

A Research Protocol of Hands-On Healthy Meal Preparation Intervention (Kidchen Study) to Improve Children's Nutritional Outcomes

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ABSTRACT

The objective of this paper is to describe the protocol of a 12-week hands-on healthy meal preparation intervention among children, up to a 3-month follow-up. The aim of KidChen Study (kids in kitchen) is to improve children's nutritional outcomes. In this randomized-controlled trial, simple random sampling will be used to select schools in Kuala Lumpur, Malaysia. Subsequently, the selected schools (n=2) will be assigned randomly to either the intervention or control group. The current study will include healthy Malaysian children aged 10–11 years old with no serious disease or food allergy. The intervention is based on Social Cognitive Theory that addresses personal and environmental factors for changing children's behaviour. Children from the intervention group will receive a 60-minute home food environment module with their parents consisting of nutrition talk, healthy food tasting, parent-child quiz; and five 60 minute interactive hands-on healthy meal preparation modules focusing on core food groups coupled with storytelling sessions to incorporate nutrition education. Outcome measures are children's psychosocial factors towards healthy meal preparation (knowledge, attitude, practice, self-efficacy), dietary behaviour, food consumption pattern, home food availability and anthropometric measures (BMI-for-age z-score, body fat percentage, waist circumference). Repeated measures ANOVA will be used to evaluate the intervention outcomes. KidChen Study is an experiential learning approach to instil a positive attitude towards nutrition and empower children with nutrition skills. We anticipate that the intervention will advocate healthy eating behaviour among children, impacting their nutritional outcomes over time.

Keywords: children, healthy meal preparation, intervention, Malaysia, nutrition

INTRODUCTION

Globally, 340 million children are affected by overweight/obesity problem (WHO 2018). Many did not achieve the recommended dietary guideline for whole grains, vegetables, fruits, legumes and milk (Banfield *et al.* 2016; Faught *et al.* 2017). Further, unhealthy eating habits such as snacking, high intakes of fried foods, sugary foods, fast foods and low intakes of fruits and vegetables among school-aged children are now very common (Febriani & Sudarti 2019; Hoque *et al.* 2016). The health consequences to this serious epidemic include increased vulnerability of children affected by chronic diseases, adverse effect on a child's development and reduced quality of life, which can track into adulthood

(WHO 2018). Other negative implications include the effect on children's academic performance and psychological health (Rankin *et al.* 2016).

According to a systematic review and meta-analysis of school-based nutrition interventions among children, nutrition lessons, improvement in the school environment and food marketing did not increase vegetable intake by a useful amount (Evans *et al.* 2012). In Asia, most studies frequently target behavioural modification through health education lectures and/or physical activity sessions which demonstrated a lack of effect in anthropometry outcomes (Uijtdewilligen *et al.* 2016). Further, interventions are largely approached in the same way and only repackaged slightly, which is inadequate to address key barriers (The Academy of Medical Sciences

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2017). The main basis of interventions is often to increase knowledge and nutrition awareness but the emphasis on experiential learning, increasing motivations and enhancing skills for long term health benefits are minimal.

Since obesity is the result of people responding normally to the obesogenic environment (Swinburn *et al.* 2011), it is important to equip children with the skills to counteract this epidemic and for the sustainability of healthy behaviours. Recently, there is a global interest to involve children in healthy meal preparation to improve their nutrition. When children prepare healthy meals, there were increased nutrition knowledge, attitude and self-efficacy towards cooking, fruits and vegetable preferences/consumption as well as communication to family about healthy eating (Cunningham-Sabo & Lohse 2013; Jarpe-Ratner *et al.* 2016). However, none of these interventions involved populations other than in the US, Europe, Australia and New Zealand (Battjes-Fries *et al.* 2016; Black *et al.* 2018; Caraher *et al.* 2013; Chen *et al.* 2014; Cunningham-Sabo & Lohse 2013; Jarpe-Ratner *et al.* 2016). Due to the cultural differences between Western and Asian countries, interventions should be tailored to the needs of the population of interest (Barrera *et al.* 2013). Overall, there is a lack of high-quality interventions on childhood cooking programs, especially with a long-term effect on nutritional outcomes (Hersch *et al.* 2014).

