Implementation of a worksite educational program focused on promoting healthy eating habits [version 1; peer review: 1 approved, 1 approved with reservations]

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Abstract

Objective: To estimate the effectiveness of a short-term educational-counseling worksite program focused on lipid intake, by monitoring the possible change on nutrition knowledge and eating habits.

Methods: an 8-week educational program based on the Health Belief Model was implemented in a honey packaging and sales company in Greece. 20 out of the 29 employees initially enrolled completed the program. Knowledge level and eating habits were evaluated prior and after the intervention by the “Nutrition Knowledge Questionnaire” and the “Food Habits Questionnaire”. ANOVA, Spearman rho test and paired Wilcoxon test were employed in statistical analysis.

Results: Non smokers and those with higher educational level had healthier eating habits. Knowledge following the intervention was significantly improved concerning recommendations and basic food ingredients but as far as eating habits were concerned, scores were not improved significantly, while intake of fried food was increased.

Conclusions and Implications: Short-term interventions may produce substantial improvement in knowledge but not necessarily modifications in unhealthy eating habits.

Keywords

Greece; worksite intervention; eating habits; health promotion programs.
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Introduction
Over the last decades, obesity has rapidly turned into a global epidemic in both developed and developing countries, affecting adults, children and adolescents as well. Currently, the number of people suffering from obesity is estimated at approximately 400 million people worldwide. Moreover, increased body mass index (BMI) is associated with higher risk of cardiovascular diseases, some types of cancer and type II diabetes. Recent data from Greece have shown obesity is an epidemic problem. In recent years, Greeks have abandoned the traditional Mediterranean diet; one study reports that only 33% of Greek men and 43% of Greek women adhere to a traditional Mediterranean diet.

Among various individual and lifestyle factors, many work-related factors are responsible for the modification of dietary patterns including working conditions, such as: working overtime, high job demands, occupational stress and others. On the other hand, the workplace has been identified as a promising setting for health promotion although the findings of many worksite health promotion (WHP) programs indicate that these programs are associated with only moderate improvement in dietary intake. Furthermore, it was shown that diet mediterranisation is feasible in a food-at-work intervention, affecting lunch consumption at the workers canteen. However in a systematic review, participation levels in health promotion (WHP) programs indicate that these programs are associated with high adherence and high engagement. In Greece, the percentage of employees who perform regular physical activity has been increased from 53% at the year 2000 to 62% in 2013. Additionally, the percentage of employees who adhere to a traditional Mediterranean diet has increased from 33% to 43% and the percentage of subjects with a healthy weight has increased from 47% to 54%.

The purpose of the present study was to evaluate the effectiveness of an educational worksite intervention focused on lowering fat intake, by affecting nutrition knowledge and eating habits.

Methods
Study population
The 48 employees working in the factory premises of a honey company, were asked to participate in this study. Most of the 48 employees were employed in jobs that required mild to moderate manual and intellectual activity (blue collar workers) and five were employed as food scientists and technologists, and supervisors. No inclusion or exclusion criteria were used and as there were no medical contraindications for participation in the program, as judged by the occupational health physician, all employees were eligible for participation. Twenty-nine employees responded positively (60%) to the invitation and gave their written informed consent. The Medical School Review Board judged that further approval was not required, since this program was under the occupational physician’s supervision and control. During the program, seven employees failed to attend day 2 and/or 3 and another two did not return the final questionnaires and all nine were excluded from the final analysis (see Table 1).

Survey questionnaires
Initially, all employees were informed about the program and were asked to participate by signing informed consent. Two questionnaires were used in order to estimate (Q1) the employees’ nutrition knowledge level and (Q2) their eating habits (see Supplementary File Q1 and Supplementary File Q2). The questionnaires were translated into Greek by two bilingual expert nutritionists and were piloted in 10 college students and blue collar employees for linguistic validation.

Nutrition knowledge was assessed using the “Nutrition Knowledge Questionnaire” (see Supplementary File Q1). The questionnaire covers four sections: (i) knowledge on experts’ recommendations regarding the optimum intake of different food groups (maximum score: 11); (ii) nutrient knowledge (maximum score: 69); (iii) food choice (which asks people to choose between different options, e.g., to pick the snack that is low in fat and high in fibers), (maximum score: 10); and (iv) the relationships between diet and disease (maximum score: 20). This last section looks at beliefs about the associations between food type, food quantity and diseases.

The eating habits of the participants were assessed by the “Food Habits Questionnaire” (see Supplementary File Q2), which has been widely used to estimate dietary changes. Questions were rated on a 4-point scale, where 1 reflects the healthiest and 4 the unhealthiest eating habits, respectively. The questionnaire included five sections regarding the following habits: (i) replacing high fat foods with low fat substitutes (score range: 7–28); (ii) modifying high fat foods, e.g., fat removal from meat (score range: 3–12); (iii) avoiding high fat cooking methods (fried food) (score range: 4–16); (iv) consumption of fresh fruit and vegetables as a snack (score range: 3–12); and (v) choosing specially manufactured low fat foods products instead of high fat ones (score range: 5–20). The total score of eating habits is calculated from the sum of section scores divided by 5 (ranged from 4.4 to 17).

Data on age, family status, children, educational level, job position, smoking habit, BMI, arterial blood pressure and number of cigarettes/years of smoking were also collected (see Table 2).

Table 1. Description of the health promotion program.

| Phase | Description                                                                 | Duration | Participants |
|-------|-----------------------------------------------------------------------------|----------|--------------|
| 0     | Informing workers about the health promotion program                        | 0.5 h    | 48           |
| 1: day 1 | Presentation and distribution of the questionnaires Measurements of blood pressure/weight/height | 1.5 h    | 29           |
| 2: day 16 | Lecture, discussion, distribution of printed material                      | 2 h      | 24           |
| 3: day 23 | Issues derived from questionnaire analysis (knowledge gaps) Restrictive factors and alternative suggestions (bad habits) | 2 h      | 20           |
| 4: day 45 | Redistribution of the questionnaires                                      | 0.5 h    | 20           |
| 5: day 52 | Final meeting, results presentation, individual counseling                  | 3 h      | 20           |
Table 2. Demographic and individual characteristics of the intervention group (n=20).

| Demographic characteristics |  
|-----------------------------|
| Age in years (mean ± SD)    | 44.6 ± 9.1 |
| ≤ 35 (n (%))                | 4 (20)     |
| 36–44                       | 6 (30)     |
| ≥ 45                        | 10 (50)    |
| Female (n (%))              | 18 (90)    |
| Family status (n (%))       |            |
| Married, living with other  | 18 (90)    |
| Divorced, living alone      | 2 (10)     |
| Parenthood (n (%))          | 19 (95)    |
| Educational level (n (%))   |            |
| < 6 years (elementary)      | 7 (35)     |
| 6–9 years (basic)           | 4 (20)     |
| 9–12 years (high or technical school) | 7 (35) |
| > 12 years                  | 2 (10)     |
| Individual characteristics  |            |
| BMI kg/m² (mean ± SD)       | 26.5 ± 6.2 |
| < 25 kg/m² (n, %)           | 11 (61)    |
| 25–29.9 kg/m² (n, %)        | 4 (22)     |
| > 30 kg/m² (n, %)           | 3 (17)     |
| Smoking                     |            |
| Smoker (n, %)               | 9 (45)     |
| Pack-years (mean ± SD)      | 8.9 ± 11.6 |
| Non smokers (n, %)          | 11 (55)    |

The intervention took place in three distinct phases over a total of 7–8 weeks (Table 1) and it was based on the Health Belief Model which suggests that health behaviors are determined by health beliefs and readiness to take action. Behavioral theory has increasingly been used to guide nutrition research to improve intervention efficacy. The Health Belief Model was developed in the 1950s to explain health behavior associated with the failure of people to participate in programs that would reduce disease risk. Constructs central to the HBM consist of perceived susceptibility, perceived severity, perceived benefits, perceived barriers, and other mediating variables. The construct of self-efficacy is frequently included in applications of the HBM11,14.

