

Editorial

The rising rate of childhood overweight and obesity is a concern. Tackling it requires a family approach and is no easy task. Many parents find it difficult to say whether their child is of normal weight, overweight or obese. Perceptions about weight are often different between health professionals and parents. A health professional may assess a child as overweight/obese using BMI or growth charts, yet the parents will not see their child as overweight or obese. Weight control is "top of mind" as a benefit of healthy eating by health professionals, yet not so by parents.

In this issue of Heinz Sight, Dr Jenny O'Dea discusses childhood overweight and obesity, particularly in relation to parental perceptions, and provides some guidelines as to how health professionals can help parents encourage healthy eating and weight control.

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Childhood Obesity Prevention: What do parents want and need?

This article will discuss the feeding and parenting issues around childhood obesity as well as some recent research with mothers of children aged 2-6 years. The following questions will be addressed:

- What is the prevalence of overweight and obesity in Australian children?
- How do parents perceive child obesity?
- What information do we have from recent research studies of parents?
- How do parents see their role in prevention of childhood obesity?
- What do parents want to assist them in child feeding and obesity prevention?

Prevalence of overweight and obesity among Australian schoolchildren

In 2000, nearly 5000 primary and secondary school children from every state and territory of Australia were surveyed^{1,2}.

About 6 percent were obese, indicating that they are probably carrying a level of body fat that may be detrimental to their current or future health, especially if they have a family history of type 2 diabetes or high blood pressure.

The 17 percent of students in the "overweight" category indicate that these children are big and certainly bigger than their peers, but not necessarily "too fat" or at risk of imminent illness due to their weight. However, these students may be approaching a level of body weight that puts them at risk of becoming obese. In the youngest children (less than 9 years of age), a very similar percentage were "overweight" (11.6%) or "obese" (6.3%).

In a recent study of 2-6 year old children in 2005³, 6.3% were obese and 15.3% overweight.

Similar results have been found in other studies⁴ and in a 2004 study of NSW kindergarten children conducted by NSW Health⁵, 5-6% were obese and 12% overweight.

A national study of children from the same schools surveyed in 2000¹ is currently underway to estimate any change in the prevalence of overweight and obesity since then and 2006.

Parental perceptions of childhood obesity

Research Studies

There is great variation in how parents see their child's weight. This variation is likely to be influenced not only by cultural factors but also by the varying clinical definitions of overweight and obesity used to make a broad assessment of a child's weight status.

Health professionals currently use growth charts as well as BMI charts to assess the weight status of a child. Parents find these measures confusing and difficult to understand. It is no wonder that they find it difficult to say whether their child is at a healthy weight, overweight or obese. The following results from research studies should be interpreted with this in mind.

a. Parental perception of weight status – UK

The EarlyBird Study in the UK⁶ demonstrated how confusing it is for parents to understand their child's weight status. Researchers assessed 277 healthy children and found that:

- 19 % of the children were overweight or obese
- 52% of mothers and 72% of fathers were overweight or obese
- Only 40% of mothers judged themselves as overweight
- Only 45% of fathers judged themselves as overweight

The researchers also asked how parents judged their child's weight.

- Only 25% of parents judged their overweight child as overweight
- Even when the child was obese, 33% of mothers and 57% of fathers said that their child's weight was "about right"
- Mothers were more likely to be correct about their child's weight than fathers – 84% versus 76%
- Parents were less likely to detect overweight in their sons than daughters

The results of this study are quite typical and probably reflect cultural perceptions, as well as confusion between the "overweight" and obese category. Many parents of obese children – a third of the mothers and half of the fathers – did not perceive their child's weight to be excessive or abnormal.

b. Parental readiness to help overweight children – USA

In the USA, researchers interviewed 151 parents of overweight children to assess how ready parents were to make changes to help their child lose weight⁷. They found:-

- 44% of parents hadn't thought of making any changes. They were in the "Pre-Contemplation" stage
- 18% had thought about it - "Contemplation" stage
- 38% were ready and starting to make changes - "Preparation/Action stage"

Of the 38 percent of parents who were ready and making changes, many were overweight themselves, had other overweight children and/or believed that their own weight or their child's weight was a health problem.

c. An unsuccessful attempt to tackle overweight – UK

Making parents more aware of their child's weight status and offering help may not necessarily be the answer. A group of researchers in the UK⁸ attempted to recruit 20 overweight children for a weight reduction program. Overweight children were encouraged to join the program by school nurses, general practitioners (GPs) and an advertisement in the local newspaper.

