Tackling childhood obesity

Childhood obesity is on the rise but evidence shows that healthcare professionals lack confidence and ability when it comes to addressing the issue. **Amalia Burca Bouch** explores the problem.

Obesity, with its associated conditions, is a serious risk to public health. Obese children are of particular concern because those who are overweight or obese as youngsters are at greater risk of developing a multitude of health issues. They are also more likely to become obese adults, therefore leading to serious health risks within their life span (Griffiths et al, 2010). The emotional consequences of obesity in childhood can also be severe and long-lasting, including bullying, low self-esteem and social exclusion.

Childhood obesity is becoming more of a problem. The National Child Measurement Programme (NCMP, 2016), states that more than a fifth of reception-year children were overweight or obese. In year six, it was more than a third. And the prevalence of obesity has increased since 2014/15 in reception and year six. In reception, it increased from 9.1% to 9.3% and, in year six, from 19.1% to 19.8%. Many illnesses that previously were seldom heard of in children – such as Type 2 diabetes and heart disease – are now being seen.

Eating and activity habits, including food preferences, are developed early in life. But, as many healthcare practitioners will testify, obesity is a difficult issue to tackle. NICE 2013 guidelines say that health-care providers are recommended to implement strategies such as accurate measuring and recording of a child's height and weight to determine BMI percentile (while using age and gender-specific charts) and be familiar with the local weight management pathways and locally approved co-morbidities assessment tools. They also should assess whether referral to a lifestyle weight management programme is appropriate and assess the need for referral to specialist obesity or other specialist services (such as paediatric services). And they need to be able to identify suitable lifestyle weight management programmes for children and their families while providing them with information and ongoing support. And, before all this, raise and discuss the issue of weight management confidently and sensitively with families, and assist parents and carers in identifying when a child is overweight or obese.

Another helpful policy, for health visitors in particular, is the Department of Health's (DH) *Healthy Child Programme* (2009), which has an emphasis on early involvement and health endorsement in the varied phases of a child's life, and it plainly underlines the value of reducing childhood obesity. Education about weight could start as early as the antenatal period so that parents may be informed about healthy weight during pregnancy. This is especially important since many overweight mothers-to-be need to have an awareness that this can cause complications to themselves and their baby (Public Health England, 2015).

INEFFECTIVE POLICIES?

Redsell et al (2013) states that health professionals are still ineffective at dealing with childhood obesity, in spite of the guidelines. This may be because many do not read them. Turner et al (2009) stated

KEY POINTS

- **Obese children are at greater risk of developing health issues, including illnesses previously seldom seen in children.**
- **The emotional consequences of childhood obesity can be severe and lasting.**
- **Healthcare professionals are still ineffective at dealing with childhood obesity (Redsell et al, 2013).**
- **Health visitors may face difficulties in engaging with obese children's parents, who may be unwilling to accept their child has a weight issue.**
- **Preventive strategies need to be implemented while maintaining awareness of cultural and socioeconomic factors.**
- **Health visitors have the chance to persuade entire families towards healthy nutrition and physical activity.**

that the majority of primary care practitioners are uninformed of the existing national guidelines. This research found only 10% of interviewed practitioners had read the recent NICE obesity guidance. The reason was that many do not consider it an effective intervention, although it is also due to other issues such as lack of time, lack of experience in this particular area, or lack of resources.

Turner et al (2009), Edvardsson et al (2009), and Larsen et al (2015) explored the thoughts of healthcare professionals, including health visitors, on research articles. In the process, they found that practitioners find it complicated to engage with the parents of obese children. Health visitors perceive it to be quite difficult to make parents recognise and accept the problem of obesity – they are likely to become defensive, in denial of the issue, or verbally aggressive. Interviewed participants remarked that obesity is a societal, rather than a medical, problem, and supervision of this issue ought not to pertain to them alone. It was also remarked by the participants that there is a lack of proficiency and full understanding of referral options, and of the most valuable and efficient childhood obesity treatments.

Although several health professionals – such as GPs and health visitors – have regular contact with families with overweight or obese children, the ways in which the matter is approached differs from one practitioner to another. According to Larsen et al (2015), not all of them will consistently provide the necessary and suitable health guidance, or spend much time assessing a child's nutritional intake while informing parents about healthy diet and lifestyle. The rest will only somewhat bring up concerns when a child's weight is higher than it ought to be, relative to their height/weight ratio. Rapid weight gain or an elevated weight on the growth chart can often be overlooked and not articulated to the parents concisely.