In our program (Phase 1), all employees who initially responded to the invitation attended a 30 minute meeting in which a brief presentation of the self-administered questionnaires was done and instructions about the proper completion of both questionnaires were given. Further clarifications were answered the following days during the collection, where necessary. Data on individual characteristics (age, marital status, children, education, smoking status etc.), were also collected and blood pressure, weight and height of the subjects were measured (Seca® 764, Sigma Medical Co, Athens, Greece) at the end of the meeting. Completed questionnaires were collected, recorded in an electronic database and statistically analyzed. In Phase 2, 15 days after the questionnaires were initially distributed, a 45-minute lecture on healthy eating and Mediterranean diet was held followed by discussion and distribution of printed material with practical proposals for adoption of healthier eating habits. Overall, the whole session lasted approximately two hours. A week later a second meeting took place (Phase 3) in order to discuss and clarify issues derived from the conclusions of the initial analysis. Specifically, knowledge gaps and restrictive factors for the adoption of healthier nutritional choices were further discussed. The intervention was completed 22 days later (Phase 4) when the participants were asked to fill in the questionnaires again. In the last phase (Phase 5), a final meeting took place to present and discuss the results, and for individual counseling by the research team.

Statistical analysis
Analysis of variance (ANOVA) was used to reveal statistically significant differences among various subgroups. Due to the small sample, Spearman rho test was used to examine correlations of the quantitative variables while the paired signed Wilcoxon test was used to compare average values of continuous variables for each category of nominal variables in the intervention group (before and after). A p-value of <0.05 was considered statistically significant. Statistical processing and data analysis were performed using commercial software (SPSS version 16.0, SPSS Inc., 2007).

Results
General characteristics of the study population
From the 29 workers who initially responded positively, 20 workers (67%) attended all phases and completed the WHP program (Table 1). Losses were mainly due to absences on the days of intervention, or inability or failure to return the study questionnaires in time. Between the final and initial groups there were no significant differences in any of the variables.

Analysis of the knowledge questionnaire, returned by the 29 workers who initially responded, showed a lack of knowledge of food composition in saturated fat, fibers, and salt, of the origin of fatty acids (monosaturated, polysaturated and saturated) and of the sources of antioxidant vitamins. Education level correlated significantly with the partial score, i.e. the higher the education level the higher the scores.

Analysis of the habits questionnaire showed that dietary habits included medium to large consumption of fatty foods. However, the score of the workers corresponding to the avoidance of fried foods was pretty high, reaching almost the excellent level. No significant correlations were found between variables under study and the two first subscales (replacement of fatty foods and meat modification). Men, people living with others, and those without children had a tendency to avoid the more fatty substances. Meanwhile, women consumed less fried foods.

Post-intervention analysis was done in the 20 workers who had participated in all phases. Table 2 shows the demographic and individual characteristics of these workers. Women and blue collar workers accounted for 90% and 95%, respectively, a fact that limits
the possibility of revealing significant effects of these variables (sex and job title) on the results of the intervention.

As expected, there were significant correlations between the sections (scales) of the two questionnaires prior to, and following, the intervention. By contrast, between the different questionnaires, scales were less and weakly correlated with the exception of the group of the avoidance of fatty substances. Very high Cronbach alpha score (above 0.80) shows satisfactory reliability of all subscales of both questionnaires. Table 3 presents the scores per category (section) of nutritional knowledge prior to, and following, the intervention in the 20 workers. Significant improvement was seen in the sections of “dietary recommendations”, in “basic food ingredients” and in the total score. Prior to intervention, non-smokers had higher (better) scores concerning the subscales of the “basic food ingredients” (41.0 vs 33.1, p=0.08) and the “selection of healthier foods” (6.2 vs 4.8, p=0.06) but these differences did not reach statistical significance. Following the intervention, non-smokers improved more in the “selection of healthier foods” (6.8 vs 5.2, p=0.04).

Table 4 presents the dietary habit scores prior to, and following, the intervention. The mean score was improved in the categories of “replacement of fatty foods”, “meat modification”, “consumption of food and vegetables”, “avoidance of fatty substances” and in the total score but the difference was far from significant. On the contrary in the habit of “avoidance of fried foods”, the score was significantly worse, a paradox that might be explained by the very high initial score (tendency towards regression to the mean).

Workers with a normal BMI exhibited better habits compared with overweight and obese subjects in terms of “meat modification” (4.6 vs 12.7, p=0.002). Non-smokers had lower scores compared with smokers in “fat avoidance” (12.6 vs 15.0, p=0.06) and in “avoidance of fried food” (6.5 vs 7.7, p=0.05).

Discussion

In the present study, a short-term intervention regarding eating knowledge and habits was implemented in a worksite. Knowledge was significantly improved following this intervention, while no significant improvement was achieved concerning dietary habits. The paradox regarding the fact that average consumption of fried, browned or breaded food (“avoidance of fried food”) increased following the intervention could be partially attributed to the very high (excellent) initial score combined with the fact that some vacations also coincided with the program. The finding that knowledge gain did not lead to habit modification may be explained by the short duration of the program and the complexity that characterizes the conscious or unconscious choices of adults. Health promotion programs in workplaces have shown to be cost-effective, especially for long-term interventions[20].

In our study, a number of factors, i.e. education level, job title, family situation and smoking status was shown to be related to the level of nutrition knowledge and dietary habits. However, the small number of participants prevented these correlations to be concurrently analyzed in multivariate analysis. Other factors known to influence dietary behavior including socio-economic factors, stress and organizational

| Knowledge category                  | Prior to the intervention | Following the intervention | Paired difference |
|-------------------------------------|---------------------------|---------------------------|------------------|
|                                     | Max score                 | Median | Mean  | SD | Median | Mean  | SD | Mean | 95% CI | p-value |
| Dietary recommendations             | 11                        | 7      | 7.13  | 1.81 | 8      | 8.00  | 1.76 | -0.88 | -1.68  | -0.07   | 0.035   |
| Basic food ingredients              | 69                        | 39     | 37.45 | 9.99 | 48     | 44.05 | 12.01 | -6.60 | -11.85 | -1.35   | 0.016   |
| Selection of healthier foods        | 10                        | 6      | 5.55  | 1.70 | 6      | 6.10  | 1.74 | -0.55 | -1.33  | 0.23    | 0.157   |
| Diet – health relationship          | 20                        | 14     | 12.50 | 4.80 | 15     | 13.20 | 4.456| -0.70 | -2.92  | 1.52    | 0.518   |
| Total score                         | 110                       | 66     | 62.63 | 15.40| 77     | 71.35 | 16.39| -8.73 | -15.55 | -1.90   | 0.015   |

| Dietary habits                      | Prior to the intervention | Following the intervention | Paired difference |
|-------------------------------------|---------------------------|---------------------------|------------------|
|                                     | Max score                 | Median | Mean  | SD | Median | Mean  | SD | Mean | 95% CI | p-value |
| Replacement of fatty foods          | 28                        | 21     | 20.11 | 7.35 | 18     | 19.15 | 6.77 | 0.97  | -2.45  | 4.39    | 0.560   |
| Meat modification                   | 12                        | 5.50   | 6.88  | 3.85 | 6      | 6.60  | 2.41 | 0.28  | -1.14  | 1.69    | 0.690   |
| Avoidance of fried foods            | 16                        | 6      | 6.12  | 1.44 | 7      | 7.03  | 1.30 | -0.92 | -1.56  | -0.27   | 0.008   |
| Food and vegetables consumption     | 12                        | 8.50   | 7.92  | 2.33 | 8.50   | 7.67  | 2.47 | 0.25  | -0.61  | 1.11    | 0.549   |
| Avoidance of fatty substances       | 20                        | 13     | 13.54 | 2.95 | 13     | 13.08 | 4.20 | 0.46  | -1.39  | 2.31    | 0.610   |
| Total score                         | 88                        | 11.44  | 10.84 | 2.31 | 11.79  | 10.45 | 2.60 | 0.39  | -0.62  | 1.40    | 0.470   |
factors (increased work demands, low skills motivation, overtime employment) were not analyzed in our study, but in our setting, the population was highly homogeneous and most of these factors are not anticipated to have a significant discriminatory impact. However, recent findings show that these interventions can be easily incorporated into the daily working routine programs, and if combined with stress management programs, may result in better results.

