



UNIVERSITI PUTRA MALAYSIA

***DEVELOPMENT AND VALIDATION OF FOOD FREQUENCY  
QUESTIONNAIRE FOR URBAN HEMODIALYSIS POPULATION IN  
SELECTED DIALYSIS CENTRES AT THE KLANG VALLEY,  
MALAYSIA***

MOHAMMAD SYAFIQ BIN MD ALI

FPSK(m) 2020 40



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**MOHAMMAD SYAFIQ BIN MD ALI**

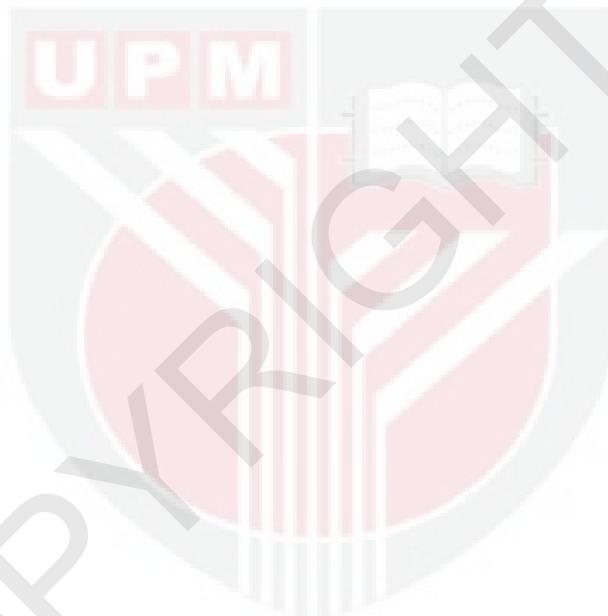
**Thesis Submitted to the School of Graduate Studies, Universiti Putra Malaysia, in  
Fulfilment of the Requirement for the Degree of Master of Science**

**March 2020**

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## **DEDICATION**

This thesis is dedicated to my parents and my lovely wife.



Abstract of thesis presented to Senate of Universiti Putra Malaysia in fulfillment of the requirements for the degree of Master of Science

**DEVELOPMENT AND VALIDATION OF FOOD FREQUENCY  
QUESTIONNAIRE FOR URBAN HEMODIALYSIS POPULATION IN  
SELECTED DIALYSIS CENTRES AT THE KLANG VALLEY, MALAYSIA**