KidChen Study implies the “kids in kitchen” study. The idea of KidChen Study is to allow children to obtain the first-hand experience in preparing their own healthy meals incorporating all 5 senses—touch, sight, taste, hearing and smell. This current protocol aimed to describe the design of KidChen Study, a hands-on healthy meal preparation intervention involving all the core food groups among Malaysian children.

METHODS

Design, location and time

KidChen Study is a randomized-controlled trial located at Kuala Lumpur, the national capital of Malaysia. The study location, Kuala Lumpur consists of various zones; Bangsar-Pudu, Sentul and Keramat. A zone will be randomly selected, and subsequently, two primary schools from the selected zone will be randomly assigned to either

intervention or control group using Research Randomizer. Inclusion criteria include: (1) healthy Malaysian children aged 10–11 years; (2) can understand English/Malay language and with; (3) parent’s informed consent and individual assent. Children with: (1) food allergies (e.g.: wheat/gluten, dairy or peanuts); (2) any serious diseases that require medical attention; (3) physically/mentally disabled children and/or; (4) are exposed to preparing healthy meals at home will be excluded.

Sampling

The sample size for present trial is determined using a formula by Chan (2003): $m = \frac{2c}{\delta^2} + 1$, where m = size per group, $c = 7.9$ for 80% power, $\delta = \frac{|\mu_2 - \mu_1|}{\sigma}$ is the standardised effect size, μ_1 and μ_2 are the means of the two treatment groups σ is the common standard deviation = $\sqrt{\frac{SD_1^2 + SD_2^2}{2}}$ SD1 and SD2 is the standard deviation for group 1 and 2 respectively. Based on a randomized-controlled trial by Fulkerson *et al.* (2011), SD1 and SD2 are 3.2. The sample size required for the present study is 32 per group. Taking into account of non-compliance and dropout rate of 50% (Koo *et al.* 2018), the required sample size for each group is increased to 48; therefore, the total number is 96. Any children that wish to drop-out can do so, with the reasons being noted for documentation.

Intervention framework and modules development

KidChen Study is designed based on the Social Cognitive Theory (SCT) and experiential learning theory (Bandura 1999; Kolb *et al.* 2001). According to the SCT, learning occurs through social context with dynamic interactions between environmental factors (home food availability) and individual factors (knowledge, attitude and self-efficacy towards healthy meal preparation) that eventually influences an individual’s behaviour (e.g. the practice of healthy meal preparation, dietary behaviour and food consumption pattern). As applied to KidChen Study, this theory holds that children’s psychosocial factors and home food environment will influence their health related behaviour, in relation to their nutritional status.

Experiential learning theory involves processes where the learner actively experiences an activity, attempts to conceptualize what is observed, reflects on that experience and

finally tries to plan for a forthcoming experience (Seel 2012). In KidChen Study, intervention children will experience hands-on healthy meal preparation continuously in which they acquire various skills such as self-reflection, problem solving and abstract thinking (Efstratia 2014). No nutrition intervention will be conducted for children and parents from the control group. However, for ethical reasons, delayed KidChen intervention modules will be conducted for the control group after the study has ended.

The content of current intervention modules was already developed and validated. It was designed using evidence-based nutrition information, comprising all the core food groups needed by children for healthy growth and development. Literature searches were conducted in scientific databases namely Google Scholar, PubMed, Science Direct and Scopus for development of the modules. Reports, research articles and books were referred to develop evidence-based modules. Each module comprises nutrition education and hands-on healthy meal preparation tasks, aimed to achieve the specific learning outcomes and objectives. Content validity of the intervention modules was established by 2 academicians in the nutrition field, an academician expert in child psychology, a primary school teacher, a parent of a 10- and 11-year old child and a nutritionist. The expert panels were selected due to their experience in the development of nutrition modules for children and/or experience in understanding children's behaviour. Content validity form was provided to each of the experts. Every expert was required to rate the modules to ensure that the modules are in line to achieve the specific objectives and learning outcomes set. Every module was rated based on content, language (sentence structure, readability) and design/layout with a score of 1 as poor (to reject), 2 as average (major revision) and 3 as good (minor/no revision). Suggestions were given to improve the module in terms of content, language and design. Feedbacks from the expert panels were discussed among the research team and necessary changes to the intervention modules were made accordingly.