Limitations of this study arise from the small sample size and the short duration of the program. For organizational reasons, we did not attempt to allocate a control group by randomization. On the other hand, the homogeneity of the population concerning socioeconomic aspects, the supportive environment, and the good relationships between colleagues are considered to minimize confounding of the different factors.

Short-term interventions may produce substantial improvement in knowledge but not necessarily accompanied by changes in unhealthy eating habits. These types of programs are not far from those commonly encountered in every day practice but do not seem to be effective in changing unhealthy eating habits. Participation by the employees in defining their needs and priorities; planning long-term interventions, and incorporating self-empowerment and stress management techniques might be necessary for cost-effective worksite health promotion programs to succeed in reducing unhealthy eating habits.

Author contributions
Conception and design of the study: DT, YT and ECA; Questionnaire validation and data collection: DT, DP and ER; Intervention team: DT, ER and ECA; Data analysis: DP and ECA; Draft writing: DP, ER and ECA; Co-ordination: YT and ECA; Guarantor of the study: ECA.

Competing interests
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**Fat-Related Diet Habits Questionnaire**

I. Interviewer Administered Format

Please consider your food choices over the past MONTH

**In the past month…**

1. Did you eat chicken?
   - 1 YES → When you ate chicken
   - 2 NO
   - 3 NA/REF
   - (READ RESPONSES IF NECESSARY)
   - 1a. How often was it fried?
     - 1 2 3 4 ref
   - 1b. How often did you remove the skin?
     - (READ 1 – 4) 1 2 3 4 ref

2. Did you eat red meat such as beef, pork or lamb?
   - 1 YES → When you ate red meat
   - 2 NO
   - 3 NA/REF
   - (READ RESPONSES IF NECESSARY)
   - 2a. How often did you trim all the visible fat?
     - 1 2 3 4 ref

3. Did you eat ground meat?
   - 1 YES → When you ate ground meat
   - 2 NO
   - 3 NA/REF
   - 3a. How often was it extra lean? 1 2 3 4 ref

4. Did you eat fish?
   - 1 YES → When you ate fish
   - 2 NO
   - 3 NA/REF
   - 4a. How often was it fried? 1 2 3 4 ref

5. Did you have at least one vegetarian dinner or main meal – that is, without meat, fish, eggs or cheese?
   - 1 YES → 5a. How often did you have a vegetarian dinner? 1 2 3 4 ref
   - 2 NO
   - 3 NA/REF

6. Did you eat spaghetti or noodles?
   - 1 YES → When you ate spaghetti or noodles
   - 2 NO
   - 3 NA/REF
   - 6a. Were they plain, or with a red or tomato sauce without meat? 1 2 3 4 ref

7. Did you eat cooked vegetables?
   - 1 YES → When you ate cooked vegetables
   - 2 NO
   - 3 NA/REF
   - 7a. How often did you add butter, margarine or other fat? 1 2 3 4 ref
   - 7b. How often were they fried? 1 2 3 4 ref
In the past month…

8. Did you eat potatoes?
   1 YES → When you ate potatoes
   2 NO
   3 NA/REF
   8a. How often were they fried, like French fries or hash browns?
      1 Usually
      2 Often
      3 Sometimes
      4 Rarely or Never
      REF

9. Did you eat baked or boiled potatoes?
   1 YES → When you ate baked or boiled potatoes
   2 NO
   3 NA/REF
   9a. How often did you eat them without any butter, margarine or sour cream?
      1 Usually
      2 Often
      3 Sometimes
      4 Rarely or Never
      REF

10. Did you eat green salads?
    1 YES → When you ate green salads
    2 NO
    3 NA/REF
    10a. How often did you use no dressing?
   1 Usually
   2 Often
   3 Sometimes
   4 Rarely or Never
   REF
    10b. How often did you use low-fat or non-fat dressing?
       1 Usually
       2 Often
       3 Sometimes
       4 Rarely or Never
       REF

11. Did you eat bread, rolls or muffins?
    1 YES → When you ate bread, rolls or muffins
    2 NO
    3 NA/REF
    11a. How often did you eat them without butter or margarine?
       1 Usually
       2 Often
       3 Sometimes
       4 Rarely or Never
       REF

12. Did you drink milk or use milk on cereal?
    1 YES → When you had milk
    2 NO
    3 NA/REF
    12a. How often was it 1% or nonfat milk?
       1 Usually
       2 Often
       3 Sometimes
       4 Rarely or Never
       REF

13. Did you eat cheese, including on sandwiches or in cooking?
    1 YES → When you ate cheese
    2 NO
    3 NA/REF
    13a. How often was it specially-made low-fat cheese?
       1 Usually
       2 Often
       3 Sometimes
       4 Rarely or Never
       REF

14. Did you eat dessert?
    1 YES → When you ate dessert
    2 NO
    3 NA/REF
    14a. How often did you eat only fruit?
       1 Usually
       2 Often
       3 Sometimes
       4 Rarely or Never
       REF
In the past month…

15. Did you eat home-baked cookies, cakes or pies?  
   1 YES → When you ate home-baked cookies,  
     2 NO cakes or pies  
   3 NA/REF 15a. How often were they made with less butter, margarine or oil than the recipe called for?  
     Usually Often Sometimes Rarely or Never REF

16. Did you eat frozen desserts like ice cream or sherbet?  
   1 YES → When you ate frozen desserts  
   2 NO 16a. How often did you choose frozen yogurt, sherbet or low-fat or non-fat ice cream?  
   3 NA/REF 1 2 3 4 ref

17. Did you eat snacks between meals?  
   1 YES → When you ate snacks between meals  
   2 NO 17a. How often did you eat raw vegetables or fresh fruit?  
   3 NA/REF 1 2 3 4 ref

18. Did you sauté or pan fry any foods?  
   1 YES → When you sautéed or pan fried foods  
   2 NO 18a. How often did you use Pam® or other non-stick spray instead of oil, margarine or butter?  
   3 NA/REF 1 2 3 4 ref

19. Did you use mayonnaise or mayonnaise-type spread?  
   1 YES → When you used mayonnaise or mayonnaise type spread  
   2 NO 19a. How often did you choose low-fat or nonfat types?  
   3 NA/REF 1 2 3 4 ref

20. Did you eat breakfast?  
   1 YES → When you ate breakfast  
   2 NO 20a. How often did you have fresh fruit?  
   3 NA/REF 1 2 3 4 ref

21. Did you eat lunch?  
   1 YES → When you ate lunch  
   2 NO 21a. How often did you have one or more vegetables, not including potatoes or salad?  
   3 NA/REF 1 2 3 4 ref

22. At dinner (or your main meal), how often did you have two or more vegetables, not including potatoes or salad?  
   1 2 3 4 ref
# Fat-Related Diet Habits Questionnaire

