

114 Overweight or At Risk of Overweight (Infants and Children)

Definition/Cut-Off Value

Weight Classification	Age	Definition/Cut-off value
Overweight	2 - 5 years	$\geq 85^{\text{th}}$ and $< 95^{\text{th}}$ percentile Body Mass Index (BMI)-for-age or weight-for-stature as plotted on the 2000 Centers for Disease Control and Prevention (CDC) 2-20 years gender specific growth charts (1,2).*
At Risk of Overweight	< 12 months (infant of obese mother)	Biological mother with a BMI ≥ 30 at the time of conception or at any point in the first trimester of pregnancy.**
	≥ 12 months (child of obese mother)	Biological mother with a BMI ≥ 30 at the time of certification.** (If the mother is pregnant or has had a baby within the past 6 months, use her preconceptual weight to assess for obesity since her current weight will be influenced by pregnancy-related weight gain.)
	Birth to 5 years (infant or child of obese father)	Biological father with a BMI ≥ 30 at the time of certification.**

* The cut off is based on standing height measurements. Therefore, recumbent length measurements may not be used to determine this risk. See Clarification for more information.

** BMI must be based on self-reported weight and height by the parent in attendance (i.e., one parent may not "self report" for the other parent) or weight and height measurements taken by staff at the time of certification.

Note: The 2000 CDC 2 – 20 years growth charts are available at: www.cdc.gov/growthcharts.

Participant Category and Priority Level

Category	Priority
Infants	I
Children	III

Justification

The rise in the prevalence of overweight and obesity in children and adolescents is one of the most important public health issues in the United States today. The National Health and Nutrition Examination Survey (NHANES) from the mid-1960s to the early 2000s document a significant increase in overweight among children from preschool age through adolescence. These trends parallel a concurrent increase in obesity among adults, suggesting that fundamental shifts in dietary and/or physical activity behaviors are having an adverse effect on overall energy balance (3).

BMI is a measure of body weight adjusted for height. While not a direct measure of body fatness, BMI is a useful screening tool to assess adiposity (3). Children ≥ 2 years of age, with a BMI-for-age $\geq 85^{\text{th}}$ and $< 95^{\text{th}}$ percentile are considered *overweight* and those at or above the 95^{th} percentile, *obese* (4). Research on BMI and body fatness shows that the majority of children with BMI-for-age at or above the 95^{th} percentile have high adiposity and less than one-half of the children in the 85^{th} to $< 95^{\text{th}}$ percentiles have high adiposity (4). Although an imperfect tool, elevated BMI among children most often indicates increased risk for future adverse health outcomes and/or development of diseases (5). BMI should serve as the initial screen and as the starting point for classification of health risks (3).

Increasingly, attention is being focused on the need for comprehensive strategies that focus on preventing overweight/obesity and a sedentary lifestyle for all ages. Scientific evidence suggests that the presence of obesity in a parent greatly increases the risk of overweight in preschoolers, even when no other overt signs of increasing body mass are present (6). The presence of parental obesity should lead to greater efforts by nutrition services staff to assist families in establishing or improving healthy behaviors (3).

Implications for WIC Nutrition Services

The WIC Program plays an important role in public health efforts to reduce the prevalence of obesity by actively identifying and enrolling infants and children who may be overweight or at risk of overweight in childhood or adolescence. When identifying this risk, it is important to communicate it in a way that is supportive, nonjudgmental, and with a careful choice of words to convey an empathetic attitude and to minimize embarrassment or harm to a child's self-esteem (4). In recognition of the importance of language, the 2007 American Medical Association expert committee report recommends the use of the terms *overweight* and *obese* for documentation and risk assessment **only** and the use of more neutral terms (e.g., *weight disproportional to height*, *excess weight*, *BMI*) when discussing a child's weight with a parent/caregiver (3).

BMI is calculated and plotted on growth charts at each WIC certification. However, growth charts are meant to be used as a screening tool and comprise only one aspect of the overall growth assessment. A clinical assessment to determine if a child is at a healthy weight is more complex. Weight classification (derived from the growth chart) should be integrated with the growth pattern, familial obesity, medical risks, and dietary and physical activity habits to determine the child's obesity risk (1,5).

