGP webinars as part of their membership. Software can improve job efficiency for GPs by automating real-time transcription of consultations, saving doctors time on documentation. This allows GPs to focus more on patient interaction and streamline workflows to reduce administrative burdens.

Stakeholder	Outcome	Valuation approach	Value of financial proxy (annual)	Rationale
				Additionally, the cost to purchase timesaving and evidence-based nutrition resources designed for use in primary care was used. The weighted average was calculated based on the frequency of the three responses from results of the GP survey (n=100) to estimate the financial proxy for this outcome.
Primary care nurses	Job satisfaction	Revealed preference	$502 [28-30]	During stakeholder consultation, primary care nurses advised that a range of continuing professional development (attending face-to-face conferences, online training via APNA or AUSMED) would improve their job satisfaction. Attending yearly conferences for primary care nurses provides opportunities for continuing education, networking, professional growth, exposure to new products and services, and a source for inspiration and motivation. Membership with APNA gives access to online learning modules for free. Additionally, AUSMED offers a wide range of online continuing professional development courses and resources for healthcare professionals. The weighted average was calculated based on the frequency of the responses from results of the primary care nurse survey (n=70) to estimate the financial proxy for this outcome.
	Job efficiency	Revealed preference	$480 [26-30]	During stakeholder consultation, primary care nurses advised that a range of continuing professional development (attending face to face conferences, online training via APNA or AUSMED), patient education materials and client management software would improve their job satisfaction. Attending yearly conferences for primary care nurses provides opportunities for continuing education, networking, professional growth, exposure to new products and services, and a source for inspiration and motivation. Membership with APNA gives access to online learning modules for free. Additionally, AUSMED offers a wide range of online continuing professional development courses and resources for healthcare professionals. Software can enhance job efficiency for primary care nurses by automating real-time documentation of patient interactions, saving nurses time on paperwork. This allows nurses to focus more on direct patient care and streamline workflows to reduce administrative tasks. Additionally, the cost to purchase timesaving and evidence-based nutrition resources made to be used in primary care was used.

Stakeholder	Outcome	Valuation approach	Value of financial proxy (annual)	Rationale
				The weighted average was calculated based on the frequency of the responses from results of the primary care nurse survey (n=70) to estimate the financial proxy for this outcome.

Abbreviations: APNA, Australian primary health care nurses association; CAL, Centre for Advanced Learning; DA, Dietitians Australia; DC, Dietitian Connection; RACGP, Royal Australian College of General Practitioners

APPENDIX V PROPORTION OF STAKEHOLDERS IMPACTED

It is not assumed that all stakeholders included in the model experience every outcome, nor experience outcomes in a similar way. For example, not every nutrition healthcare professional will experience improved job opportunities if information materials are provided to them. However, it is not expected that people would experience *reduced* job opportunities as a result of effective information materials (i.e. the opposing negative outcome).

For this SROI, the proportion of people experiencing each outcome was determined by stakeholder survey. Survey participants were asked to indicate whether key indicators of change would be improved, worsened or no different if they were to have the MEBC nutrition communication materials available to them. The key indicators included in the survey were intended as indicators of the final outcomes based on prior stakeholder interviews. The proportion of participants who indicated that the key indicators of change for an outcome would be improved was taken to be the proportion of stakeholders who would experience improvement in the outcome. If any participants indicated that key indicators would worsen, that proportion of participants was subtracted from the total proportion reported to experience improvement. This was done to reduce the risk of overclaiming, and accounting for potential negative impacts.

The proportion of stakeholders impacted and the rationale for each outcome are outlined in Table 20.

Table 20 Proportion of stakeholders impacted

Stakeholder	Outcome	Q10: if you had MEBC available, which outcomes change?	Worsened	No different	Improved	Proportion (improved-worsen)	Rationale
Dietitians	Job satisfaction	Positive feedback from clients	0.8%	36.2%	63.0%	**70.3%**	Dietitians (N=327) were surveyed and asked whether the key indicators of job satisfaction would change if MEBC was available to them. This result has been adjusted for those who anticipated indicators of worsened job satisfaction.
		Ability to change perceptions around unhealthy/restrictive diets	0.8%	24.5%	74.7%		
		Ability to have a positive impact on clients and/or students	0.4%	23.4%	76.2%		
		Enjoyment from sharing more holistic approaches to nutrition	0.4%	26.0%	73.6%		
		Ability to motivate clients effectively	0.0%	33.6%	66.4%		
	Job efficiency	Time to create new and high-quality communication content	1.5%	32.1%	66.4%	**64.7%**	Dietitians (N=327) were surveyed and asked whether the key indicators of job efficiency would change if MEBC was available to them. This result has been adjusted for those who anticipated indicators of worsened job satisfaction.
		Ability to keep up to date with dietary recommendations	0.0%	35.5%	64.5%		
		Communication of dietary guidelines with clients	1.1%	26.4%	72.5%		
		Efficiency in creating care plans for clients	0.4%	44.9%	54.7%		