## II. Example of Self-Administered Format

### MEAT, FISH AND MAIN DISHES

**IN THE PAST 3 MONTHS...**

|   | Usually or | Always | Often | Sometimes | Rarely or | Never |
|---|-------------|--------|-------|-----------|-----------|-------|
| 1. Did you eat fish? |           |        |       |           |           |       |
| No | Yes         | When you ate fish, how often was it: |       |           |           |       |
|    |             | □      | □     | (answer  | a. broiled, baked or poached? | 1     | 2     | 3     | 4     |          |       |
|    |             |        |       | both     | b. fried? | 1     | 2     | 3     | 4     |          |       |
|    |             | □      |       |          |          |       |       |       |       |          |       |
| 2. Did you eat chicken? |           |        |       |           |           |       |
| No | Yes         | When you ate chicken, how often did you: |       |           |           |       |
|    |             | □      | □     | (answer  | a. have it broiled, or baked? | 1     | 2     | 3     | 4     |          |       |
|    |             |        |       | all three| b. fried? | 1     | 2     | 3     | 4     |          |       |
|    |             | □      |       |          | c. take off the skin? | 1     | 2     | 3     | 4     |          |       |
| 3. Did you eat spaghetti or noodles? |           |        |       |           |           |       |
| No | Yes         | When you ate spaghetti or noodles, how |       |           |           |       |
|    |             | □      | □     |          | a. do you eat them plain or with a tomato sauce without meat? | 1     | 2     | 3     | 4     |          |       |
|    |             | □      |       |          |          |       |       |       |       |          |       |
| 4. Did you eat red meat (beef, pork, lamb)? |           |        |       |           |           |       |
| No | Yes         | When you ate red meat, how often did you |       |           |           |       |
|    |             | □      | □     |          | trime all the visible fat? | 1     | 2     | 3     | 4     |          |       |
Fat-Related Diet Habits Questionnaire Eating Pattern Score Sheet

| QUESTION | RESPONSE |
|----------|----------|
| **Factor 1 (Substitution)** | 10_b  | 12_a  | 13_a  | 15_a  | 16_a  | 18_a  | 19_a  |
|          | _______ | _______ | _______ | _______ | _______ | _______ | _______ |
| **Total** | _______ + number answered = Factor 1 score ____ |

| **Factor 2 (Modify meat)** | 1_b  | 2_a  | 3_a  |
|----------------------------|------|------|------|
|                            | _______ | _______ | _______ |
| **Total** | _______ + number answered = Factor 2 score ____ |

| **Factor 3 (Avoid frying)** | 1_a*  | 4_a*  | 7_b*  | 8_a*  |
|-----------------------------|-------|-------|-------|-------|
|                            | _______ | _______ | _______ | _______ |
| **Total** | _______ + number answered = Factor 3 score ____ |

| **Factor 4 (Replacement)** | 5_a  | 14_a  | 17_a  |
|----------------------------|------|-------|-------|
|                            | _______ | _______ | _______ |
| **Total** | _______ + number answered = Factor 4 score ____ |

| **Factor 5 (Avoid fat)** | 6_a  | 7_a*  | 9_a  | 10_a  | 11_a  |
|--------------------------|------|-------|------|-------|-------|
|                          | _______ | _______ | _______ | _______ | _______ |
| **Total** | _______ + number answered = Factor 5 score ____ |

**Summary score**

\[
\sum \text{Factors} \div 5 = \text{ } \\
\]

*Reverse order scoring (done as follows: 1=4, 2=3, 3=2, 4=1). For example, a recorded score of 1 will be noted as a 4 on this score sheet, a 2 will be scored as a 3, and so on.

Items 14, 17, 20, 21, and 22 are used for vegetable-related dietary patterns. See: Satia JA, et al, Nutrition, 18: 247-54, 2002, for more information.
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Development of a general nutrition knowledge questionnaire for adults

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Objective: This paper describes the development of a reliable and valid questionnaire to provide a comprehensive measure of the nutritional knowledge of UK adults. The instrument will help to identify areas of weakness in people’s understanding of healthy eating and will also provide useful data for examining the relationship between nutrition knowledge and dietary behaviour which, up until now, has been far from clear.

Design: Items were generated paying particular attention to content validity. The initial version of the questionnaire was piloted and assessed on psychometric criteria. Items which did not reach acceptable validity were excluded, and the final 50 item version was administered to two groups differing in nutritional expertise on two occasions to assess the construct validity and test-retest reliability.

Setting: The questionnaire was developed in 1994 in the UK.

Subjects: Three hundred and ninety-one members of the general public, recruited via their places of work, completed the questionnaire at the piloting stage. The final version was administered to 168 dietitians and computer science students following a university lecture.

Results: The internal consistency of each section was high (Cronbach’s alpha = 0.70–0.97) and the test-retest reliability was also well above the minimum requirement of 0.7. Nutrition experts scored significantly better than computer experts [F(1,167) = 200.5, P < 0.001], suggesting good construct validity.

Conclusions: The findings demonstrate that the instrument meets psychometric criteria for reliability and construct validity. It should provide a useful scale with which to reassess the relationship between knowledge and dietary behaviour.

Sponsorship: The study was funded by a grant from the Biotechnology and Biological Sciences Research Council.

Descriptors: nutrition knowledge; psychometrics; diet; questionnaire

Introduction

Since the 1950s the link between diet and chronic diseases such as cancer and cardiovascular disorders has been increasingly well recognised world-wide (WHO, 1990). In the UK, attempts to improve the nation’s health through dietary change have tended to centre around education. Underlying this approach is the assumption that providing people with the information necessary to choose healthy foods will ultimately lead to an improvement in diet. According to this view, given accurate information about what they should be eating and the implications for their health if they eat the ‘wrong’ foods, people will change their diets appropriately. Organisations like the Health Education Authority in the UK produce extensive literature aimed at informing people about appropriate dietary behaviour. Their most recent leaflet, entitled ‘Eight Guidelines for a Healthy Diet’ (HEA, 1997) includes advice to eat more starchy foods, plenty of fruit and vegetables and to cut down on fatty and sugary foods, as well as information about what these foods are, explanations of the kinds of health benefits of following the guidelines and practical tips

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Finally, when administered to samples known, on other grounds, to vary on the attribute in question, for example, by virtue of specialist training, the scores should be significantly different (construct validity). Apart from content validity, which is assessed qualitatively, all these are statistically measurable and there are standard cut-off values for reliability and validity, beyond which items or scales become unacceptable.

Nutrition questionnaires developed to date generally have limitations in one or more of these areas (see Table 1 for a summary). Either they lack the kind of psychometric validation described above, or they cover only a limited area of nutrition knowledge. For example, Towler & Shepherd's (1990) questionnaire is shown to have good construct validity and internal reliability, but the authors say little about how the items were generated and the content validity is therefore questionable. It is, for example, hard to see how an item which asks about the hormones involved in hunger would be related to dietary behaviour. There are no questions about diet-disease links, and although knowledge about the nutrient content of foods is thoroughly tested, there is no systematic questioning about dietary recommendations.

By contrast, Anderson et al (1988) used a questionnaire with good content validity and a sound rationale. Items tested familiarity with nutrition terms, knowledge about current dietary recommendations, and the practical applications of these recommendations. However, the instrument was not subjected to rigorous psychometric validation, so nothing can be said about the construct validity or test-retest reliability, and the internal consistency is shown to be poor. This is also true of McDougall's (1998) study, although her questionnaire has good content validity. However, construct validity was not assessed and the test-retest reliability was measured at an interval of only a day, so although it was found to be high, it is not possible to know whether the measure would be stable over a longer period of time. As the questionnaire is specifically designed for use with teenagers, it might not be suitable for use with an adult sample.

Other studies have used reliable instruments on adult samples, but have concentrated on a particular aspect of nutrition, for example, fat (Steenhuis et al, 1996) or fat, fibre and cholesterol (Resnicow et al, 1997). These, although useful, would not, therefore, be appropriate for use in measuring the overall nutrition knowledge of a population.

A large-scale study in the USA (Sapp & Jensen, 1997) assessed the reliability and validity of the nutrition knowledge measures used in the Diet and Health Knowledge surveys carried out between 1989 and 1991. Using extensive psychometric evaluation, the authors found that the nutrition knowledge questionnaire did not meet standards for reliability, highlighting the need for a more reliable instrument. They did, however, find that the questionnaire used to test awareness of the relationship between diet and health has acceptable reliability as well as good construct validity.

Further encouragement that it is possible to develop instruments which meet psychometric criteria comes from a study in the Netherlands. Stafleu et al (1996) used an adaptation of a questionnaire based on Dutch dietary guidelines. Reliability and validity were both found to be high. Again, the scope of the questionnaire is narrow, to cover only fat and cholesterol, so it could not be used to assess overall nutrition knowledge. As well as this, because of cultural variations in eating habits and precise dietary recommendations, an instrument developed in the Netherlands would not necessarily be valid for a UK population. Although general recommendations are typically similar across different westernised countries, specific questionnaires might need adapting to take account of cultural variations in diet.