The goal in WIC nutrition counseling is to help the child achieve recommended rates of growth and development. WIC staff can frame the discussion to make achieving normal growth a shared goal of the WIC Program and the parent/caregiver. Studies have shown that the early childhood eating environment provides a great opportunity for preventive intervention (7). Parents/caregivers of infants and toddlers may need education on recognition of satiety cues and other physiological needs that lead to crying, and ways to comfort a child (holding, reading, rocking) other than by feeding. Young children look upon their parents as role models for eating behaviors. Through client-centered counseling, WIC staff can emphasize

the importance of prevention and can assist families in making changes that improve parenting skills that promote healthy eating, and physical activity behaviors and a healthy weight in children. Also, the foods provided by the WIC Program are scientifically-based and intended to address the supplemental nutritional needs of the Program's target population and can be tailored to meet the needs of individual participants.

Beliefs about what is an attractive or healthy weight, the importance of physical activity, what foods are desirable or appropriate for parents to provide to children, family mealtime routines, and many other lifestyle habits are influenced by different cultures, and should be considered during the nutrition assessment and counseling (8). The following resources for obesity prevention can be found at:

- Fit WIC Materials:
http://www.nal.usda.gov/wicworks/Sharing_Center/gallery/foodfunfamilies.htm.
- MyPyramid for Preschoolers: <http://www.mypyramid.gov/preschoolers/index.html>

In addition, WIC staff can greatly assist families by providing referrals to medical providers and other services, if available, in their community. Such resources may provide the recommended medical assessments, in order to rule out or confirm medical conditions, and offer treatment when necessary and/or in cases where growth improvement is slow to respond to dietary interventions.

References

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2. Grummer-Strawn LM, Reinold C, Krebs NF. Use of World Health Organization and CDC growth charts for children aged 0-59 Months in the United States. CDC Morbidity and Mortality Weekly Report (September 2010); no 59(rr09); 1-15. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5909a1.htm?s_cid=rr5909a1_w. Accessed September 2010.
3. Barlow SE, Expert Committee. Expert committee recommendations regarding the prevention, assessment, and treatment of child and adolescent overweight and obesity: Summary report. Pediatrics. 2007; 120; S164-S192.
4. Ogden CL, Flegal KM. Changes in Terminology for childhood overweight and obesity. National health statistics reports; no. 25. Hyattsville (MD): National Center for Health Statistics. 2010.
5. U.S. Department of Health and Human Services. The Surgeon General's vision for a healthy and fit nation. Rockville (MD): U.S. Department of Health and Human Services, Office of the Surgeon General. 2010.
6. Whitaker RC, Wright JA, Pepe MS, Seidel KD, Dietz WH. Predicting obesity in young adulthood from childhood and parental obesity. NEJM, Vol 337, No 13, September 25, 1997. pgs 869-873.
7. Anzman SL, Rollins BY, Birch LL. Parental influence on children's early eating environments and obesity risk: implications for prevention. International Journal of Obesity 34, 1116-1124 (July 2010).
8. Krebs NF, Himes JH, Jacobson D, Nicklas TA, Guilday P, Styne D. Assessment of child and adolescent overweight and obesity. Pediatrics 2007; 120 Suppl 4:S103-S228.

Clarification

The 2000 CDC Birth to 36 months growth charts cannot be used as a screening tool for the purpose of assigning this risk because these charts are based on recumbent length rather than standing height data. However, these charts may be used as an assessment tool for evaluating growth in children aged 24-36 months who are not able to be measured for the standing height required for the 2000 CDC 2-20 years growth charts.

Abbreviated Body Mass Index (BMI) Table*

Height	Inches	Weight (lbs) equal to BMI 30
4' 10"	58	143
4' 11"	59	148
5' 0"	60	153
5' 1"	61	158
5' 2"	62	164
5' 3"	63	169
5' 4"	64	174
5' 5"	65	180
5' 6"	66	186
5' 7"	67	191
5' 8"	68	197
5' 9"	69	203
5' 10"	70	209
5' 11"	71	215
5' 12"	72	221
6' 1"	73	227
6' 2"	74	233
6' 3"	75	240

**This table may be used to determine parental (male or female) obesity (BMI > 30).*

Source

Evidence Report of Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, 1998. National Institutes of Health/National Heart, Lung, and Blood Institute (NHLBI).

Note: A complete BMI table is available on the NHLBI website:

www.nhlbi.gov/guidelines/obesity/ob_home.htm.