By

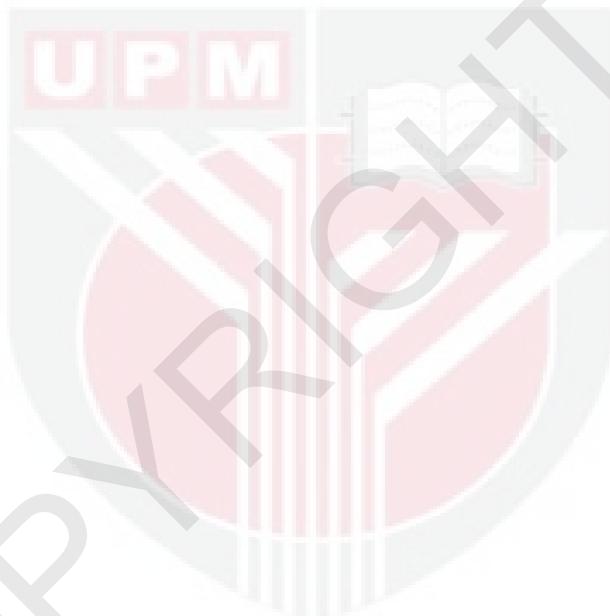
**MOHAMMAD SYAFIQ BIN MD ALI**

**March 2020**

**Chairman: Zulfitri 'Azuan Mat Daud, PhD**  
**Faculty : Medicine and Health Sciences**

Dietary assessment among hemodialysis population plays a crucial role in evaluating the quality of patients' dietary intake. Adequate dietary intake will prevent malnutrition thus decrease the mortality rate among the population. A rapid and reliable tool that can be appropriately applied to quantify macronutrients and micronutrients consumed by Malaysian hemodialysis population is lacking. Therefore, the aim of this study is to develop and validate a food frequency questionnaire (FFQ) applicable to assess dietary intake for urban hemodialysis population in Malaysia. This study was divided into three phases: Phase I was the development of the FFQ whilst Phase II and Phase III provided for the validation of the FFQ. In Phase I, three days dietary recall (3DDR) from 388 subjects in the 'Nutrition Status and Lifestyle Assessment in Hemodialysis Population, Malaysia' study was selected based on inclusion criteria, and were used to construct a food item list using the Block's method. A food nutrient database was then built inclusive of macro- and micronutrients. In Phase II, face validation ( $n=10$ ) and content validation ( $n=10$ ) were carried out. The final FFQ consisted of 123 food items. In Phase III, relative validation was then carried out with 121 subjects selected through consecutive sampling method [Malay=64%, Chinese=23% and Indian=13%; female=45%, male=55%; mean age= $53\pm12$  years; blood pressure=155/83, Malnutrition Inflammation Score  $\geq 6$  (Malnourished=24%)]. Anthropometry, biochemical profiles and dietary assessment for these subjects were assessed. The face validation of the FFQ indicated most food groups were well understood by lay persons and nutrition experts with the exception for 'cooked rice' groups ( $p<0.05$ ). Mean time to complete the FFQ was  $42\pm5$  minutes. The mean difference for absolute intakes of total energy, carbohydrate, protein, total fat, sodium, potassium, phosphate, calcium and iron assessed by 3DDR and FFQ were significant ( $p<0.01$ ). There was a significant correlation between FFQ and 3DDR assessments when comparing absolute intakes for total energy, carbohydrate, protein, total fat, sodium, potassium, phosphate, calcium and iron with correlations ranging from 0.35-0.47 ( $p<0.01$ ). Cross-quartile classification indicated 70% to 82% subjects were classified into same or adjacent quartiles and 3.3% to 7.4% subjects were grossly misclassified

when comparing absolute intakes assessed by FFQ and 3DDR. Bland-Altman plots showed more than 90% of subjects were scattered within the limit of agreement for all the nutrients between FFQ and 3DDR. This FFQ was developed appropriate to assess dietary intake of urban Malaysian hemodialysis population. The FFQ is suitable to be applied in nutritional epidemiological studies to assess populations' diets contribute to malnutrition or any other health conditions.



Abstrak tesis yang dikemukakan kepada Senat Universiti Putra Malaysia sebagai memenuhi keperluan untuk Ijazah Sarjana Sains

**PEMBANGUNAN DAN PENGESAHAN BORANG SOAL SELIDIK  
KEKERAPAN MAKANAN DALAM KALANGAN POPULASI  
HEMODIALISIS DI PUSAT DIALISIS TERPILIH DI LEMBAH KLANG,  
MALAYSIA**