Given the problems of measuring nutrition knowledge and the ambiguity of the findings to date, it is perhaps premature to dismiss the link between knowledge and behaviour without first trying to develop a reliable and valid instrument with which to test a broad range of nutrition knowledge of adults. The aim of this study, therefore, is to develop and validate such a questionnaire which can then be used to look again at the relationship between nutritional knowledge and dietary behaviour.

**Methods**

**Developing the questionnaire item pool**

On the basis of this review of current material containing dietary advice and the literature linking diet with disease, it was decided to divide the questionnaire into five main sections: the understanding of terms (such as fibre and cholesterol); awareness of dietary recommendations (in leaflets like the one described earlier); knowledge of food sources related to the advice, that is, which foods contain which nutrients; using the information to make dietary choices (practical food choice); and awareness of diet-disease associations. Using these broad categories, an item pool of 1201 was generated. Some items were taken from existing questionnaires while others were generated from the literature with expert advice from dieticians where necessary. It is believed that this process served to
maximise the content validity of the questionnaire, that is, that the items selected were representative of the whole area of knowledge being measured.

Using this pool of items, two reviews were carried out by a panel of four psychologists and four dieticians to select the best in terms of clarity of the questions, accuracy of the dietary knowledge being tapped, and interpretability. This process reduced the number of items to 102. The preliminary instrument was then ready for piloting in a general population sample.

A number of demographic questions were included in the survey to characterise respondents. A literature search of existing questions was carried out and 12 items chosen from a pool of 58. These asked about sex, age, marital status, ethnic origin (categories taken from the UK 1991 Census), number of children, children under 18 years living at home, educational level, nutrition-related qualifications, occupation and partner’s occupation (classified according to the Standard Occupational Classification system), employment status and details of any special diets.

Subject and method of distribution for the preliminary questionnaire

Nine hundred questionnaires were distributed to a variety of organisations for their employees with the request that they complete and return them (in a pre-paid envelope) and add any comments that might occur to them. Hierarchical organisations were canvassed, in the hope of reaching people from a range of socio-economic backgrounds. Of the 900 questionnaires, 43.3% were completed and returned, although given that distribution was left to the recruited organisations, this is probably an underestimate of the actual response rate. The majority of respondents were women (72.1%), aged between 18 and 44 years (72.4%), white (95.4%) and had non-manual occupations (82.4%). The demographic characteristics are shown in Table 2.

| Table 2 Sample characteristics (n = 391) |
|-----------------------------------------|
| Gender                                  |
| Male                                    | 109 | 27.9 |
| Female                                  | 282 | 72.1 |
| Age                                     |
| Under 18                                | 29  | 7.4  |
| 18–24                                   | 92  | 23.5 |
| 25–34                                   | 116 | 29.7 |
| 35–44                                   | 75  | 19.2 |
| 45–54                                   | 45  | 11.5 |
| 55–64                                   | 18  | 4.6  |
| 65–74                                   | 12  | 3.1  |
| 75 and over                             | 4   | 1.0  |
| Socio-economic status                   |
| Non-manual                              | 253 | 82.4 |
| Manual                                  | 54  | 17.6 |
| Ethnic origin                           |
| White                                    | 373 | 95.4 |
| Other                                    | 18  | 4.6  |
| Marital status                          |
| Single                                  | 162 | 41.4 |
| Married/cohabiting                      | 198 | 50.7 |
| Divorced/widowed                        | 31  | 7.9  |
| Employment status                       |
| Employed full time                      | 189 | 48.3 |
| Employed part time                      | 63  | 16.1 |
| Other                                   | 139 | 35.6 |

Analyses and results

The results were analysed both quantitatively (for item difficulty, item discrimination and internal consistency) and qualitatively (which involved looking at comments made by respondents).

Item difficulty

According to Kline (1993) items are not useful if they are answered correctly by more than 80% or fewer than 20% of respondents. These indices were adjusted upwards slightly as the pilot sample was skewed towards characteristics which have previously been associated with higher than average nutrition knowledge (Crawford & Baghurst, 1990; Levy et al., 1993). Items were therefore rejected over 90% or under 30% of respondents answered them correctly. Of the items which did not meet these criteria, about a quarter were retained on the grounds of content validity, that is they were considered to be testing an essential aspect of nutrition knowledge not covered elsewhere in the questionnaire.

Item discrimination

The ability of each individual item to discriminate between people with different levels of knowledge was measured by correlating the score on each item with the overall test score. An item-to-total-score correlation of 0.2 has been cited as the cut-off point below which items should be discarded (Kline, 1986; Streiner & Norman, 1992). This was adhered to except in circumstances where an item was considered particularly important in terms of content validity.

Internal consistency

This was measured separately for the different sections, each of which was tapping a different area of knowledge. The minimum requirement for internal consistency has been recommended as 0.7 (Kline, 1993). It was calculated for each section as follows (using Cronbach’s alpha): understanding of terms: 0.69; dietary recommendations: 0.76; sources of nutrients: 0.8; choosing everyday foods: 0.66; diet-disease relationships: 0.79.

Respondents’ comments

Some changes to wording were made in response to comments written on the questionnaires, in order to reduce ambiguity and maximise the clarity of the questions.

On the basis of the analysis described above, the number of items was reduced to 50. The first section (the understanding of terms) was removed completely as so few items met statistical criteria while others were judged to be too scientific and not relevant to behaviour. The final survey was presented as a four page booklet. (Questions are shown in Appendix 1. Copies of the questionnaire booklet are available from authors on request).

Evaluation of validity and reliability of the final scale

The next step was to test construct validity (Streiner & Norman, 1992; Kline, 1993) of the final version by administering it to two groups known to differ in their nutrition knowledge. Test-retest reliability had to be verified to make sure that the results produced were consistent over time (Streiner & Norman, 1992; Nunnally, 1978). Internal consistency was also reassessed for the final version of the
questionnaire. Minimum requirements for test-retest reliability and internal consistency were 0.7 (Kline, 1993).

Subjects and methods
Participants in this study were final year undergraduate students, studying either dietetics or computer sciences. This ensured that one group had a greater knowledge of nutrition, while other variables such as age and socio-economic status were fairly similar for both groups. Questionnaires were administered at the end of lectures on two separate occasions, with an interval of two weeks between them. Two weeks was expected to be long enough for participants to have forgotten their original responses, but not sufficiently long for much real change in nutrition knowledge to have taken place. Participants were not aware of the intended second administration at the time of the first. Dates of birth were used to match the two sets of questionnaires.

The responses from the first administration were used to assess construct validity and internal consistency. The two sets of responses were used to measure test-retest reliability.

Results
At both sessions, compliance was good with almost all students present completing the measure. 168 participants completed the questionnaire at least once, 74 dietetic students and 94 computer science students. 105 of these completed the questionnaire twice (53 dietetic and 52 computer science students). There was a significant gender difference between the two groups, with 90% of the dieticians being female and 84% of computer scientists being male. Differences in age and ethnic origin between the two groups were not significant. The demographic characteristics of the two groups are shown in Table 3.

| Characteristic | Dietetic students (n = 74) | Computer students (n = 94) |
|---------------|--------------------------|--------------------------|
| Gender        | n | %   | n | %   |
| Male          | 7 | 9.5 | 79 | 84.0 |
| Female        | 67 | 90.5 | 15 | 16.0 |
| Age           | 18–24 | 55 | 74.3 | 55 | 56.4 |
|               | 25–34 | 17 | 23.0 | 34 | 36.2 |
|               | 35–44 | 2 | 2.7 | 7 | 7.4 |
| Ethnic origin | White | 57 | 77.0 | 66 | 70.2 |
|               | Other | 17 | 23.0 | 28 | 29.8 |

Construct validity
Table 4 shows that the dietetics students scored consistently higher than the computer science students on all sections of the questionnaire (P < 0.001).

Given the different gender balance of the two groups, gender was controlled for in an analysis of covariance but this had little effect on the results. The questionnaire therefore met the criterion for construct validity.

Internal reliability
The reliability of each section was established using Cronbach’s alpha. Correlations ranged from 0.7 – 0.97 (see Table 5).