		Time efficiency during client consults	0.4%	45.7%	54.0%		
		Availability of practical nutrition advice for clients	0.0%	20.8%	79.2%		
	Job opportunities	Revenue streams from increased social media promotion	2.6%	74.0%	23.4%	**30.2%**	Dietitians (N=327) were surveyed and asked whether the key indicators of job opportunities would change if MEBC was available to them. This result has been adjusted for those who anticipated indicators of worsened job satisfaction.
		Reach from effective social media communication	1.5%	57.4%	41.1%		
	Reputation	Credibility from using high-quality resources	2.3%	29.8%	67.9%	**56.8%**	Dietitians (N=327) were surveyed and asked whether the key indicators of reputation would change if MEBC was available to them. This result has been adjusted for those who anticipated indicators of worsened job satisfaction.
		Reputation when starting out in your career	2.3%	61.5%	36.2%		
		Perception of your organisation's commitment to sustainability targets	3.0%	45.7%	51.3%		
		Alignment across dietitians on key messaging and issues	1.9%	30.9%	67.2%		
		Client perception of quality of care through availability of well-designed resources	0.4%	28.7%	70.9%		
General practitioners	Job satisfaction	Confidence in the nutrition advice provided to your patients	2.0%	23.0%	74.0%	**73.0%**	GPs (N=100) were surveyed and asked whether the key indicators of job satisfaction would change if MEBC was available to them. The survey data indicated that for 73% of GPs, job satisfaction would improve if MEBC was available to them. This result has been adjusted for those who anticipated indicators of worsened job satisfaction. GPs (N=100) were surveyed and asked whether the key indicators of job efficiency would change if MEBC was available to them. The survey data indicated that for 50% of GPs, job efficiency would improve if MEBC was available to them. This result has been adjusted for those who anticipated indicators of worsened job efficiency.
		Ability to disseminate nutrition information	4.0%	20.0%	75.0%		
		Patient awareness and education	3.0%	18.0%	79.0%		
		Time efficiency during consultations with patients	15.0%	41.0%	42.0%		
	Job efficiency	Ability to keep up to date with current dietary recommendations	6.0%	49.0%	44.0%	**33.5%**	
Primary care nurses	Job satisfaction	Confidence in the nutrition advice provided to your patients	0.0%	20.0%	80.0%	**83.9%**	Primary care nurses (N=70) were surveyed and asked whether the key indicators of job satisfaction would change if MEBC was available to them. The survey data indicated that for 83% of primary care nurses, job satisfaction
		Ability to disseminate nutrition information	0.0%	22.9%	77.1%		
		Patient awareness and education	0.0%	8.6%	91.4%		

						would improve if MEBC was available to them.
Job efficiency	Time efficiency during consultations with patients	5.7%	37.1%	57.1%	**66.2%**	Primary care nurses (N=70) were surveyed and asked whether the key indicators of job efficiency would change if MEBC was available to them. The survey data indicated that for 66% of primary care nurses, job efficiency would improve if MEBC was available to them. This result has been adjusted for those who anticipated indicators of worsened job efficiency.
	Efficiency in creating care plans for your patients	1.4%	38.6%	60.0%		
	Ability to keep up to date with current dietary recommendations	0.0%	11.4%	88.6%		

Abbreviations: GP, general practitioner; MEBC, make every bite count

APPENDIX VI IMPORTANCE

A weight representing importance was applied to each valuation to account for the degree to which the outcome matters to the stakeholder. Each financial proxy is weighted by importance, which was determined based on the stakeholder consultation surveys.

Survey participants were asked to rate the importance of each key indicator directly on a 5-point Likert scale (Table 21). The scale also included importance represented as a percentage (Table 21). The average of responses was taken to be the importance weight for each final outcome.

Table 21 Importance Likert scale: 'How important is this outcome to you?'

	Not at all important	A little important	Moderately important	Very important	Completely important
Weighting	0%	25%	50%	75%	100%

The importance weighting and rationale for each outcome is outlined in Table 22.

