



GUIDELINE	
Overweight and obesity	
Scope (Staff):	Community health staff
Scope (Area):	CACH, WACHS

This document should be read in conjunction with this [DISCLAIMER](#)

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Aim

This document aims to guide Community health staff to assist parents/caregivers to manage overweight and obesity in children.

Risk

Children and young people who are overweight or obese in childhood or adolescence are at increased risk of developing chronic health conditions, and of experiencing psychosocial harm. Overweight and obesity in childhood increases the likelihood that children will become overweight or obese adults, and therefore, may experience mental and physical health conditions long-term.

Background

Overweight and obesity develops from a long-term imbalance between energy intake (from food and beverages consumed) and energy output (physical exertion) that leads to fat accumulation.¹ An individual's physical and psychological make-up is influenced by societal, environmental, socio-economic, health and biomedical factors. The prevention and early intervention of overweight and obesity is vital due to the long-term impacts of obesity and the current lack of insufficient, evidence-based treatment options to manage obesity once established. It is important to understand these many factors when addressing the issue of overweight and obesity in children and families.²

The propensity for overweight and obesity start early, with feeding choices made during infancy being influential in a person's health over their life course. There is convincing evidence for infants who breastfeed having reduced risk of becoming obese in childhood, adolescence and early adulthood, compared to infants who are infant formula fed.³ Data from seven (7) longitudinal studies of infant growth, determined that infants who breastfeed for at least twelve (12) months grew more rapidly in the first two (2) months and less rapidly from three (3) to twelve (12) months of age.⁴ In a Western Australian study, infants who breastfed for more than twelve (12) months were leaner at one (1) year of age.⁵

Further research links the protein levels in infant formula and cow's milk with the development of obesity and chronic disease in adulthood. These findings have led to recommendations for infant formula composition to promote growth rates similar to that of breastfeeding infants.³

Research indicates that approximately one-quarter of children and adolescents aged between five and 17 years of age are considered overweight or obese (27.4%)⁶, and almost one-third of Aboriginal children aged between two and 14 years are overweight or obese.⁷ If current trends continue, the proportion of overweight or obese children and young people aged between 5 and 24 in 2020 could be as high as 41%. Table 1 shows the rates of overweight and obesity in Australian children.

Table 1: Weight status of Australian children

		Not overweight or obese (%)	Overweight (%)	Obese (%)
	2-4 years	Recent data is not available for children in this age group		
Age ⁶	5-9 years	75.7	17	7.3
	10-15 years	77	19.1	4.0
Gender ⁶	Male	77.8	16.5	5.7
	Female	74.9	19.8	5.3
All ages ⁶		76.4	18.1	5.5
Aboriginal children (aged 2-14) ⁷		70	20	10

Overweight and obesity incur a significant cost to the Australian economy, with estimates suggesting that in 2005 overweight and obesity cost \$56.6 billion.⁸ Obese children under the age of 5 years were more likely to be hospitalised than non-obese children, and to cost the economy more than 1.5 times the cost of a non-obese child.⁹

Overweight and obese children and adolescents are likely to remain overweight or obese adults, thereby, increasing their risk of developing associated chronic diseases. Children and young people who are overweight or obese are more likely to experience poor physical health outcomes, such as type 2 diabetes, sleep apnoea and gastro-intestinal problems¹⁰, polyuria, polydipsia, type 2 diabetes; headaches; sleep problems/daytime sleepiness, abdominal pain; and hip or knee pain.¹⁰

As well as physical health concerns, overweight and obese children and adolescents may experience anxiety, sadness, body dissatisfaction, social isolation and depression; and avoid school. Typically, adolescents view the short-term psychosocial consequences of overweight and obesity (i.e. teasing and bullying, social exclusion, inability to participate in

activities) to be of greater importance than the long-term physical consequences (i.e. adult obesity and chronic diseases).¹¹

Research indicates that parents are poorly skilled at identifying weight concerns in their own children. Results from parent perception surveys highlight significant misalignment between parental perceptions of children's weight status and clinically robust population surveys.^{4,6}

Weight is often viewed as a sensitive topic for parents and their children. Many parents do not perceive that their child has a weight problem, and many others are not willing to acknowledge or address weight issues.⁷ Parent involvement, however, is critical to the success of any child's weight management intervention.¹⁰ The way the nurse approaches the issue of childhood overweight and obesity significantly influences parents' willingness to seek help and take action. In order to engage well with parents, nurses require a good understanding of parental views and circumstances, and a sensitive approach when broaching the issue.