The project was well funded. Parents were offered a free initial consultation with an enthusiastic multidisciplinary medical team, free choice of an exercise program, free dietetic advice and \$30 worth of fresh fruit and vegetables. The researchers were extremely surprised and disappointed that only 4 children were recruited and concluded

"... it would seem likely that a difference in perception of the seriousness of overweight and the need for action between parents and professionals explained our disappointing outcomes...."

d. Predictors of overweight in children - USA

The Stanford Birth Cohort Study⁹ in the US followed 150 children from birth to age 10 to find out what predicts overweight. Their results found that the greatest predictor of child overweight was parental overweight. Other important predictors were:-

- Child temperament and degree of "soothability". An angry, frustrated and "highly emotional child" was more likely to be overweight and may act like a "squeaky wheel" until placated with food or drink
- Children who threw tantrums over food and
- Shorter daytime sleepers, suggesting that low physical activity may make them less tired.

e. Child feeding practices and mother's perceptions of overweight – Australia

A recent study of 112 mothers of 2-6 year olds³ found:

- 6.3% of children were obese and 15.3% overweight
- Mothers were very accurate regarding perceptions of their own weight
- Mothers were accurate about their obese child's weight status but not their overweight child
- 5 of 7 obese children were perceived as overweight
- 4 of 17 overweight children were perceived as overweight
- Mothers may perceive the two weight categories as quite different and a child may need to be obese before they are perceived as "too fat"

When asked how their feeding patterns changed when they had an obese child:

- Mothers were more concerned about their daughter being overweight than their son
- Mothers of obese children were more likely to restrict their foods and less likely to encourage them to eat more. This effect was graded with the child's weight
- Mothers with lowest education encouraged their child to eat more and to finish all food on their plate. This "over feeding" may be associated with the greater incidence of child obesity and overweight found in children from lower socioeconomic backgrounds¹.

Focus Groups

In preparation for "Positive Food For Kids"¹⁰, focus groups were held with over 100 parents. They were asked: *What are the benefits of healthy eating for you and your child?*

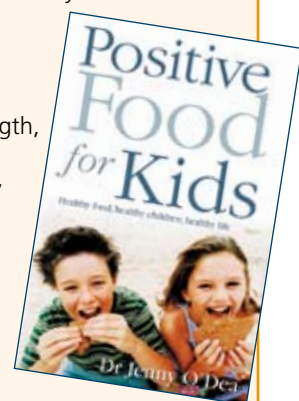
The three major re-occurring themes were:

1. Health Protection

- "Health" is short term and means strength, resilience, not being sick
- "It protects children from colds and flu"
- "I worry that if he breaks a bone that it might not heal..."

2. Instinctual feeding

- Nutrition, growth - "I know healthy food is important for my child"
- Feeding is an instinct - "I am so happy when they eat" "I like to see them eating"



3. Conflict Avoidance

- Conflict avoidance – “I can’t be bothered fighting over food so they eat what they want”
- “It makes life easier when they eat well”

When parents were asked “Why is physical activity important for your child?” their main responses were:-

- It helps them sleep
- Keeps them healthy (“health” means not being sick and being active)
- Helps them have friends

This result is a fine example of how the perceptions of parents and those of health professionals are quite different.

When asked what parents would like to help them in feeding their child, the main responses were:-

- They want to be able to get their child to eat what they want them to eat!
- They want child feeding to be “easier”

These responses again show that the benefits of healthy eating for their child are not necessarily congruent with those of health professionals. The idea of “not becoming overweight” is not perceived as a benefit – parents want tangible, short term benefits. While parental responsibility for feeding is high, parental self efficacy is low.

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How can Health Professionals help parents to encourage healthy eating and weight control

- Monitor the child’s weight but don’t expect it to motivate parents!
- Teach parents how to use positive (not negative) child settling, distraction and behaviour management techniques
- Teach parents how to develop positive food parenting skills¹⁰
- Reinforce 3 meals plus morning and afternoon tea with nothing but water in between
- No grazing!
- Remind parents that they are the adult and they are in control
- Promote the many different benefits of good child nutrition e.g. brain function and IQ

Finally, we must always remember that child health encompasses a state of complete physical, mental and social well-being¹¹ and not merely the absence of disease and overweight. As health professionals we must always work towards the healthy development of the whole child within a framework that is well understood by parents.

Small Talk



1. New International Child Growth Standards.

The World Health Organisation (WHO) has released new growth charts for infants and children up to age 5 years. Developed over 9 years, they involved 8,440 children from countries including Brazil, Ghana, India, Norway, Oman and the USA.

These new standards are based on the breast fed child as the norm for growth and development. Children included in the study were raised in healthy environments with few infections and good diets. Their mothers were non smokers during and after pregnancy, and while breast feeding. The standards show that children given the best start in life grow within similar ranges of weight and height, irrespective of where they were born.