Table 22 Importance weighting

Stakeholder	Outcome	Q10: if you had MEBC available, which outcomes change?	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)	Importance (weighted average)	Rationale
Dietitians	Job satisfaction	Positive feedback from clients	1.2%	3.7%	18.4%	33.6%	42.6%	**80.5%**	Dietitians (N=327) were surveyed and asked the importance of the key indicators of job satisfaction. The importance of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
		Ability to change perceptions around unhealthy/restrictive diets	0.8%	3.3%	11.1%	38.9%	45.5%		
		Ability to have a positive impact on clients and/or students	0.4%	2.9%	11.5%	32.4%	52.5%		
		Enjoyment from sharing more holistic approaches to nutrition	1.2%	4.1%	19.3%	35.2%	40.2%		
		Ability to motivate clients effectively	0.0%	2.0%	12.3%	35.2%	50.0%		
	Job efficiency	Time to create new and high-quality communication content	3.3%	3.3%	22.1%	32.8%	38.1%	**76.8%**	Dietitians (N=327) were surveyed and asked the importance of the key indicators of job efficiency. The importance of each outcome was determined on a 5-point Likert scale which was
		Ability to keep up to date with dietary recommendations	1.6%	2.5%	15.2%	37.3%	43.0%		
		Communication of dietary guidelines with clients	0.4%	4.1%	18.9%	36.9%	39.3%		

		Efficiency in creating care plans for clients	2.0%	5.7%	25.0%	32.4%	34.8%		transformed into a percentage (see scale above) based on SROI best practice.
		Time efficiency during client consults	3.7%	4.5%	16.8%	36.5%	38.1%		
		Availability of practical nutrition advice for clients	1.2%	2.0%	11.1%	38.9%	46.3%		
	Job opportunities	Revenue streams from increased social media promotion	31.6%	17.2%	28.3%	14.8%	8.2%	**39.4%**	Dietitians (N=327) were surveyed and asked the importance of the key indicators of job opportunities. The importance of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
		Reach from effective social media communication	27.0%	18.9%	26.2%	18.4%	9.4%		
	Reputation	Credibility from using high-quality resources	0.8%	4.9%	13.1%	43.0%	37.3%	**70.4%**	Dietitians (N=327) were surveyed and asked the importance of the key indicators of reputation. The importance of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
		Reputation when starting out in your career	11.9%	10.2%	27.5%	26.6%	23.4%		
		Perception of your organisation's commitment to sustainability targets	4.9%	11.5%	31.6%	36.1%	15.6%		
		Alignment across dietitians on key messaging and issues	0.4%	4.1%	18.0%	46.7%	30.3%		
		Client perception of quality of care through availability of well-designed resources	0.0%	4.1%	15.2%	42.2%	38.1%		
General practitioners	Job satisfaction	Confidence in the nutrition advice provided to your patients	2.0%	8.0%	27.0%	42.0%	21.0%	**68.0%**	GPs (N=100) were surveyed and asked the importance of the key indicators of job satisfaction. The importance of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
		Ability to disseminate nutrition information	1.0%	14.0%	25.0%	48.0%	12.0%		
		Patient awareness and education	2.0%	3.0%	23.0%	49.0%	23.0%		
	Job efficiency	Time efficiency during consultations with patients	10.0%	11.0%	19.0%	42.0%	18.0%	**65.1%**	GPs (N=100) were surveyed and asked the importance of the key indicators of job efficiency. The importance of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
		Ability to keep up to date with current dietary recommendations	4.0%	6.0%	23.0%	46.0%	21.0%		
Primary care nurses	Job satisfaction	Confidence in the nutrition advice provided to your patients	0.0%	7.1%	15.7%	47.1%	30.0%	**76.5%**	Primary care nurses (N=70) were surveyed and asked the

	Ability to disseminate nutrition information	1.4%	2.9%	20.0%	42.9%	32.9%		importance of the key indicators of job satisfaction. The importance of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
	Patient awareness and education	0.0%	5.7%	12.9%	41.4%	40.0%		
Job efficiency	Time efficiency during consultations with patients	2.9%	7.1%	27.1%	35.7%	27.1%	**72.4%**	Primary care nurses (N=70) were surveyed and asked the importance of the key indicators of job efficiency. The importance of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
	Efficiency in creating care plans for your patients	2.9%	12.9%	17.1%	35.7%	31.4%		
	Ability to keep up to date with current dietary recommendations	0.0%	10.0%	10.0%	38.6%	41.4%		

Abbreviations: GPS, general practitioners; SROI, social return on investment; N, number

APPENDIX VII DURATION

Duration details the length of time the outcome is expected to last (in years). This analysis is a forecast SROI with a time horizon of one year.