Through the conduct of growth assessments including weight, length/height, head circumference and body mass index at universal and additional contacts (see Table 2), nurses are well placed to identify changes in growth trajectory. Additionally, nurses will undertake a holistic assessment of the child (and family) by gathering information from parents, identifying risk factors, reviewing previous health professional assessments (if available) and acting on professional judgement.

Table 2: Growth assessment opportunities

Growth assessment opportunities		Indicators of overweight and obesity	Additional Information
Universal contacts with length, weight, and head circumference	0-14 days 8 weeks 4 months 12 months	WHO chart Rapid increases or decreases on the percentiles Weight, length, or height increasing percentiles Weight or length / height above the 97th centile	For infants and young children, see Appendix A
Universal Plus contacts with height, weight and head circumference	Birth to 2 years	WHO chart Rapid increases or decreases on the percentiles Weight, length, or height increasing percentiles Weight or length / height above the 97th centile	For infants and young children, see Appendix A
Universal contact with height, weight and BMI	2 years	WHO/CDC BMI charts Rapid increases or decreases on the percentiles Weight, length, or height increasing percentiles Weight or length / height above the 97th centile Overweight >85th centile Obesity >95th centile	For infants and young children, see Appendix A
Universal Plus contact with height, weight and BMI	2 years plus	WHO/CDC BMI charts Rapid increases or decreases on the percentiles Weight, length, or height increasing percentiles Weight or length / height above the 97th centile Overweight >85th centile Obesity >95th centile	For infants and young children, see Appendix A
School Entry Health Assessment (SEHA) with height, weight and BMI	School entry	CDC BMI chart Overweight >85th centile Obesity >95th centile	For children in primary school aged see Appendix B
Targeted primary school assessment with height, weight and BMI	4 years plus		For children in primary school aged see Appendix B
No assessments recommended for secondary school age students			For young people in secondary school see Appendix C

Additional monitoring and referral should be considered by nurses where a child's weight velocity increases within or across a centile and is not tracking in proportion to length/height.¹²

Parents/caregivers may view the identification of weight issues as a criticism of their parenting rather than a chance for their child or young person to achieve a weight within the healthy weight range. Rather than discussing weight directly, it may be more appropriate to discuss function. For example, a child's inability to sit comfortably on the mat or chair, or an inability to participate in physical activities may be easier to broach with parents/caregivers.

There are a range of risk factors for the development of obesity and overweight that are not modifiable. Risk and protective factors are included in **Appendix D: Risk and protective factors for childhood obesity**.

Key points

- While the cut-off points for weight categories on the BMI percentile charts are clearly defined, their application should be used with professional judgement and consideration of several factors when assessing individuals. For example:
 - Some children may have a higher than average muscle mass;
 - A BMI reference chart relevant to the ethno-cultural mix of the current Australian demographic has not yet been developed (NHMRC); Children who have ongoing obesity may grow in height faster than they are genetically predisposed. This may mask their obesity in BMI assessment¹². Plotting on height, weight and BMI charts will help to identify deviations
- Weight gain/loss diets for children and young people should be discouraged without first consulting a paediatric specialist or dietitian. Where possible, children should be encouraged to maintain their weight, and grow into it as they get taller.
- A focus on healthy behaviours for the whole family (good eating habits and daily physical activity) should be promoted. Successful long term weight management for children is most likely to be achieved in families who adopt healthier lifestyle habits as a family unit.
- The support and cooperation of parents/caregivers is essential when addressing overweight and obesity in children and young people. Although parents/caregivers may be unwilling to address a problem with weight at the first visit, raising the issue is an important first step which may lead to parents/caregivers being more receptive to discussions in the future.
- Changing norms in childhood weight have led to many parents/caregivers and young people now perceiving an overweight body to be 'normal'.¹³
- Approaching parents/caregivers to discuss overweight and obesity can be challenging. The following points are useful to keep in mind:
 - It is not recommended that weight assessment be undertaken with adolescents. Current best practice supports BMI being calculated at age 2 and school entry.
 - Undertake training or refresh skills available through Department of Health endorsed online training [Talking with parents/caregivers about children's weight](#)
 - Maintain open and honest communication to gain the parent's confidence.

- o Maximise the chances of a positive conversation by developing an understanding of the family situation.
- Refer children and adolescents to hospital or paediatric services if:
 - o They are aged between 2 and 18 years, and have a BMI above the 95th centile on US-CDC growth charts or the 97th centile on WHO growth charts ¹
 - o They are younger than 2 years, above the 97th centile on WHO growth charts and gaining weight rapidly ¹
 - o They have serious related comorbidities that require weight management (e.g. sleep apnoea, orthopaedic problems, risk factors for cardiovascular disease or type 2 diabetes, psychological distress) ¹
 - o An underlying medical or endocrine cause is suspected, or there are concerns about height and development.¹
- In extreme situations where parents/caregivers of severely obese children refuse to acknowledge the issue and will not attempt to make changes for the health benefit of the child, then nurses are encouraged to discuss the issue with their manager and/or Clinical Nurse Specialist. Also consider discussing with the child protection unit at PMH and refer to *Information Sheet 8: Child Obesity and Child Protection* (in Useful resources list at the end).