The Standard includes height/length for age, weight for age and BMI for age charts for both sexes. The Windows of Achievement Chart describes the time ranges for reaching gross motor developmental milestones such as sitting, standing, crawling and walking.

WHO is encouraging all countries to adopt these Standards as they more accurately reflect how children should grow. Current growth charts used in Australia and overseas are limiting, as they are based on the growth of a small sample of children from the USA who were largely formula fed. They don’t reflect the growth of children born in other countries nor who are breast fed.

Further information and copies of the charts can be accessed at www.who.int/childgrowth/en/

Small Talk CONT.

2. Rice and Oat Beverages Unsuitable for Young Children.

Food Standards Australia New Zealand (FSANZ) recommend that cereal based beverages such as those made from rice and oats not be given to children under 5 years. These beverages are often given when a child is allergic or intolerant to soy and dairy foods. However, they are too low in protein (less than 10% of the protein contained in cows milk) and do not contain important vitamins and minerals such as calcium and riboflavin that growing children need. Labels of rice and oat beverages with low protein contents are now required to carry the warning statement *this product is not suitable as a complete milk replacement for children under the age of five years*. FSANZ has produced a fact sheet which is available at www.foodstandards.gov.au/newsroom/factsheets/factsheets2006/cerealbasedbeverages3270.cfm

3. Why are breast fed babies smarter?

A recent paper in the online British Medical Journal has challenged the notion that breast fed children are smarter because of what's in breast milk¹. The study looked at 5,475 children of 3,161 mothers from the 1979 US national longitudinal survey. The researchers controlled for factors that can influence intelligence such as sex, maternal smoking, race, birth order, birth weight, mother's age, education, maternal intelligence, home environment, race and family economic status. What they found was that maternal intelligence, as measured by IQ, was the most important factor in predicting a child's intelligence, not breast feeding. Intelligence is an inherited trait and mothers who breast feed tend to be more intelligent, highly educated and provide a more stimulating home environment for their child. The research also looked at siblings, one breast fed and the other bottle fed and found no significant difference in intelligence between the two. Regardless of these findings, breast feeding is still recommended as the best way to feed infants.

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Heinz Update



What is the role of toddler milk?

Toddlers sometimes go through stages where they do not eat well and toddler milk can help to increase the nutrient density of a child's diet, while their eating behaviour is improving. It is particularly useful for fussy eaters and active toddlers who are not eating enough.

One glass of Heinz Nuture Gold Toddler™ milk provides 50% of the daily requirement for iron and iodine. With no added sucrose and no added flavours, Heinz Nuture Toddler milk will not spoil their appetite for cow's milk. Too much milk can be a problem, and we recommend 1-2 glasses of Toddler milk per day in place of cow's milk, so appetite is not reduced for other nutritious foods.

Heinz Nuture Gold Toddler™

A unique combination of nutrients for active, growing toddlers:

One Serve (250mL) provides:

Omega 3 DHA:	37.4mg per serve of Omega 3 DHA, the highest level of any toddler milk. This equates to DHA in around 2 tablespoons of tuna.
Iron:	50% of toddler's daily need
Iodine:	50% of toddler's daily need
Vitamin D:	33% of toddler's daily need

In addition to other important vitamins and minerals, Heinz Nuture Gold Toddler™ milk provides the highest level of Omega 3 DHA of any toddler milk, important for brain and eye development. It also provides prebiotic resistant maltodextrin and probiotic Acidophilus for gut health.

Complementing toddler milk is the Heinz Nuture Gold infant formula range (Starter and Follow-On) for infants less than 12 months, incorporating Omega 3 DHA, nucleotides and probiotic bifidus.

For further information regarding our formula and toddler milks, or for copies of our new Toddler Eating brochure please contact me via our Careline on 1800 633 333, or your HIFAS representative.

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Please see our Health Professional information enclosed.

Please note: Breastfeeding is best for babies. Maternal nutrition requirements increase during breastfeeding. Before introducing infant formula, always seek professional advice. Once bottle feeding has been commenced it is difficult to reverse the decision. Partial bottle feeding may also adversely affect breastfeeding. Always use infant formula as directed because improper use can affect the health of the infant. Always consider the social and financial implications before selecting a method of infant feeding.

www.heinzforbaby.com.au

Visit the new health professional section on our website

The Heinz Product Info Line 1800 633 333 provides information to callers on Heinz Baby Food products.

All callers are asked to contact the child health service in their state for individual advice.

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In this issue of
Heinz Sight, we
enclose a sample of
Heinz Nuture Gold
Toddler™ milk
for you.