For each outcome, it is assumed that at least some of all stakeholder groups will experience the outcome for the duration of the forecast. The value of the program was measured over a one-year timeframe as this period would be sufficient to capture the outcomes and impact to the stakeholders, while limiting uncertainty associated with long-term extrapolations and assumptions. For example, a healthcare professional using the intervention in a primary care setting would likely experience improved job satisfaction through increased confidence in the nutrition advice provided to patients during the consultation period and subsequent follow-ups over the year (short-term). Therefore, during this period it was assumed that a drop-off would not occur as long as the stakeholder group has access to the intervention. Additionally, the program is intended to be updated annually to align with evolving dietary guidelines and nutrition evidence.

The duration and rationale for each outcome is outlined in Table 23.

Table 23 Duration

Stakeholders	Outcome	Duration	Rationale
Dietitians	Job satisfaction	1 year	This model considers an annual impact only.
	Job efficiency	1 year	This model considers an annual impact only.
	Job opportunities	1 year	This model considers an annual impact only.
	Reputation	1 year	This model considers an annual impact only.
General practitioners	Job satisfaction	1 year	This model considers an annual impact only.
	Job efficiency	1 year	This model considers an annual impact only.
Primary care nurses	Job satisfaction	1 year	This model considers an annual impact only.
	Job efficiency	1 year	This model considers an annual impact only.

APPENDIX VIII ATTRIBUTION

Attribution accounts for external factors which could have influenced the outcome in addition to the intervention.

Attribution was determined using the stakeholder surveys. For each indicator of change, if a survey participant indicated that it would improve or worsen with MEBC, they were subsequently asked to indicate how much MEBC would contribute to this change, on a 5-point Likert scale. The scale also included attribution represented as a percentage (Table 24). If the change was considered to be primarily the result of MEBC (i.e. completely or very), then the presence of other factors is assumed to not have a substantial impact. Therefore, MEBC is likely to be the main contributing factor to the change in these outcomes.

This report does not assess the changes in individual nutritional behaviours but rather the empowerment of health professionals, and therefore there is no attribution associated with potential societal changes. In addition, the stakeholder engagement focussed on asking the stakeholder what the value of the specific MEBC resources would be, as an addition to the materials and resources already available to them. As the time horizon was limited to one year, it is unlikely that unforeseen changes in the resources available to healthcare professional would take place during that single year.

Table 24 Attribution transformation scale: 'How much does MEBC contribute to the change in [outcome]?'

Likert scale	The outcome is not at all due to MEBC	The outcome is a little due to MEBC	The outcome is moderately due to MEBC	The outcome is very much due to MEBC	The outcome is completely due to MEBC
Scoring	0%	25%	50%	75%	100%

The attribution value and rationale for each outcome is outlined in Table 25.

Table 25 Attribution filters

Stakeholder	Outcome	Q10: if you had MEBC available, which outcomes change?	Not at all (0%)	A little (25%)	Moderately (50%)	Very (75%)	Completely (100%)	Importance (weighted average)	Rationale
Dietitians	Job satisfaction	Positive feedback from clients	1.2%	3.7%	18.4%	33.6%	42.6%	**80.5%**	Dietitians (N=327) were surveyed and asked how much MEBC would contribute to the change in key indicators of job satisfaction. Only the response of those who reported that MEBC would improve their job satisfaction were included. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage
		Ability to change perceptions around unhealthy/restrictive diets	0.8%	3.3%	11.1%	38.9%	45.5%		
		Ability to have a positive impact on clients and/or students	0.4%	2.9%	11.5%	32.4%	52.5%		
		Enjoyment from sharing more holistic approaches to nutrition	1.2%	4.1%	19.3%	35.2%	40.2%		
		Ability to motivate clients effectively	0.0%	2.0%	12.3%	35.2%	50.0%		