Test-retest reliability
Pearson’s correlation was used to assess test-retest reliability on the scores of the 105 respondents who completed the questionnaire twice. As shown in Table 5, the reliability for each of the sections was very high, ranging from 0.8 – 0.97 and the overall reliability was 0.98.

Discussion
Studies aiming to assess the relationship between nutrition knowledge and dietary behaviour in the UK have often been criticised on the grounds of uncertain validity and reliability of the instruments used to measure nutritional knowledge (see, for example, Axelsson et al., 1985; Shepherd and Towler, 1992; Anderson et al., 1988). The aim of the present study was to develop a psychometrically reliable and valid questionnaire covering all aspects of practical nutrition knowledge which could be used in future studies to look at the relationship between nutrition knowledge, demographic characteristics and dietary behaviour.

Significant differences between the scores of the dietetic students (nutritional experts within the university environment) and the computer scientists (who had no specialist knowledge of nutrition) indicate that the questionnaire had a satisfactory construct validity, even when taking into the account the skewed gender characteristics of the two groups. The dietetic students scored higher on all sections

| Knowledge section (max score) | Dietetic students (n = 74) | Computer science students (n = 94) |
|------------------------------|---------------------------|-----------------------------------|
|                              | Mean | s.d. | Mean | s.d. | F (1,167) |
| 1. Dietary recommendations (11) | 10.2 | 1.1 | 7.4 | 1.6 | 82.0* |
| 2. Sources of nutrients (69) | 62.2 | 5.0 | 40.4 | 11.6 | 134.6* |
| 3. Choosing everyday foods (10) | 9.1 | 1.1 | 5.9 | 2.1 | 81.4* |
| 4. Diet-disease relationships (20) | 17.3 | 2.3 | 6.2 | 3.1 | 321.3* |
| Total (110) | 98.8 | 8.1 | 60.1 | 16.1 | 200.5* |

*P < 0.001.
of the questionnaire, and showed a particularly marked superiority with regard to knowledge about the links between diet and disease (section 4—see Table 4).

The reliability of the final instrument was high. A few items which lacked consistency with the rest of the questionnaire were retained for the sake of content validity, but the internal reliability remained high. The test-retest reliability was also very good.

As well as achieving statistical significance in terms of validity and reliability, the initial process by which the items were generated ensured that all aspects of the subject area were covered, and thus the content validity, though not statistically measurable, was undoubtedly high.

The questionnaire covers current dietary recommendations, sources of nutrients, everyday food choices and diet-disease relationships. These four areas underlie the main aspects relating knowledge to dietary behaviour:

- do people know what current expert dietary recommendations are?
- do they know which foods provide the nutrients referred to in the recommendations?
- can they choose between different foods to identify the healthiest ones?
- do they know what the health implications of eating or failing to eat particular foods are?

This represents a more comprehensive assessment of nutrition knowledge than has generally been achieved. Given that dietary behaviour is so complex, any attempts to understand it in terms of nutrition knowledge must begin with a clear understanding of knowledge. Students have tended either to concentrate on a specific area of knowledge like fat or cholesterol, or have covered a wide variety of knowledge but have not been sufficiently systematic to gain a true understanding of what people know. This, together with the general lack of psychometric validation of measures, may explain the variability of the results of studies looking at the knowledge-behaviour relationship in the area of nutrition.

Conclusion

This questionnaire (see Appendix 1) should provide a useful tool in research on food choice and permit a clearer understanding of the relationship between knowledge and behaviour than has previously been possible. Thanks to its broad coverage in terms of content, it should also be a useful tool for identifying gaps in the public’s nutrition knowledge and in evaluating the success of health education campaigns.

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Appendix 1

Nutrition survey

This is a survey, not a test. Your answers will help identify which dietary advice people find confusing.

1. It is important that you complete it by yourself.
2. Your answers will remain anonymous.
3. If you do not know the answer, mark ‘not sure’ rather than guess.
The first few items are about what advice you think experts are giving us

1 Do you think health experts recommend that people should be eating more, the same amount, or less of these foods? (tick one box per food)

|                | More | Same | Less | Not sure |
|----------------|------|------|------|----------|
| Vegetables     |      |      |      |          |
| Sugary foods   |      |      |      |          |
| Meat           |      |      |      |          |
| Starchy foods  |      |      |      |          |
| Fatty foods    |      |      |      |          |
| High fibre foods|     |      |      |          |
| Fruit          |      |      |      |          |
| Salty foods    |      |      |      |          |

2 How many servings of fruit and vegetables a day do you think experts are advising people to eat? (One serving could be, for example, an apple or a handful of chopped carrots)

3 Which fat do experts say is most important for people to cut down on? (tick one)

(a) monounsaturated fat  
(b) polyunsaturated fat  
(c) saturated fat  
(d) not sure

4 What version of dairy foods do experts say people should eat? (tick one)

(a) full fat  
(b) lower fat  
(c) mixture of full fat and lower fat  
(d) neither, dairy foods should be cut out  
(e) not sure

Experts classify foods into groups. We are interested to see whether people are aware of what foods are in these groups

1 Do you think these are high or low in added sugar? (tick one box per food)

|                | High | Low | Not sure |
|----------------|------|-----|----------|
| Bananas        |      |     |          |
| Unflavoured yoghurt |    |     |          |
| Ice-cream      |      |     |          |
| Orange squash  |      |     |          |
| Tomato ketchup |      |     |          |
| Tinned fruit in natural juice | | | |

2 Do you think these are high or low in fat? (tick one box per food)

|                | High | Low | Not sure |
|----------------|------|-----|----------|
| Pasta (without sauce) |    |     |          |
| Low fat spread      |      |     |          |
| Baked beans         |      |     |          |
| Luncheon meat       |      |     |          |
| Honey               |      |     |          |
| Scotch egg          |      |     |          |
| Nuts                |      |     |          |
| Bread               |      |     |          |
| Cottage cheese      |      |     |          |
| Polyunsaturated margarine | | | |

3 Do you think experts put these in the starchy foods group? (tick one box per food)

|                | Yes | No | Not sure |
|----------------|-----|----|----------|
| Cheese         |     |    |          |
| Pasta          |     |    |          |
| Butter         |     |    |          |
| Nuts           |     |    |          |
| Rice           |     |    |          |
| Porridge       |     |    |          |

4 Do you think these are high or low in salt? (tick one box per food)

|                | High | Low | Not sure |
|----------------|------|-----|----------|
| Sausages       |      |     |          |
| Pasta          |      |     |          |
| Kippers        |      |     |          |
| Red meat       |      |     |          |
| Frozen vegetables |    |    |          |
| Cheese         |      |     |          |

5 Do you think these are high or low in protein? (tick one box per food)

|                | High | Low | Not sure |
|----------------|------|-----|----------|
| Chicken        |      |     |          |
| Cheese         |      |     |          |
| Fruit          |      |     |          |
| Baked beans    |      |     |          |
| Butter         |      |     |          |
| Cream          |      |     |          |

6 Do you think these are high or low in fibre/roughage? (tick one box per food)

|                | High | Low | Not sure |
|----------------|------|-----|----------|
| Cornflakes     |      |     |          |
| Bananas        |      |     |          |
| Eggs           |      |     |          |
| Red Meat       |      |     |          |
| Broccoli       |      |     |          |
| Nuts           |      |     |          |
| Fish           |      |     |          |
| Baked potatoes with skins | | | |
| Chicken        |      |     |          |
| Baked beans    |      |     |          |
7 Do you think these fatty foods are high or low in saturated fat? (tick one box per food)

| Food            | High | Low | Not sure |
|-----------------|------|-----|----------|
| Mackerel        | ☐    | ☐   | ☐        |
| Whole milk      | ☐    | ☐   | ☐        |
| Olive oil       | ☐    | ☐   | ☐        |
| Red meat        | ☐    | ☐   | ☐        |
| Sunflower margarine | ☐ | ☐ | ☐ |
| Chocolate       | ☐    | ☐   | ☐        |