Data collection

Assessment will be made at pre-, post-intervention and a follow-up after 3 months. Outcomes measurements include children's

psychosocial factors towards healthy meal preparation, home food availability, dietary behaviour, food consumption pattern and anthropometric measurement.

Children's psychosocial factors (knowledge, attitude, practice and self-efficacy) towards healthy meal preparation will be assessed using a validated, self-administered, guided questionnaire (Ng *et al.* 2020a). Parents will receive a validated home food availability questionnaire (Couch *et al.* 2014; Glanz & Steffen 2008; Marsh *et al.* 2003). Sociodemographic characteristics such as monthly household income, highest educational attainment in the family and parents' age are collected in the first section of the questionnaire. Subsequent information includes the availability of various fruits, vegetables, healthy and unhealthy foods at home during the past 1 week. Apart from those foods from the validated questionnaires, several fruits, vegetables and foods will be included, reflecting Malaysians' usual foods consumption (Institute for Public Health (IPH) 2014). The home food availability questionnaire was tested for internal consistency (unpublished data, $n=200$, Cronbach's $\alpha=0.72$).

Dietary behaviours namely breakfast consumption and fast food consumption will be self-reported using a guided questionnaire. The same questionnaire assessed children's food consumption pattern (frequency of usual food groups consumption). Questions are adapted, with consideration of Malaysian Dietary Guidelines for Children and Adolescents (Ainuki *et al.* 2013; Ministry of Health Malaysia 2013; Wilson *et al.* 2008). Children will be asked the number of times they consume breakfast, morning snack, lunch, afternoon snack, dinner and supper in a week, and the food groups that they usually consumed for each specific meal. They will be allowed to select more than one food group or none if they usually skipped their meals. Pictures and food models will be utilized to assist children.

Children's anthropometric measurements include height, weight, waist circumference, and Body Mass Index (BMI)-for-age. Height will be measured to the nearest 0.1 cm using portable stadiometer Seca 213. As the standard height measurement protocol, children will stand straight without shoes, head in Frankfurt plane, arms at side with palms facing the thighs, heels together and shoulder blades, buttocks and heels

touching the vertical surface of the stadiometer (Gibson 2005). Tanita Body Composition Analyzer SC-330 will be used to measure body fat percentage and weight to the nearest 0.1kg. Children will stand straight barefooted in the center of the platform, looking straight ahead in light indoor clothing during measurement (Gibson 2005). Weight and height will be computed into body mass index-for age (BMI z-score) using AnthroPlus software as per World Health Organization (WHO) growth reference. Waist circumference will be measured to the nearest 0.1 cm over the skin midway between the tenth rib and the iliac crest at the end of normal expiration using a non-stretchable measuring tape and further classified using percentile charts for the Malaysian childhood population to define abdominal obesity (Poh *et al.* 2011). All measurements will be taken twice to obtain an average reading.

Evaluation of KidChen intervention modules

After each module, children will be given a set of questions for providing insights and evaluation of the intervention modules. The evaluation includes their overall acceptance of the storytelling/drama as well. Questions are developed and revised by the research team to ensure its simplicity, relevance and appropriateness for children and parents.

Data analysis

Statistical analysis will be conducted using Statistical Package for Social Science (SPSS) Version 20. Data will be entered, cleaned and checked before proceeding to data analysis. All variables will be tested for normality distribution. Categorical variables are presented as number (percentage), meanwhile continuous variables are reported as mean (standard deviation). The differences between intervention and control group's psychosocial factors towards healthy meal preparation, home food availability, dietary behaviour, food consumption pattern and anthropometric measurements will be assessed using independent t-test. Differences within groups will be determined using dependent sample t-test. Association between categorical variables items will be determined using the Chi-square test. Repeated measures ANOVA will be used to determine will be used to determine the effectiveness of KidChen intervention on changes

of psychosocial factors, home food environment, dietary behaviour, food consumption pattern and anthropometric measurements among children (within-group to assess the effect of time: pre-, post-intervention and 3-months follow up; and between-groups to assess the effect of groups: intervention versus control group). Significance value is set at $p < 0.05$.