									(see scale above) based on SROI best practice.
	Job efficiency	Time to create new and high-quality communication content	3.3%	3.3%	22.1%	32.8%	38.1%	**76.8%**	Dietitians (N=327) were surveyed and asked how much MEBC would contribute to the change in key indicators of job efficiency. Only the response of those who reported that MEBC would improve their job efficiency were included. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
		Ability to keep up to date with dietary recommendations	1.6%	2.5%	15.2%	37.3%	43.0%		
		Communication of dietary guidelines with clients	0.4%	4.1%	18.9%	36.9%	39.3%		
		Efficiency in creating care plans for clients	2.0%	5.7%	25.0%	32.4%	34.8%		
		Time efficiency during client consults	3.7%	4.5%	16.8%	36.5%	38.1%		
		Availability of practical nutrition advice for clients	1.2%	2.0%	11.1%	38.9%	46.3%		
	Job opportunities	Revenue streams from increased social media promotion	31.6%	17.2%	28.3%	14.8%	8.2%	**39.4%**	Dietitians (N=327) were surveyed and asked how much MEBC would contribute to the change in key indicators of job opportunities. Only the response of those who reported that MEBC would improve their job opportunities were included. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
		Reach from effective social media communication	27.0%	18.9%	26.2%	18.4%	9.4%		
	Reputation	Credibility from using high-quality resources	0.8%	4.9%	13.1%	43.0%	37.3%	**70.4%**	Dietitians (N=327) were surveyed and asked how much MEBC would contribute to the change in key indicators of reputation. Only the response of those who reported that MEBC would improve their reputation were included. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
		Reputation when starting out in your career	11.9%	10.2%	27.5%	26.6%	23.4%		
		Perception of your organisation's commitment to sustainability targets	4.9%	11.5%	31.6%	36.1%	15.6%		
		Alignment across dietitians on key messaging and issues	0.4%	4.1%	18.0%	46.7%	30.3%		
		Client perception of quality of care through availability of well-designed resources	0.0%	4.1%	15.2%	42.2%	38.1%		
General practitioners	Job satisfaction	Confidence in the nutrition advice provided to your patients	0.0%	12.0%	34.7%	37.3%	16.0%	**66.3%**	GPs (N=100) were surveyed and asked how much MEBC would contribute to the change in key indicators of job satisfaction.
		Ability to disseminate nutrition information	0.0%	14.5%	23.7%	44.7%	17.1%		

	Job efficiency	Patient awareness and education	0.0%	5.1%	31.6%	48.1%	15.2%	**65.2%**	The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice. Of those who reported that MEBC would improve their key indicators of job satisfaction, 66% of this was attributed to MEBC. GPs (N=100) were surveyed and asked how much MEBC would contribute to the change in key indicators of job efficiency. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice. Of those who reported that MEBC would improve their key indicators of job efficiency, 65% of this was attributed to MEBC.
		Time efficiency during consultations with patients	0.0%	15.9%	20.5%	50.0%	13.6%		
		Ability to keep up to date with current dietary recommendations	1.3%	12.0%	25.3%	48.0%	13.3%		
Primary care nurses	Job satisfaction	Confidence in the nutrition advice provided to your patients	0.0%	1.8%	19.6%	50.0%	28.6%	**76.3%**	Primary care nurses (N=70) were surveyed and asked how much MEBC would contribute to the change in key indicators of job satisfaction. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice. Of those who reported that MEBC would improve their key indicators of job satisfaction, 76% of this was attributed to MEBC.
		Ability to disseminate nutrition information	0.0%	3.7%	16.7%	48.1%	31.5%		
		Patient awareness and education	0.0%	3.1%	21.9%	43.8%	31.3%		
	Job efficiency	Time efficiency during consultations with patients	2.5%	7.5%	20.0%	45.0%	25.0%	**72.8%**	Primary care nurses (N=70) were surveyed and asked how much MEBC would contribute to the change in key indicators of job efficiency. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best
		Efficiency in creating care plans for your patients	2.4%	4.8%	19.0%	54.8%	19.0%		
		Ability to keep up to date with current dietary recommendations	0.0%	4.8%	12.9%	51.6%	30.6%		

			practice. Of those who reported that MEBC would improve their key indicators of job efficiency, 73% of this was attributed to MEBC.

Stakeholders	Outcome	Attribution	Rationale
Dietitians	Job satisfaction	69%	Dietitians (N=327) were surveyed and asked how much MEBC would contribute to the change in key indicators of job satisfaction. Only the response of those who reported that MEBC would improve their job satisfaction were included. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
	Job efficiency	72%	Dietitians (N=327) were surveyed and asked how much MEBC would contribute to the change in key indicators of job efficiency. Only the response of those who reported that MEBC would improve their job efficiency were included. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
	Job opportunities	61%	Dietitians (N=327) were surveyed and asked how much MEBC would contribute to the change in key indicators of job opportunities. Only the response of those who reported that MEBC would improve their job opportunities were included. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
	Reputation	66%	Dietitians (N=327) were surveyed and asked how much MEBC would contribute to the change in key indicators of reputation. Only the response of those who reported that MEBC would improve their reputation were included. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice.
General practitioners	Job satisfaction	66%	GPs (N=100) were surveyed and asked how much MEBC would contribute to the change in key indicators of job satisfaction. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice. Of those who reported that MEBC would improve their key indicators of job satisfaction, 66% of this was attributed to MEBC.
	Job efficiency	65%	GPs (N=100) were surveyed and asked how much MEBC would contribute to the change in key indicators of job efficiency. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice. Of those who reported that MEBC would improve their key indicators of job efficiency, 65% of this was attributed to MEBC.