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Penilaian diet dalam kalangan pesakit hemodialisis memainkan peranan penting dalam menilai kualiti pengambilan makanan pesakit. Pengambilan makanan yang mencukupi akan mencegah malnutrisi sekali gus mengurangkan kadar kematian dalam kalangan pesakit. Alat yang pantas dan tepat yang boleh digunakan untuk mengukur makronutrien dan mikronutrien yang diambil oleh pesakit hemodialisis di Malaysia adalah kurang. Oleh itu, matlamat kajian ini adalah untuk membina dan mengesahkan borang soal selidik kekerapan makanan (*FFQ*) yang digunakan untuk menilai pengambilan makanan bagi pesakit hemodialisis yang tinggal di kawasan bandar di Malaysia. Kajian ini dibahagikan kepada tiga fasa: Fasa I adalah pembangunan *FFQ* manakala Fasa II and Fasa III disediakan untuk pengesahan *FFQ*. Pada Fasa I, pengambilan pemakanan tiga hari (*3DDR*) daripada 388 subjek yang terlibat dalam kajian 'Status Pemakanan dan Penilaian Gaya Hidup dalam Populasi Hemodialisis, Malaysia' dipilih berdasarkan inklusi kriteria dan digunakan untuk membina senarai makanan dengan menggunakan kaedah *Blok*. Pangkalan data nutrien makanan kemudian dibina termasuk makro- dan mikronutrien. Dalam Fasa II, pengesahan muka *FFQ* ( $n = 10$ ) dan pengesahan kandungan *FFQ* ( $n = 10$ ) telah dijalankan. *FFQ* yang akhir terdiri daripada 123 item makanan. Dalam Fasa III, pengesahan relatif kemudian dilakukan dengan 121 subjek yang dipilih melalui kaedah pensampelan berturut-turut (Melayu = 64%, Cina = 23% dan India = 13%; perempuan = 45%, lelaki = 55%; purata umur =  $53 \pm 12$  tahun; tekanan darah = 155/83; Skor Keradangan Malnutrisi  $\geq 6$  (Malnutrisi = 24%). Penilaian antropometri, profil biokimia dan penilaian pemakanan untuk subjek ini dinilai. Pengesahan muka *FFQ* menunjukkan kebanyakan kumpulan makanan difahami dengan baik oleh orang awam dan pakar pemakanan kecuali kumpulan 'beras yang dimasak' ( $p < 0.05$ ). Purata masa untuk melengkapkan *FFQ* ialah  $42 \pm 5$  minit. Perbezaan purata bagi pengambilan mutlak jumlah tenaga, karbohidrat, protein, jumlah lemak, natrium, kalium, fosfat, kalsium dan zat besi yang dinilai oleh *3DDR* dan *FFQ* adalah signifikan ( $p < 0.01$ ). Terdapat korelasi yang signifikan antara penilaian *FFQ* dan *3DDR* apabila membandingkan pengambilan mutlak untuk jumlah tenaga, karbohidrat, protein, jumlah

lemak, natrium, kalium, fosfat, kalsium dan zat besi dengan korelasi antara 0.35-0.47 ( $p<0.01$ ). Klasifikasi kuartil bersilang menunjukkan 70% hingga 82% subjek diklasifikasikan ke dalam kuartil yang sama atau bersebelahan dan 3.3% hingga 7.4% subjek telah diklasifikasikan dalam kuartil yang bertentangan apabila dibandingkan pengambilan mutlak yang dinilai oleh *FFQ* dan *3DDR*. Plot *Bland-Altman* menunjukkan lebih daripada 90% subjek berada dalam had persetujuan bagi semua nutrien apabila dibandingkan antara *FFQ* dan *3DDR*. *FFQ* yang dibangunkan ini sesuai digunakan untuk menilai pengambilan makanan pesakit hemodialisis yang tinggal di kawasan bandar di Malaysia. *FFQ* ini juga sesuai untuk digunakan dalam kajian epidemiologi pemakanan untuk menilai diet populasi hemodialisis dan perkaitannya dengan kekurangan zat makanan atau keadaan kesihatan lain.

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Syafiq Ali, 2020

This thesis was submitted to the Senate of Universiti Putra Malaysia and has been accepted as fulfilment of the requirements for the degree of Master of Science. The members of the Supervisory Committee were as follows:

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Date: 13 August 2020

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## LIST OF ABBREVIATIONS

|        |   |
|--------|---|
| AARP   | American Association of Retired Person                        |
| ACE    | Angiotensin converting enzyme                                 |
| BP     | Blood pressure  |
| BMI    | Body mass index   |
| BMR    | Basal metabolic rate  |
| BW     | Body weight   |
| CKD    | Chronic Kidney Disease  |
| CVI    | Content validation index                                      |
| CVD    | Cardiovascular Disease  |
| CHO    | Carbohydrate  |
| DHQ    | Diet History Questionnaire                                    |
| DBP    | Diastolic blood pressure                                      |
| DEI    | Dietary energy intake   |
| DPI    | Dietary protein intake  |
| eGFR   | Estimated Glomerular Filtration Rate                          |
| EPIC   | European Prospective Investigation into Cancer                |
| EI     | Energy Intake   |
| ESRD   | End-Stage Renal Disease                                       |
| FFQ    | Food Frequency Questionnaire                                  |
| FAO    | Food Agriculture Organisation                                 |
| GM     | Grossly misclassified   |
| HD     | Hemodialysis  |
| HGS    | Hand-grip strength  |
| HD-FFQ | Hemodialysis-Food Frequency Questionnaire                     |
| HTN    | Hypertension  |
| HDL-C  | High density lipoprotein cholesterol                          |
| Hb     | Haemoglobin   |
| HBV    | High Biological Value   |
| ISAK   | International Society for the Advancement of Kinanthropometry |
| IDWG   | Interdialytic weight gain                                     |
| K      | Potassium   |
| KDIGO  | Kidney Disease Improving Global Outcome                       |
| KDOQI  | Kidney Disease Outcome Quality Initiative                     |
| LER    | Low energy reporters  |
| LOA    | Limit of agreement  |
| LDL-C  | Low density lipoprotein cholesterol                           |
| MAC    | Mid-arm circumference   |
| MBD    | Mineral Bone Disorder   |
| MANS   | Malaysian Adult Nutrition Survey                              |

|        |  |
|--------|--|
| MUFA   | Monounsaturated Fatty Acid                       |
| MIS    | Malnutrition Inflammation Score                  |
| MAMC   | Mid-arm muscle circumference                     |
| MAMA   | Mid-arm muscle area                              |
| MD     | Mean difference                                  |
| NHANES | National Health and Nutrition Examination Survey |
| NSAIDs | Nonsteroidal anti-inflammatory drugs             |
| NPA    | Nitrogen protein appearance                      |
| PTH    | Parathyroid hormone                              |
| pmp    | per million population                           |
| PEW    | Protein Energy Wasting                           |
| PD     | Peritoneal Dialysis                              |
| PUFA   | Polyunsaturated Fatty Acid                       |
| RRT    | Renal Replacement Therapy                        |
| RNI    | Recommended Nutrient Intakes                     |
| SD     | Standard deviation                               |
| SBP    | Systolic blood pressure                          |
| SPSS   | Statistical Package for Social Sciences          |
| SFA    | Saturated Fatty Acid                             |
| TP     | Total protein                                    |
| TSF    | Triceps skinfold thickness                       |
| TFA    | Trans Fatty Acid                                 |
| TG     | Triglyceride                                     |
| TC     | Total cholesterol                                |
| TEI    | Total energy intake                              |
| USRDS  | United States Renal Data System                  |
| USDA   | United States Department of Agriculture          |
| WHO    | World Health Organization                        |
| 3DDR   | 3-Day Diet Recall                                |

## CHAPTER 1

### INTRODUCTION

#### 1.1 Research background

End-stage Renal Disease (ESRD) is the final stage of Chronic Kidney Disease (CKD) requiring the individuals to commence renal replacement therapy (RRT) (White et al., 2005). The prevalence of CKD and ESRD is increasing worldwide. In 2016, the prevalence of treated ESRD was highest in Taiwan with the prevalence of 3392 pmp (United States Renal Data System (USRDS), 2018). While in Japan, the United States and Singapore, the prevalence of ESRD were 2599, 2196 and 2076 pmp respectively for the same year. The prevalence of treated ESRD in Malaysia is 1352 pmp which was included in the ten countries having the highest percentage rise in ESRD prevalence rate from 2003 to 2016 (USRDS, 2018).