RESULT AND DISCUSSION

This current protocol describes the design of KidChen Study, a hands-on healthy meal preparation intervention among children. To the best of our knowledge, KidChen Study could be the first family-based experimental study on hands-on healthy meal preparation involving all core food groups with the element of storytelling/drama in nutrition education, aimed to improve the nutritional outcomes of children. The overview of KidChen intervention components is displayed in Table 1.

Table 2 displays the content validity of the intervention modules. All experts rated that the content and design of the modules are suitable (maximum score of 3, good with minor revision). In terms of language, 3 and 2 experts rated that 'home is where the (healthy) food is' and 'vibrant vegetables' module respectively as average (score of 2 with major revision needed). Meanwhile, the remaining experts rated the modules as good with minor revision in terms of language. Subsequently, changes are made to the modules according to the panel's comments to ensure that the content is in line with the aim, language is simple and easy to understand, while the design is suitable for children.

Generally, the intervention consists of a home food environment module (parent-child session) and 5 hands-on healthy meal preparation sessions among children. The main basis of KidChen Study is to allow children to learn about foods through experience and incorporate the concept of having fun while learning through storytelling/drama. In addition, parental involvement is included as the gatekeeper of home food availability. Given that parents are responsible for the physical and social development of their child, parental involvement can potentially improve intervention effectiveness (Ritchie *et al.* 2005; Black *et al.* 2017). Table 3 displays the specific nutrition education topics

Table 1. Overview of KidChen intervention component

| Component | Details |
|---|--|
| Home food environment modules (parent-child)“Home is where the (healthy) food is” | <p>This is the first module for parents to come along with their child.</p> <ul style="list-style-type: none"> • 15 minutes of interactive nutrition talk on the role of parents and home food availability • 15 minutes of learning how to use food labels and food labels quiz (parent-child pair activity) • 15 minutes of healthful food tasting (meal consisting of core food groups) • 15 minutes of apron fitting, interactive food and kitchen safety talk |
| Hands-on healthy meal preparation modules for children | <p>Five modules with a focus on a food group: (1) good grains; (2) power protein foods; (3) vibrant vegetables; (4) amazing dairy; (5) fit fruits; each consisting of 15 minutes of storytelling and drama related to nutrition principles, 30 minutes of hands-on activity and lastly, 15 minutes of meal sharing and discussion.</p> <p>After each module, children will be given a nutrition booklet containing meal preparation information, recipe and healthful food ingredients to bring home, depending on the main food group of the module. Children will also receive a set of measuring cups and spoons.</p> |

incorporated during the storytelling/drama session and the hands-on healthy meal preparation activities for every module.

In KidChen Study, every children module begins with storytelling/drama using fictional characters to deliver nutrition education. Storytelling/drama is a simple yet powerful method in education (Seipel *et al.* 2014) that allows the essence of complex concepts to be conveyed in a meaningful and non-threatening manner (Suzuki *et al.* 2018). In KidChen Study, a main story is written which centres around kids’ adventure to unlock various food groups. The main story is divided into 5 different parts, each representing a main food group whereby nutrition principles are incorporated into these stories to enhance learning and span throughout the 5 modules for children. Continuity element in the story is important to get the children excited for the following module and to remember the nutrition concepts. Helpers with a nutrition background will be assigned to various characters. Drama rehearsal will be conducted prior to the nutrition module to ensure that the drama/story would be an entertaining and educational for children. The duration of nutrition education and storytelling/drama sessions are 15 minutes as it was demonstrated that children typically have a short attention span (Bunce *et al.* 2010). Foods to be prepared by children will be hinted

during drama session and at the end, it will be revealed to children their hands-on healthy meal preparation task for the session. The connection between storytelling/drama with the later hands-on healthy meal preparation activity was crucial for increasing curiosity in children and familiarity towards various foods.