8 Some foods contain a lot of fat but no cholesterol.
   (a) agree ☐
   (b) disagree ☐
   (c) not sure ☐

9 Do you think experts call these a healthy alternative to red meat? (tick one box per food)

| Food            | Yes | No | Not sure |
|-----------------|-----|----|----------|
| Liver pate      | ☐   | ☐  | ☐        |
| Luncheon meat   | ☐   | ☐  | ☐        |
| Baked beans     | ☐   | ☐  | ☐        |
| Nuts            | ☐   | ☐  | ☐        |
| Low fat cheese  | ☐   | ☐  | ☐        |
| Quiche          | ☐   | ☐  | ☐        |

10 A glass of unsweetened fruit juice counts as a helping of fruit.
   (a) agree ☐
   (b) disagree ☐
   (c) not sure ☐

11 Saturated fats are mainly found in: (tick one)
   (a) vegetable oils ☐
   (b) dairy products ☐
   (c) both (a) and (b) ☐
   (d) not sure ☐

12 Brown sugar is a healthy alternative to white sugar.
   (a) agree ☐
   (b) disagree ☐
   (c) not sure ☐

13 There is more protein in a glass of whole milk than in a glass of skimmed milk.
   (a) agree ☐
   (b) disagree ☐
   (c) not sure ☐

14 Polysaturated margarine contains less fat than butter.
   (a) agree ☐
   (b) disagree ☐
   (c) not sure ☐

15 Which of these breads contain the most vitamins and minerals? (tick one)
   (a) white ☐
   (b) brown ☐
   (c) wholegrain ☐
   (d) not sure ☐

16 Which do you think is higher in calories: butter or regular margarine? (tick one)
   (a) butter ☐
   (b) regular margarine ☐
   (c) both the same ☐
   (d) not sure ☐

17 A type of oil which contains mostly monounsaturated fat is: (tick one)
   (a) coconut oil ☐
   (b) sunflower oil ☐
   (c) olive oil ☐
   (d) not sure ☐

18 There is more calcium in a glass of whole milk than a glass of skimmed milk.
   (a) agree ☐
   (b) disagree ☐
   (c) not sure ☐
19 Which **one** of the following has the most calories for the same weight? **(tick one)**

(a) sugar  
(b) starchy foods  
(c) fibre/roughage  
(d) fat  
(e) not sure

---

20 Harder fats contain more: **(tick one)**

(a) monounsaturates  
(b) polyunsaturates  
(c) saturates  
(d) not sure

---

21 Polyunsaturated fats are mainly found in: **(tick one)**

(a) vegetable oils  
(b) dairy products  
(c) both (a) and (b)  
(d) not sure

---

**The next few items are about choosing foods**

Please answer what is being asked and not whether you like or dislike the food!

*For example, suppose you were asked . . . . . .

‘If a person wanted to cut down on fat, which cheese would be best to eat?’

(a) cheddar cheese  
(b) camembert  
(c) cream cheese  
(d) cottage cheese

*If you didn’t like cottage cheese, but knew it was the right answer, you would still tick cottage cheese.*

1 Which would be the best choice for a low fat, high fibre snack? **(tick one)**

(a) diet strawberry yoghurt  
(b) raisins  
(c) muesli bar  
(d) wholemeal crackers and cheddar cheese

---

2 Which would be the best choice for a low fat, high fibre light meal? **(tick one)**

(a) grilled chicken  
(b) cheese on wholemeal toast  
(c) beans on wholemeal toast  
(d) quiche

---

3 Which kind of sandwich do you think is healthiest? **(tick one)**

(a) two thick slices of bread with a thin slice of cheddar cheese filling  
(b) two thin slices of bread with a thick slice of cheddar cheese filling

---

4 Many people eat spaghetti bolognese (pasta with a tomato and meat sauce). Which do you think is healthier? **(tick one)**

(a) a large amount of pasta with a little sauce on top  
(b) a small amount of pasta with a lot of sauce on top

---

5 If a person wanted to reduce the amount of fat in their diet, which would be the best choice? **(tick one)**

(a) steak, grilled  
(b) sausages, grilled  
(c) turkey, grilled  
(d) pork chop, grilled

---

6 If a person wanted to reduce the amount of fat in their diet, but didn’t want to give up chips, which one would be the best choice? **(tick one)**

(a) thick cut chips  
(b) thin cut chips  
(c) crinkle cut chips

---

7 If a person felt like something sweet, but was trying to cut down on sugar, which would be the best choice? **(tick one)**

(a) honey on toast  
(b) a cereal snack bar  
(c) plain Digestive biscuit  
(d) banana with plain yoghurt

---

8 Which of these would be the healthiest pudding? **(tick one)**

(a) baked apple  
(b) strawberry yoghurt  
(c) wholemeal crackers and cheddar cheese  
(d) carrot cake with cream cheese topping
9 Which cheese would be the best choice as a lower fat option? (tick one)

(a) plain cream cheese
(b) Edam
(c) cheddar
(d) Stilton

If yes, what diseases or health problems do you think are related to sugar?

4 Are you aware of any major health problems or diseases that are related to how much salt or sodium people eat?

(a) yes
(b) no
(c) not sure

If yes, what diseases or health problems do you think are related to salt?

This section is about health problems or diseases

1 Are you aware of any major health problems or diseases that are related to a low intake of fruit and vegetables?

(a) yes
(b) no
(c) not sure

If yes, what diseases or health problems do you think are related to a low intake of fruit and vegetables?

2 Are you aware of any major health problems or diseases that are related to a low intake of fibre?

(a) yes
(b) no
(c) not sure

If yes, what diseases or health problems do you think are related to sugar?

5 Are you aware of any major health problems or diseases that are related to the amount of fat people eat?

(a) yes
(b) no
(c) not sure

If yes, what diseases or health problems do you think are related to fat?

6 Do you think these help to reduce the chances of getting certain kinds of cancer? (answer each one)

| Eating | Yes | No | Not sure |
|--------|-----|----|----------|
| more fibre | ☐ | ☐ | ☐ |
| less sugar | ☐ | ☐ | ☐ |
| less fruit | ☐ | ☐ | ☐ |
| less salt | ☐ | ☐ | ☐ |
| more fruit and vegetables | ☐ | ☐ | ☐ |
| less preservatives/additives | ☐ | ☐ | ☐ |

7 Do you think these help prevent heart disease? (answer each one)

| Eating | Yes | No | Not sure |
|--------|-----|----|----------|
| more fibre | ☐ | ☐ | ☐ |
| less saturated fat | ☐ | ☐ | ☐ |
| less salt | ☐ | ☐ | ☐ |
| more fruit and vegetables | ☐ | ☐ | ☐ |
| less preservatives/additives | ☐ | ☐ | ☐ |
8. Which one of these is more likely to raise people's blood cholesterol level? (tick one)

(a) antioxidants
(b) polyunsaturated fats
(c) saturated fats
(d) cholesterol in the diet
(e) not sure

9. Have you heard of antioxidant vitamins?

(a) yes
(b) no

10. If YES to question 9, do you think these are antioxidant vitamins? (answer each one)

Vitamin A
Yes
No
Not sure

B Complex Vitamins
Yes
No
Not sure

Vitamin C
Yes
No
Not sure

Vitamin D
Yes
No
Not sure

Vitamin E
Yes
No
Not sure

Vitamin K
Yes
No
Not sure

Finally, we would like to ask you a few questions about yourself

1. Are you male or female?

(a) Male
(b) Female

2. How old are you?

(a) less than 18
(b) 18–24
(c) 25–34
(d) 35–44
(e) 45–54
(f) 55–64
(g) 65–74
(h) more than 75

3. Are you:

(a) single
(b) married
(c) living as married
(d) separated
(e) divorced
(f) widowed

4. What is your ethnic origin?

(a) White
(b) Black Caribbean
(c) Black African
(d) Black other
(e) Indian
(f) Pakistani
(g) Bangladeshi
(h) Chinese
(i) Asian - other

Please specify:

(j) Any other ethnic group

Please specify:

5. Do you have any children?

(a) No
(b) 1
(c) 2
(d) 3
(e) 4
(f) more than 4

6. Do you have any children, under 18 years, living with you?

(a) Yes
(b) No

7. What is the highest level of education you have completed?

(a) primary school
(b) secondary school
(c) O levels/GCSEs
(d) A levels
(e) Technical or trade certificate
(f) Diploma
(g) Degree
(h) Post-graduate degree

8. Do you have any health or nutrition related qualifications?

(a) Yes

Please specify:

(b) No

9. What is your job? If you are not working now, what is your usual job? (please be specific).

........................................................................