Individual diagnosed with ESRD once estimated glomerular filtration rate (eGFR) reached a value of less than 15ml/min/1.73m<sup>2</sup> and the functions of the kidney only works 10-15% which requires the individual to start RRT. There are several option of RRT available including hemodialysis (HD), peritoneal dialysis or renal organ transplant (National Kidney Foundation, 2002). The most common modality of RRT in Malaysia is HD treatment (Ghazali et al., 2016). HD is a procedure used to maintain a patient with ESRD by using an artificial kidney or known as dialyzer to replace the excretory function of the failed kidneys. Blood from the patient is pumped from the body through special tubing to the dialysis machine, where it circulates through the filtering membrane of dialyzer to remove toxic impurities and going back to the patient. The recommendation by Kidney Disease Outcome Quality Initiative (KDOQI) states that patients should at least undergo HD treatment three times a week and with the minimum dialysis time of three hours for each session (Daugirdas et al., 2015). The HD treatment recommendation in Malaysia is to have 4 hours per session and 3 treatments a week (National Kidney Foundation Malaysia, 2019).

HD patients generally require to follow certain pattern of dietary and lifestyle modifications. Adequate energy and protein consumption is important as HD patients are prone to become malnourished over the time (Abdallah & Yousif, 2016; Sabatino et al., 2017). Besides, long term insufficient dietary intake of calorie and protein will put the patients in protein-energy wasting (PEW) state whereby it increases the risk of morbidity and mortality (Alp Ikizler et al., 2013). Additionally, HD patients need to restrict fluid and certain micronutrients such as sodium, potassium, and phosphate as their body unable to regulate the excess fluid and micronutrients as normal healthy individuals (Blaine et al., 2015; Zoccali et al., 2017). Compliance failure to the dietary recommendation may incur life-threatening condition (Kalantar-Zadeh et al., 2015; Mc Causland, Waikar, & Brunelli, 2012; Noori, Kalantar-Zadeh, Kovesdy, Bross, et al., 2010; Noori, Kalantar-Zadeh, Kovesdy, Murali, et al., 2010; Tsuruya et al., 2015).

Dietary assessment, therefore, would play a crucial role in evaluating the quality of patients' dietary intake (Noori et al., 2010). In Malaysian research settings, the common dietary assessment method to assess nutritional intake among the HD population are the diet recall and food record (Harvinder et al., 2013, 2016; Sahathevan et al., 2015; Yusop et al., 2013). Both dietary assessment method of diet recall and food record need a trained personnel (i.e. dietitian) to interview the subjects and cross-checked the record to attain a genuine quality of dietary data (Gibson, 2005). However, to assess the usual dietary intake of the patients, multiple days of diet recall or food record are needed (Gibson, 2005). In a large population studies, usage of diet recalls/records to estimate average dietary intake of patients has several limitations including recording bias, high cost and burden for researcher as well as the subjects (i.e. need a trained personnel and participants) (Thompson & Subar, 2013).

Meanwhile, in clinical settings, the traditional method of dietary assessment (i.e. diet recall/record) were done by trained personnel (i.e. dietitian). However, a study by Khor et al. (2018) found that the availability of dietitian in Malaysian outpatient HD centres were limited and this retard the nutrition care process pathway of the patients. On the other hand, another study done by Hand et al. (2013) proves that even though there are dietitians in the clinics, they have constraint to perform a proper dietary assessment due to the limitation of time and high burden issues. This was supported by local national surveys among practising dietitians whereby they also face similar problems during dietary assessment among the HD patients which is lack of time and tools (Lim et al., 2019).

To cather the hurdle that arise, a proposed dietary assessment method that could fit in is the food frequency questionnaire (FFQ). The concept of FFQ was introduced by Burke (1947) that compared diet recall, food record and FFQ method to assess patient's average diet. The FFQ method in assessing habitual dietary intake of large population groups had gained importance after the work of Block et al. (1986). The Block's FFQ was initially developed from the National Health and Nutrition Examination Survey II (NHANES II) database in 1985 and the FFQ has been revised again in 1998 using NHANES III food database (Block, Wakimoto, & Block, 1998). In the United States, the FFQ has been used by over 700 research groups and public agencies (Block et al., 1998).