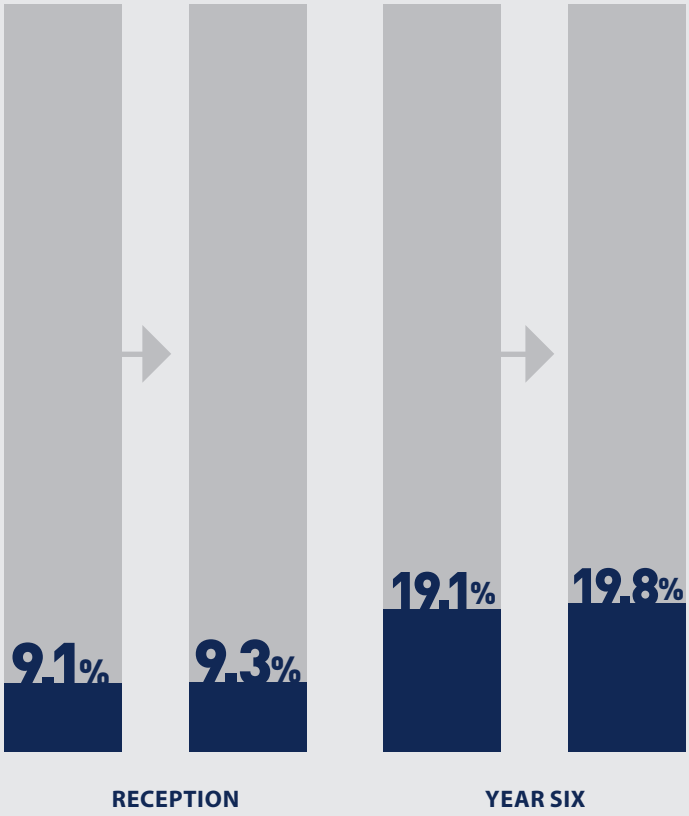
However, health professionals face a moral and ethical quandary in providing dietary recommendations as they confront a client's customs, cultural convictions and insights on their child's size. There is the possibility that addressing the issue may be considered condescending, discourteous, and potentially offensive rather than empowering and beneficial (Larsen et al, 2015).

PARENTAL RESISTANCE

As well as healthcare professionals' skills, another barrier to change is a dearth of parental knowledge and awareness of the dangers of childhood obesity (Redsell et al, 2013). According to Keenan and Stapleton (2010) and Redsell et al (2010), many parents regard large children as cute and healthy. In addition, most parents are unwilling to accept that their child has a weight issue, despite the health professionals' diagnosis, as they conform to the belief that a big child equals a happy child. Parents of large babies generally do not see a connection between a poor diet, high in calories, and an overall lack of physical activity, and obesity.

Although the role of physical activity is crucial in the deterrence of obesity both in childhood and adolescence, parents find obstacles to being active outdoors, including lack of safe local play areas or other attractive places (Redsell et al, 2010). And parents generally oppose alterations to the family behaviours and routines (Sonneville, 2009). The government Change4Life paper (DH, 2011) and website emphasises the importance of healthy weight

Increased prevalence of obesity in both reception and year six (NCMP, 2016)



through the promotion of fun activities and play. Redsell et al (2010) highlight a call for extensive professional guidance for carers related to parenting skills and change in behaviour strategies. More often than not, instructive strategies tried to convey nutritional and lifestyle information in a manner that, for many, is not relevant – parents of obese children have said that conventional measures to obesity management are at times unhelpful (Edmunds, 2005; Rudolf, 2009; and Larsen et al, 2015).

PREVENTIVE STRATEGIES

The purpose of health education is to modify actions and behaviour. Health professionals therefore ought to inspire individuals to establish healthy attitudes, rather than just providing information to change unwanted behaviour. Parents need to be inspired to understand the impact their behaviour has on the development of the eating and lifestyle patterns of their child (Rudolf, 2009).

Clearly, there is a need to develop appropriate intervention and to ensure that health professionals have the right skills. Preventive strategies around obesity need to be implemented while maintaining awareness about relevant cultural and socioeconomic factors. Factors such as race, ethnicity, lifestyle, genetics, culture, socio-economic status, and the environment, tend to have great influence on dietary choices (El-Sayed et al, 2011). Dealing with obesity is thus a multifaceted and complicated process, which involves a broad sociological awareness and understanding. It also

requires tactful and compassionate communication skills that can influence behaviour and bring about positive lifestyle changes.

If done in a knowledgeable manner, health visitors dealing with young children have the possibility to persuade entire families towards healthy nutrition and physical activity. While conducting health promotion activities, health professionals ought to clearly and effectively discuss with the whole family the key actions required for the prevention of overweight and obesity later in life. Main messages to consistently get across are: the reasons for increased duration of breastfeeding and the delay of weaning from four to six months, importance of parental role modelling around food and of establishing healthy daily routines, and the benefits of a variety of physical activities. The research results from Edvardsson et al (2009) indicate that parents desire a less authoritarian method, instead preferring a strong practitioner and client rapport when dealing with weight.

HIGHER VALUE

More research is required on how to advance communication when dealing with parents' beliefs but, for frontline practitioners, easy and consistent access to training on obesity management might improve the quality of the delivery of the *Healthy Child Programme*.

Research found that only

10%

of interviewed practitioners had read the recent NICE obesity guide (Turner et al, 2009)

The National Measurement Programme states that more than

1/5

of reception-year children were overweight or obese

(NCMP, 2016)

Also, existing obesity reduction services such as HENRY have been shown to have a high rate of success (Willis et al, 2014). HENRY is an evidence-based programme with an emphasis on helping the whole family make positive changes to their lifestyle, as well as developing healthier communities. The HENRY programme is currently working with a variety of local partners such as health trusts, local authorities, public health departments, voluntary organisations and universities.

Finally, it could be argued that health visitors are in a significant position to deal with childhood obesity and should be attributed a higher value by the government and the commissioners, as they add value in the development of a better, fitter and healthier future for the next generation. This will require re-evaluation of current financial support given to health visiting services, addressing the skills shortage, and an investment in additional training. **CP**

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