........................................................................
10 If you have a partner, what is his/her job? If he/she is not working now, what is his/her usual job? (please be specific):

THE END

Thank you very much for your time.
If there are any comments you would like to make about this questionnaire, please do so below, they would be very welcome.

11 Are you currently:

(a) employed full time
(b) employed part time
(c) unemployed
(d) full time homemaker
(e) retired
(f) student
(g) disabled or too ill to work

12 Are you on a special diet?

(a) Yes
   Please specify:

(b) No
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Thank you for the opportunity to review this paper. I have recently traveled to Greece and love traditional Greek food. It was distressing to read about low numbers of Greeks following a traditional Mediterranean diet, which has many health benefits. The authors are to be commended for undertaking this study in a worksite setting, aimed to lower fat intake. Overall, this research project represents a simple, non-invasive, low-cost method of attempting to improve health behaviors among a work force. It is unfortunate that the lack of evidence of significant change in actual health behavior is also typical of many such small-scale, short-term projects. The authors attempted to link change in knowledge with change in behavior. However, the literature is clear that change in knowledge alone is not sufficient to change behavior. The use of the Health Belief Model was presumably chosen to enhance motivation to change behaviors (even though over 60% of the population was at a normal weight, despite a “medium to large consumption of fatty foods.”). However, there was limited information presented in this paper as to how the constructs of the HBM were integrated into the classes presented to the employees. Did participants perceive any risks? Did they perceive susceptibility to a particular disease or to weight gain? This needs further explanation.

Additional issues that need to be addressed are as follows:

1. The Supplemental files (Q1 and Q2) are presented inversely from their description in text. The text indicates that the Knowledge questionnaire is File Q1, when it is in fact Q2, and the reverse is true for the Diet Habits questionnaire (actually Q1, listed as Q2 in text). [minor technicality]

2. Q1, Diet Habits, indicates that some portions of this questionnaire were administered by an interviewer, while other portions were self-administered by participants. However, in text no mention is made of interviewer participation in the questionnaire, indicating only that participants received explanation in the Phase I session how to complete the form; greater clarification of procedure is required here. Furthermore, social pressures and positive presentation bias during personal interviews with a study administrator could have resulted in participants misrepresenting (toward a “healthy” direction) the quantities and frequencies of the foods they consumed.
Particularly if the pre-intervention diet habit assessment was done via personal interview while the post-intervention was done via self-completed questionnaire, changes in dietary habits post-intervention may not have been accurately captured. This could also possibly explain the apparent increase in consumption of fried foods post-intervention.

3. The diet habits questionnaire also asks participants about their food intake over the past month (~30 days) or 3 months; however, barely 30 days elapsed between the first day of intervention (Phase 2 - day 16) and the post-intervention questionnaire (Phase 4, day 45). If dietary changes are to be captured, either a shorter-term assessment (i.e. asking about intake over the past 2 weeks) or a greater delay between intervention and post-assessment should be considered.

4. The authors note that some participants took vacations during the intervention/assessment period. Given the typical deviations from "normal" dietary habits that many people enjoy on vacation, and the recency (within the past month) of the diet habits questionnaire, this factor may function as a greater confounding variable in the observed lack of change in diet habits than the authors acknowledge.

5. The 45-minute primary intervention lecture (Phase 2) was based on the Health Belief model, and it is the authors' claim that the HBM (which links beliefs and perceptions about health behaviors/risks to an individual's personal level of risk and his/her ability to control that risk through healthier behaviors) is an effective way to approach behavior change. However, Section 4 of the Knowledge questionnaire, which addresses the Diet-Health relationship, showed the least significant change following the intervention. Therefore, either the intervention lectures did not adequately target this subsection of knowledge, or else the participants were resistant to learning in this area for other reasons. The Discussion section, addressing the lack of observed behavior change, would be strengthened by acknowledging that the supposedly most critical piece of effecting behavior change was apparently not adequately targeted by the intervention, as evidenced by the lack of change in knowledge in this area. In addition, 61% of participants were normal weight. Thus, it is unclear why the authors chose the Health Belief Model, and how the intervention was tailored to address perceived risk, perceived susceptibility, perceived barriers or perceived benefits.

6. [another technicality/clarification] Table 4 (comparison of dietary habits) would be improved with a caption or footnote clarifying that a lower score on this assessment indicates improved/more healthy eating habits.

**Competing Interests:** No competing interests were disclosed.

We have read this submission. We believe that we have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however we have significant reservations, as outlined above.
John Mooney  
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Many thanks for the opportunity to review this paper. Tanagra and colleagues present a concise, interesting and well discussed piece of research on their attempts to improve dietary practices in the workplace, using a ‘health belief model’ approach to improving awareness in the first instance of the main components of a healthy diet and food items which it is advisable to consume more sparingly (e.g. fried food). I particularly liked the focus for the most part on blue collar occupational groups and the relative homogeneity of the target population. This holds promise for being able to target higher risk occupational groups that are known to be less receptive to health promotion type interventions.

It is relatively well established among advocates of public health interventions, however, that changing actual behaviour is a much greater challenge than improving awareness of risk factors, particularly around diet and eating practices. While the contrast between the improved knowledge and no real benefit in behaviour is certainly of interest in this well controlled setting, it is not a terribly surprising or novel finding in its own right. As the authors themselves also point out, this is a study population which already has a relatively healthy diet, so their scope for encouraging and achieving improvements is necessarily limited. The narrow sample characteristics of the sub-group participating in the post-intervention follow-up (90% women) also restricts any meaningful inferences around the influence of gender and occupational group (a fact also acknowledged by the authors).

My most significant misgiving about the article in its present form however surrounds the established limitations of the ‘health belief model’ as applied to preventative public health interventions:

“The HBM is more descriptive than explanatory, and does not suggest a strategy for changing health-related actions. In preventive health behaviors, early studies showed that perceived susceptibility, benefits, and barriers were consistently associated with the desired health behavior; perceived severity was less often associated with the desired health behavior. The individual constructs are useful, depending on the health outcome of interest, but for the most effective use of the model it should be integrated with other models that account for the environmental context and suggest strategies for change.”

[Extract from Boston University MPH content around ‘Limitations of the Health Belief Model’; http://sph.bu.edu/ottf/MPH-Modules/SB/SB721-Models/SB721-Models2.html].

The call for looking at the environmental context in particular suggests a potential missed opportunity within the current study to examine the characteristics and quality of food catering within the workplace itself.

Overall, as stated at the outset, I think this is an elegant and well-presented piece of research which certainly deserves to be published, but ideally needs some additional discussion around some of its methodological drawbacks. While the authors have acknowledged the short duration and sample size issues, there could be more discussion of desirability bias in self-reporting and ‘healthy-worker’ effects, the latter of which almost certainly will have diminished their scope for demonstrating improvements. Those relatively minor issues aside, there does need to be a fuller consideration of the limitations of the health belief model and the slightly confusing absence of any details on the types of catering and foods available within the workplace itself. In terms of specific essential revisions, I would suggest:
1. Demographic characteristics (Table 2): the addition of a section within ‘individual characteristics’ on how this population compares with the general Greek population on BMI and smoking etc.

2. Acknowledgement of the drawbacks of HBM and some description of the catering opportunities within the workplace itself, and if there are aspects of availability which could be improved to compliment the educational measures.

3. Some additional discussion around the drawbacks of self reporting and to what extent other back-up measures, such as 24 hour recall diaries, had been considered to enhance and substantiate the quality of the data gathered.

**Competing Interests:** No competing interests were disclosed.

I have read this submission. I believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.