The usage of FFQ is less of a burden and easier to use and able to capture the usual dietary intake of subjects in large-scale epidemiological studies (Subar, Thompson, et al., 2001; Tucker, 2007). Furthermore, FFQ does not necessarily require dietitian as it can be self-administered by the patients itself and other healthcare professionals can administer the FFQ to assess their respective patients' dietary intake (Noori et al., 2010; Willett, 1998). In the development of the FFQ, food consumption data from a local representative population should be gathered and analyzed for its nutrient contribution. This is to identify food items and portion size usually consumed so that the included food items in the FFQ will reflect the usual consumption of the observed population (MacIntyre et al., 2001).

Any dietary questionnaire that is newly developed should be validated to ensure the tools are measuring the correct dietary info as invalid information will lead to a false association between dietary factors and diseases (Eng & Moy, 2011; Wakai, 2009). In conducting a validation study, FFQ measures are compared with an alternative method of assessing dietary intake i.e. ‘gold standard’ method (Cade, Thompson, Burley, & Warm, 2002). The suggested ‘gold standard’ reference method for FFQ validation studies is the weighed food record as it produce least correlated errors with the FFQ (Margetts & Nelson, 2010). However, not all FFQ validation studies able to conduct the ‘gold standard’ method as it imposed high respondent burden. Cade et al. (2002) that reviewed more than 200 FFQs validation studies observed that there are varieties of reference method used (i.e. weighed food record, food record or diary, 24-hour diet recall, diet history questionnaire) depends on the study design and limitations.

On the other hand, biomarkers measurements is not the main reference method for FFQ validation but it serves as an additional parameters to strengthen the validity of the newly developed FFQ (Cade et al., 2002). Biomarkers are useful in assessing validity because errors of measurement such as underreporting or poor memory recall are not present using this method (Brunner, Stallone, Juneja, Bingham, & Marmot, 2001). A study by Noori et al. (2010) found that HD patients with higher dietary potassium and phosphorus intake had higher pre-dialysis serum potassium and phosphorus levels. Another study was done by Eyberg, Pettifor and Moodley (1986) also shows a significant relationship between dietary calcium intakes with serum calcium levels. These serum biomarkers could be useful to estimate the intake of micronutrients proportionally taken by the individual.

## **1.2 Problem statement**

### **1.2.1 Research question**

Will the newly developed FFQ be able to assess macro- and micronutrients intake in Malaysian HD patients correctly?

### **1.2.2 Research justification**

There are many FFQs that have been developed and validated worldwide, including in Malaysia. However, up to date, only two studies have published their FFQ specific for HD population (Kalantar-Zadeh et al., 2011; Delgado et al., 2014). A study by Kalantar-Zadeh et al. (2011) emphasized the design and development of the FFQ only with no validation against any reference method, thus the validity of their FFQ still needs further work. On the other hand, a study by Delgado et al. (2014) modified the existing Block’s FFQ and tailored the food items specific to HD population and comparing it against food record. Both the FFQ consisting of food item that are not tailored to the local Malaysian food database. Therefore, it is inappropriate to use it among our Malaysian HD populations.

In Malaysia, there are a total of 21 FFQs that have been developed, but none are tailored for HD population. From the 21 FFQs, nine of them were developed for multi-ethnic adult, four of them were developed for elderly population, three of them were for

pregnant women population, four of them for multi-ethnic children and adolescent, and one was developed for cataract patient population. Each of the FFQs were assessing different types of nutrients namely energy, macro- and micronutrients, vitamins, minerals and some organic compound i.e. polyphenol and genistein which depends on the population and study objective. The developed FFQs were not suitable to be used in HD population in Malaysia due to the food item listed were not appropriate to the population and different types of nutrients assessment.