As for the hands-on healthy meal preparation sessions, emphasis will be made on one specific food group according to the recipe’s main ingredient. Food and kitchen safety are important factors to consider when implementing the hands-on sessions. Hence, children will be equipped with food and kitchen safety knowledge during the first module (parent-child session) and reinforced at every hands-on session. Besides, the hands-on sessions are designed from basic meal preparation tasks namely washing and serving food, to a higher level of using the knife, stirring hot foods and usage of equipment such as oven and blender. This will help children to learn from basic, before transitioning to tasks with increased difficulty. Additionally, children will participate in meal-related tasks with adult’s supervision; guidance from one main moderator (certified food handler with nutrition background) and helpers with nutrition background (ratio of 1 helper: 5 children). It was shown that a ratio of 1 adult: 4 children were needed as reported by a previous study (Jarpe-Ratner *et al.* 2016).

Table 2. The average score of every module rated by the expert panel

| Module | Criteria | | |
|-------------------------------------|----------|------------------|--------|
| | Content | Language | Design |
| Home is where the (healthy) food is | 3 | 2.5 ^a | 3 |
| Good grains | 3 | 3 | 3 |
| Power protein foods | 3 | 3 | 3 |
| Vibrant vegetables | 3 | 2.7 ^b | 3 |
| Amazing cairy | 3 | 3 | 3 |
| Fit fruits | 3 | 3 | 3 |

All modules were rated good (a maximum score of 3) based on the respective criteria by all experts unless stated

^aThree experts (academician in the nutrition field, teacher and parent) rated the module with a score of 2 (average) while the remaining experts rated the module with a score of 3 (good)

^bTwo experts (academician in the nutrition field and teacher) rated the module with a score of 2 (average) while the remaining experts rated the module with a score of 3 (good)

Considering the feasibility factor in the number of nutrition helpers needed, level of children's understanding towards healthy meal preparation in needs assessment, group discussion from intervention subsample, we deemed a ratio of 1:5 as sufficient. Further, emphasis is made to encourage children to be advocates and leaders during the hands-on meal preparation activity and to guide each other as peer support, in line with SCT. Hence, too much assistance from an adult may not be suitable. In additions, helpers will be equipped with the programme flow, modules content and are trained prior to every module to ensure standardization in the method of delivery. During each module, helpers ensure that all children perform the hands-on activity as stated in a task checklist.

After each hands-on session, an ingredient from a specific food group is provided to encourage children to prepare meals using those ingredients with their parents. Providing children with free, accessible fruits and vegetables have been experimentally shown to positively affect long-term dietary behaviour due to increased exposure and preferences, thereby suggesting that this approach is worth pursuing (DeCosta *et al.* 2017). In the current study, such approach will be implemented comprehensively with the hands-on healthy meal preparation session, nutrition education (storytelling/drama) and parental involvement to improve effectiveness, as

suggested earlier (Coyle *et al.* 2009). Past study has highlighted the facilitators in the provision of healthy ingredients, including sufficient funds and coordination among partners/suppliers (Bai *et al.* 2011). Therefore, it is highly recommended to involve stakeholders and partnerships link for the sustainability of such approach. In the present study, we are not only providing fruits and vegetables, but also other ingredients such as whole grains, seeds, nuts and dairy foods. While research usually emphasized fruits and vegetables as target foods (Van der Horst *et al.* 2014), children need a variety of food groups in their diet for healthy growth and development. Hence, we concentrate on all core food groups.

Previously, it was shown that nutrition education programs that have a long-term effect on dietary behavior are those that offer children the opportunity to engage with food in different ways and incorporating experiential, contextual knowledge and social networks, such as parents which allows nutrition knowledge and positive attitude towards healthy foods to be created (Chen *et al.* 2014; Dudley *et al.* 2015). In learning to cook, children can be empowered to prepare healthful meals, learn about ingredients, gain a strong sense of personal achievement and the knowledge that allows them to judge more healthful alternatives when eating away from home (Levy & Auld 2004). Although it was reported that children had poor knowledge and practice towards healthy meal preparation (Ng *et al.* 2020b), they had positive attitude and self-efficacy, suggesting that hands-on healthy meal preparation is liked by children and could be a potential health-promotion strategy.