Stakeholders	Outcome	Attribution	Rationale
Primary care nurses	Job satisfaction	76%	Primary care nurses (N=70) were surveyed and asked how much MEBC would contribute to the change in key indicators of job satisfaction. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice. Of those who reported that MEBC would improve their key indicators of job satisfaction, 76% of this was attributed to MEBC.
	Job efficiency	73%	Primary care nurses (N=70) were surveyed and asked how much MEBC would contribute to the change in key indicators of job efficiency. The attribution of each outcome was determined on a 5-point Likert scale which was transformed into a percentage (see scale above) based on SROI best practice. Of those who reported that MEBC would improve their key indicators of job efficiency, 73% of this was attributed to MEBC.

Abbreviations: GPS, general practitioners; MEBC, make every bit count; SROI, social return on investment; N, number

APPENDIX IX DEADWEIGHT

Deadweight accounts for a degree of change in the outcomes that would have occurred without the intervention. Deadweight is used to measure the amount of change that could have happened regardless of intervention. Therefore, to identify this figure, it is needed to consider how likely it is that outcomes would have occurred if the intervention had not occurred. Deadweight is a difficult metric to capture via stakeholder questionnaires as personal experience often distorts these estimates. In addition, stakeholders often do not have the experience of the counterfactual (i.e. what would have happened if they did not experience the intervention) and are therefore unable to accurately assess deadweight. Therefore, the author's judgement was used to estimate a deadweight value for each outcome. Considering the various factors that can contribute to stakeholder groups in their day-to-day work life, there is a high degree of uncertainty that the intervention solely plays a role in improving those outcomes. Various factors can impact job satisfaction, efficiency, opportunities, and professional reputation such as work-life balance, company culture, interpersonal relationships and access to adequate training and support. Therefore, a deadweight of 40% was applied for each outcome. This assumption could be validated during an evaluative SROI by including a specific question in the stakeholder questionnaire.

For each outcome, a six-point scale, extracted from a previously assured SROI report by ExtraBanca[31] was used to measure deadweight (Table 26).

Table 26 Deadweight transformation scale: 'Without MEBC, the change would "…" have occurred'

Likert scale	Never	Very probably not	Might	Probably	Very probably	Certainly
Scoring	0%	20%	40%	60%	80%	100%

The deadweight filter applied and rationale for each outcome is outlined in Table 27.

Table 27 Deadweight filters

Stakeholders	Outcome	Deadweight	Rationale
Dietitians	Job satisfaction	40%	It was considered that the change might have occurred even if the activity had not occurred (e.g. through use of client management software).
	Job efficiency	40%	It was considered that the change might have occurred even if the activity had not occurred (e.g. using AI software).
	Job opportunities	40%	It was considered that the change might have occurred even if the activity had not occurred (e.g. through attending in person conferences and events).
	Reputation	40%	It was considered that the change might have occurred even if the activity had not occurred (e.g. through attending in person conferences and events).

Stakeholders	Outcome	Deadweight	Rationale
General practitioners	Job satisfaction	40%	It was considered that the change might have occurred even if the activity had not occurred (e.g. through undertaking continuous professional development such as webinars).
	Job efficiency	40%	It was considered that the change might have occurred even if the activity had not occurred (e.g. through use of client management software).
Primary care nurses	Job satisfaction	40%	It was considered that the change might have occurred even if the activity had not occurred (e.g. through undertaking continuous professional development such as attending webinars and courses).
	Job efficiency	40%	It was considered that the change might have occurred even if the activity had not occurred (e.g. through use of client management software).

APPENDIX X DISPLACEMENT

Displacement is a measure of how much the outcome displaced other outcomes.

Displacement is a difficult metric to capture via stakeholder questionnaires as personal experience often distorts these estimates. As such, displacement was defined using the authors' judgement, validated with consultation with the stakeholder groups.

For this SROI, the outcomes created are not displacing other outcomes elsewhere. For example, improving job efficiency for a primary care nurse does not require displacing job efficiency from others or reducing job efficiency in another group.