Since HD patients are exposed to nutritional issues such as protein-energy wasting, electrolyte imbalances as well as fluid overload (Fouque et al., 2008; Kalantar-Zadeh et al., 2015), therefore, a proper dietary assessment tool is needed to evaluate patients' dietary intake. Current dietary assessment method (i.e. diet recall and diet record) among the HD population in clinical settings were rarely done due to limitations of time and high burden during data recording and analysis (Hand et al., 2013). Meanwhile, in research setting, the use of diet recall and records to estimate average dietary intake of patient's requires involvement of high numbers of trained personnel (i.e. dietitian), this increases the cost and time of assessment (Gibson, 2005; Willett, 1998). Additionally, with the emerging number of research in Malaysian HD population calls for an instrument, which is non-invasive, time-saving and inexpensive, and has been known most suited in nutritional epidemiological studies (Cade et al., 2002).

Results from Khor et al. (2018) national survey reveals that the assessment of dietary intake among Malaysian outpatient HD clinics were scarce due to limited number of dietitian available. Since the FFQ assessment does not necessarily require dietitian skills, it can be used by other healthcare professional or by the patients itself to assess their respective average dietary intake. It is known that the FFQ can be answered easily with correct guidance and does not burden the patient's (Molag et al., 2007; Rodrigo et al., 2015). Other issues pertaining dietary assessment among HD population is limitation to assess and analyze the related micronutrients intakes (i.e. sodium, potassium, phosphate). Surveys among practicing renal dietitians reported lack of time and tools to collect and analyze the dietary information including micronutrients intake of the HD patients (Hand et al., 2013). Another nationwide surveys among practising Malaysian dietitian also face the same concern where majority of them only estimated the micronutrients intake of the HD patients through food checklist as they reported having a limited information on the micronutrients content of the food items (Lim et al., 2019). This situation demands the development of the FFQ which could help in assessment of the micronutrients intake among the HD patients.

The development of this new FFQ specific for HD patients would give the practising dietitian a better option for dietary intake evaluation of the patients. Problem among the practising dietitians regarding lack of time and tools to analyse dietary info especially the micronutrients intake could be elevated with the presence of this newly developed FFQ. Besides that, in view of the limited numbers of dietitians availability in the Malaysian outpatient HD clinics, this FFQ would serve as new tools for the other healthcare providers (i.e. medical doctors, dialysis nurse) to assess thier patients dietary adequacy. A proper dietary evaluation could identify, stratify the patient who are at risk and those who need the dietary intervention. Early nutrition intervention for those who

need it may reduce hospitalizations, morbidity, mortality and eventually improve the patients outcomes.

### **1.3 Research objectives**

#### **1.3.1 General objective**

To develop and validate an FFQ specific for Malaysian HD patients.

#### **1.3.2 Specific objectives**

1. Phase I: To develop a FFQ instrument from dietary records collected from HD patients.
2. Phase II: To validate the FFQ through face and content validation.
3. Phase III: To validate the FFQ through relative validation with 3DDR and serum biomarkers in a HD patients population.