The National Nutrition Policy of Malaysia highlighted that good health goes beyond access to nutritious food and the nutrition knowledge to make informed and healthy dietary choices. In the same context, KidChen Study goes beyond providing knowledge by targeting long-term nutritional behavior change, equipping children with lifelong skills needed for healthy eating and includes the development of interactive educational modules on healthy eating for schoolchildren as outlined as priorities in National Plan of Action for Nutrition of Malaysia III 2016–2025. On an international level, KidChen Study is aligned with the 2030 Sustainable Development Goals (SDG) by United Nations and Global Nutrition Targets

Table 3. Nutrition education topics and hands-on activities of KidChen intervention

| Module | Hands-on activities/skills | Nutrition education |
|-------------------------------------|--|--|
| Home is where the food (healthy) is | <ul style="list-style-type: none"> • Interactive nutrition talk • Quiz • Apron fitting • Healthy food tasting from various food groups | <ul style="list-style-type: none"> • Role of parents home food availability • Using the food labels • Food safety • Kitchen safety |
| Good grains | <ul style="list-style-type: none"> • Cooking demonstration: fried brown rice • Food and kitchen safety: wearing proper attire and washing hands • Washing rice & serving food • Usage of rice cooker | <ul style="list-style-type: none"> • “<i>Suku-Suku Separuh</i>” (quarter quarter half) • Benefits of whole grains vs refined grains • Source of whole grains |
| Power protein foods | <ul style="list-style-type: none"> • Assemble own sandwich (egg & peanut butter sandwich) • Deciding own ingredients • Basic knife skills (to spread peanut butter and cut soft food) • Usage of toaster | <ul style="list-style-type: none"> • Protein (benefits) • Source of plant & animal protein • Good fats • Drawbacks of processed meat |
| Vibrant vegetables | <ul style="list-style-type: none"> • Touching and seeing real vegetables • Following recipe directions and working in groups • Washing vegetables • Cutting vegetables (higher levels of knife skills-cutting different textures of food) • Measuring ingredients • Boiling & stirring food • Using peeler, ladle and spatula | <ul style="list-style-type: none"> • Vegetables for superkids (importance of vegetables for health) • Eat a rainbow of colours (benefits of different colours of vegetables) |
| Amazing dairy | <ul style="list-style-type: none"> • Making smoothies • Preparing ingredients (washing and cutting) • Measuring ingredients • Incorporating dairy into food preparation • Usage of blender | <ul style="list-style-type: none"> • Dairy (benefits) • Source of dairy food • Flavoured vs original dairy products • Use of dairy in cooking • Drawbacks of carbonated drinks • Importance of breakfast |
| Fit fruits (children) | <ul style="list-style-type: none"> • Washing and cutting fruits • Using muffin tray, muffin liner, baking powder and baking soda • Making dough • Usage of oven • Baking fruits muffins | <ul style="list-style-type: none"> • Fruits (benefits) • Different taste of fruits (sweet, sour, sweet & sour) and how to eat them • Fresh fruits vs fruits drinks, canned fruits, fresh fruit juice |

2025 by World Health Organizations (WHO) to ensure healthy lives, promote well-being, improve nutritional status, and prevent obesity and non-communicable diseases. KidChen Study aims towards the common goals of SDG and WHO to empower vulnerable groups such as children and youth in providing support and to provide evidence of behavioural change from direct interventions which are keys for informing health and education policies.

We anticipate that this study will reveal the effectiveness of an innovative experiential

learning strategy in improving the nutritional outcomes of children. Findings of KidChen Study is important to understand the approach of hands-on healthy meal preparation in affecting children’s food-related attitude, behavior, in addition to providing insights on children’s acceptance towards hands-on healthy meal preparation.

This innovative experiential learning approach including parent’s support is based on scientific evidence and represents a way forward in nutrition education. We foresee that the

output would be well-received on a national and international level. Since this is an ongoing study, research findings will be published elsewhere once data are collected and analyzed.

TRIAL REGISTRATION

The trial is registered at <https://www.irct.ir/trial/40804> (IRCT20190626044024N1). Medical Research and Ethics Committee (MREC) has reviewed and approved the study protocol [NMRR-18-725-41268, KKM/NIHSEC/P18-815 (11)]. Approval to conduct the study in schools is obtained from the Ministry of Education Malaysia (MoE) and Kuala Lumpur Federal Territory Education Department [KPM.600-3/2/3 Jld 45 (91)]. With permission from principals of the selected primary schools, consent form and information sheet are provided to parents. The study has commenced.

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AUTHOR DISCLOSURES

The authors have no conflict of interest.

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