The displacement value and rationale for each outcome is outlined in Table 28.

Table 28 Displacement filters

Stakeholders	Outcome	Displacement	Rationale
Dietitians	Job satisfaction	0%	MEBC does not displace any other program.
	Job efficiency	0%	MEBC does not displace any other program.
	Job opportunities	0%	MEBC does not displace any other program.
	Reputation	0%	MEBC does not displace any other program.
General practitioners	Job satisfaction	0%	MEBC does not displace any other program.
	Job efficiency	0%	MEBC does not displace any other program.
Primary care nurses	Job satisfaction	0%	MEBC does not displace any other program.
	Job efficiency	0%	MEBC does not displace any other program.

APPENDIX XI DROP-OFF

Drop-off rate is the reduction in the magnitude of an outcome or in the influence that the intervention will have on the outcome over time.

A one-year time horizon was chosen to capture the short-term changes in social impacts expected to arise from providing the nutrition communication resources to health professionals. It is assumed that the impact will last for the one year as the stakeholder groups use the MEBC program and its resources as long as they are relevant and are of value. Additionally, the MEBC program is intended to be updated annually to align with evolving dietary guidelines and nutrition evidence. Therefore, drop-off was not factored into this analysis.

The drop-off value and associated rationale for each outcome is outlined in Table 29.

Table 29 Drop-off filters

Stakeholders	Outcome	Drop off	Rationale
Dietitians	Job satisfaction	0%	As this model considers an annual impact only, it is assumed that this outcome will not reduce over time.
	Job efficiency	0%	As this model considers an annual impact only, it is assumed that this outcome will not reduce over time.
	Job opportunities	0%	As this model considers an annual impact only, it is assumed that this outcome will not reduce over time.
	Reputation	0%	As this model considers an annual impact only, it is assumed that this outcome will not reduce over time.
General practitioners	Job satisfaction	0%	As this model considers an annual impact only, it is assumed that this outcome will not reduce over time.
	Job efficiency	0%	As this model considers an annual impact only, it is assumed that this outcome will not reduce over time.
Primary care nurses	Job satisfaction	0%	As this model considers an annual impact only, it is assumed that this outcome will not reduce over time.
	Job efficiency	0%	As this model considers an annual impact only, it is assumed that this outcome will not reduce over time.

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APPENDIX XII COST INPUTS

The total MEBC program cost was calculated to be $521,500. This figure includes all direct expenses related to creating and distributing program materials, as well as the salary for a program coordinator (Table 30). The MEBC materials are available free of charge to healthcare professionals.

Table 30 Cost of MEBC program

Input	Value	Source	Notes
Sponsorship of e-news, webinars, podcasts	$240,000	MLA - data on file	Conducted via medical media suppliers, including Samples Plus (Market Reach), Tonic Health Media and DC
Printing and fulfilment of practical resources	$80,000	MLA - data on file	
Production of practical resources	$40,000	MLA - data on file	Includes graphic design, recipe development, styling, photography and filming
Masterclass	$70,000	MLA - data on file	Includes PR agency (event management), talent (hosting of event and video production)
Average program coordinator salary in NFP	$91,500	Calculated based on published NFP salaries	Average program manager salary, for non-profit organisation in Australia
Total cost of MEBC program	**$521,500**		

Abbreviations: DC, Dietitian Connection; MEBC, Make every bite count; NFP, not-for-profit