### **1.4 Research hypothesis**

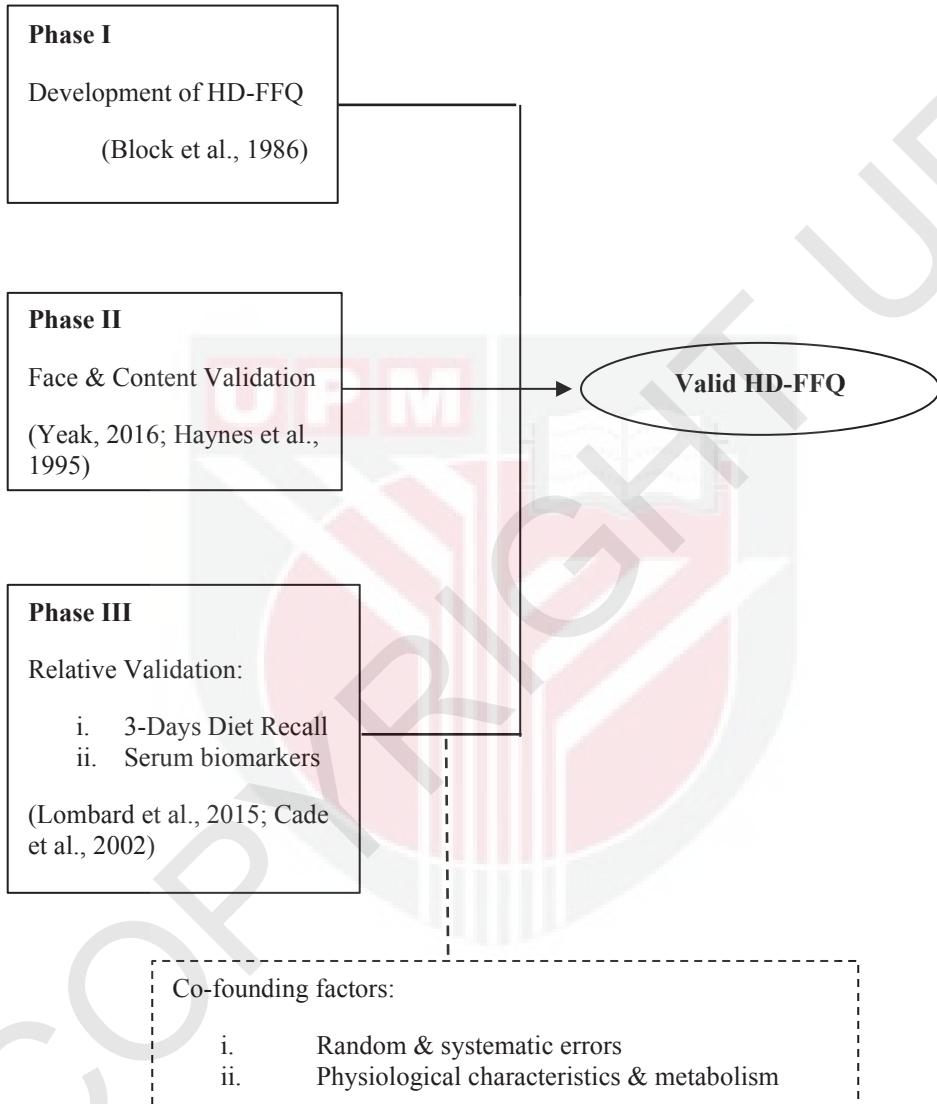
The HD-FFQ will be a valid tool in assessing and ranking dietary intake for urban HD population.

### **1.5 Conceptual framework**

Figure 1.1 showing the conceptual framework of the study. The process of development and validation of the HD-FFQ involve three phases. Phase I was the development of the HD-FFQ based on the method introduced by Block et al. (1986). In Block's method, they selected the food items for the development of the diet questionnaire based on large set of database in specific population of interest. Food items were selected on the basis of their contribution to total population intake of energy and selected nutrients, and represent over 90% of each of those nutrients. In Phase II, face and content validation was done through the experts and layperson views as proposed by Yeak (2016) and Haynes et al. (1995). The face validation was deemed to improve the flow of the questionnaire whilst the content validation is to assess the relevance of the elements of an assessment instrument and representativeness of the targeted construct for a particular assessment purpose (Cook & Beckman, 2006; Haynes et al., 1995).

Phase III was the validation of the newly developed HD-FFQ with the available reference method (i.e. another dietary assessment method). The suggested 'gold standard' for dietary assessment method for reference was weighed food record as it possess different errors compared to the test method (i.e. FFQ) (Margetts & Nelson, 2010). However, due to high subjects burden and practicality, 3-days diet recall (3DDR) was used as main reference method instead as it has been recommended in clinical practice guideline of K/DOQI as an adequate dietary assessment method for HD patients (Kopple, 2001). An additional parameters (i.e. serum biomarkers) was used to serve as an added reference method to strengthen the validity of the newly developed FFQ (Cade et al., 2002). The statistical analysis to test the validity of the HD-FFQ and the reference method included

correlation coefficients, comparison of means, cross-classifications and Bland-Altman analysis (Lombard et al., 2015).



**Figure 1.1: Conceptual framework of the study.**

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