REFERENCES

1. Commonwealth of Australia, *The National Obesity Strategy 2022-2032*. 2022: Health Ministers Meeting.
2. Lisciani, S., E. Camilli, and S. Marconi, *Enhancing Food and Nutrition Literacy: A Key Strategy for Reducing Food Waste and Improving Diet Quality*. Sustainability, 2024. **16**(5): p. 1726.
3. Nicholls, J.L., E; Neitzert, E; Goodspeed, T;, *A guide to Social Return on Investment*. 2012.
4. Le Floch, B., et al., *Which positive factors give general practitioners job satisfaction and make general practice a rewarding career? A European multicentric qualitative research by the European general practice research network*. BMC Family Practice, 2019. **20**(1): p. 96.
5. Department of Health and Aged Care. *Summary Statistics, Medical Profession*. 2024; Available from: https://hwd.health.gov.au/resources/data/summary-mdcl.html.
6. Australian Institute of Health and Welfare, *A profile of primary health care nurses*. 2020.
7. Tapan, B., et al., *Perceptions of Dieticians Regarding Job Satisfaction and Related Factors*. British Journal of Medical and Health Research, 2017. **44**.
8. Rusali, R., et al., *Management Responsibilities Among Dietitians: What is the Level of Job Satisfaction and Skills Involved? A Scoping Review*. Malaysian Journal of Medicine and Health Sciences, 2020: p. 2636-9346.
9. Landry, M.J., et al., *The Impostor Phenomenon in the Nutrition and Dietetics Profession: An Online Cross-Sectional Survey*. Int J Environ Res Public Health, 2022. **19**(9).
10. Nagy, A., et al., *The therapeutic relationship between a client and dietitian: A systematic integrative review of empirical literature*. Nutr Diet, 2022. **79**(3): p. 303-348.
11. Stobbe, E.J., P.P. Groenewegen, and W. Schäfer, *Job satisfaction of general practitioners: a cross-sectional survey in 34 countries*. Human Resources for Health, 2021. **19**(1): p. 57.
12. Giang, K.-W. and J.L. Lilja, *Strategies for achieving efficiency in the general practitioner's everyday life*. Scandinavian Journal of Primary Health Care, 2022. **40**(2): p. 261-270.
13. Desborough, J., L. Forrest, and R. Parker, *Nurse satisfaction with working in a nurse led primary care walk-in centre: An Australian experience*. Australian journal of advanced nursing : a quarterly publication of the Royal Australian Nursing Federation, The, 2013. **31**: p. 11-19.
14. Halcomb, E., et al., *Exploring job satisfaction and turnover intentions among general practice nurses in an Australian Primary Health Network*. J Nurs Manag, 2021. **29**(5): p. 943-952.
15. Lukewich, J., et al., *Effectiveness of registered nurses on patient outcomes in primary care: a systematic review*. BMC Health Services Research, 2022. **22**(1): p. 740.
16. Halcomb, E. and S. Bird, *Job Satisfaction and Career Intention of Australian General Practice Nurses: A Cross-Sectional Survey*. J Nurs Scholarsh, 2020. **52**(3): p. 270-280.
17. Dietitians Australia. *Dietitians Australia 2024 Conference*. 2024 [cited 2024 October]; Available from: https://www.da2024.com.au/registration.
18. Dietitians Australia. *Advertising opportunities*. 2024; Available from: https://dietitiansaustralia.org.au/about-us/advertising-opportunities.
19. Unite Health. *Overcoming Workplace Challenges as an Allied Health Professional*. 2024; Available from: https://www.unitehealth.com.au/blog/overcoming-workplace-challenges-as-an-allied-health-professional.
20. PowerDiary. *Powerdiary*. 2024 [cited 2024 October]; Available from: https://www.powerdiary.com/au/profession/nutritionist-practice-management-software/.
21. NutritioApp. *AI powered Nutrition software for dietitians, nutritionists, nutrition coaches and fitness trainers*. 2024 [cited 2024 October]; Available from: https://nutritioapp.com/.
22. Dietitian Connection. *Event Categories Australia*. 2024 [cited 2024 October]; Available from: https://dietitianconnection.com/event-category/australia/.
23. Nutrition & Dietetics. *Article Publication Charges (APCs)*. 2024 [cited 2024 October]; Available from: https://onlinelibrary.wiley.com/page/journal/17470080/homepage/fundedaccess.html.
24. RMIT University. *Future Skills Short Course: Digital Marketing Strategy*. 2024 [cited 2024 October]; Available from: https://online.rmit.edu.au/course/sc-digital-marketing-strategy-dmk101.
25. RACGP. *RACGP membership rates 2024-25*. 2024 [cited 2024 October]; Available from: https://www.racgp.org.au/racgp-membership/membership/membership-rates.
26. Lyrebird Health. *Lyrebird Health Pricing*. 2024 [cited 2024 October]; Available from: https://www.lyrebirdhealth.com/au/pricing.
27. Shine dietetics. *Shop for Health and Nutrition Resources*. 2024 [cited 2024 October]; Available from: https://shinedietetics.com.au/resources/.
28. APNA. *Online Learning Products*. 2024 [cited 2024 October]; Available from: https://www.apna.asn.au/online-learning-products.
29. APNA. *Festival of Nursing*. 2024 [cited 2024 October]; Available from: https://www.apna.asn.au/education/festival.
30. Ausmed Education. *Pricing*. 2024 [cited 2024 October]; Available from: https://www.ausmed.com.au/plans.
31. Broccia;, F.M.F.M.N.C.F., *A Bridge Towards Inclusion*. 2018, ExtraBanca: Milan, Italy.