Documentation

Nurses will document according to health service provider processes.

Referral options

- Allied health professionals including; physiotherapist, occupational therapist, clinical psychologist or paediatrician.
- Community leisure and recreation services.
- Dietitian - some local health services (hospitals or community health centres) have dietetic services available for children. The Dietitians Association of Australia website can help to locate private dietetic services if no local services are available or the family requests private services.
- Healthy lifestyle programs or activities according to local availability.
- Medical /general practitioner.
- *PMH/PCH Healthy Weight Program* (formerly known as *CLASP*). For children and adolescents with complicated and/or significant obesity and their families (Medical practitioner referral to the Healthy Weight Program is required. Consider mentioning PMH Healthy Weight Program on CHS663 when referring a child to a medical practitioner).
- Note: *PCH Healthy Weight Program* can provide over the phone clinical advice and guidance to support nurses working with individual cases of concern where no suitable alternative referral options are available. Contact the intake coordinator nurse on (08) 64561111.

- Triple P (Group or Seminar Series) or other locally available parenting programs.

Related internal policies, procedures and guidelines

Body Mass Index assessment – child health
Body Mass Index assessment – primary school
Bullying
Eating disorders
Growth birth – 18 years
Growth faltering
Head circumference assessment
Health promotion in schools: Healthy eating
Health promotion in schools: Physical activity
Height assessment 2-5 years
Length assessment 0-2 years
Weight assessment 0-2 years
Weight assessment 2-5 years

Useful resources

Better Health Program 7-13 years - a multi-component healthy lifestyle program for overweight and obese children aged 7-13 years and their families. Available free of charge to families in various locations across the metropolitan area. Phone 1300 822 953 or email info@betterhealthcompany.org or visit <http://www.betterhealthprogram.org/>

Child and Antenatal Nutrition (CAN) Manual – CACH resource on nutrition topics from antenatal to school age children.

[Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults, Adolescents and Children in Australia](#)

[Eat for Health](#). Australian healthy eating guidelines for children aged 2 to 18 years

Food for kids

[Food sensations for adults](#), a free nutrition and cooking course offered by Foodbank in the Perth metropolitan area, Mandurah, Bunbury and Geraldton, or via video conferencing for community groups.

[Foodbank's breakfast program](#) currently supports 450 schools in WA, and 18,300 students

by providing free breakfast
Foodbank regional strategy providing nutrition programs in regional and remote WA schools.
Girls make your move is an Australian website with events, activities and inspiration to encourage girls of all shapes and sizes to increase their physical activity.
Guidelines for healthy growth and development for your child for parents of children aged 0 to 5 years
Healthy Weight Guide – Department of Health information and tools
Information Sheet 8:Child Obesity and Child Protection
Make your move- sit less. Be active for life a resource for parents of children aged 5- 12 years
Make your move- sit less. Be active for life a resource for young people
Raising children network factsheets on Obesity and overweight
Refresh.ED provides nutrition curriculum resources suitable for Kindergarten to Year 10.
Responding to bullying lesson planning and strategy information
Superhero foods online nutrition and health promotion resources for educators from Foodbank.
Talking with Parents/caregivers about Children’s Weight This resource from the Better Health Company is funded by the Department of Health and provides guidance and tips on how to raise the issue of overweight and obesity with parents/caregivers and caregivers.
Tips to support healthy choices (2-5 years) a resource for parents of children aged 2-5 yrs
Toddler tucker

Appendix A: Infants and young children

Birth weight

Infants born large for gestational age have a greater risk of obesity during infancy, and throughout the life course, while those at a low birthweight have an increased likelihood of developing central adiposity ('fatness') and metabolic syndrome in adulthood.¹

Growth velocity

- Rapid weight gain in the first weeks or months of life is associated with an increased risk of later overweight or obesity.¹⁴
- Early adiposity rebound which occurs at a rapid rate and to a great extent indicates subsequent risk of obesity development.^{1, 15}

Breastfeeding

- Exclusive breastfeeding initiation and continuation for a minimum of 6 months reduces the risk of overweight and obesity in childhood, adolescence and adulthood.¹
- Breastfed infants are able to self-regulate intake compared with formula-fed infants who may be guided by caregivers.¹⁶

Infant formula

- *The Infant Feeding Guidelines* developed by the National Health and Medical Research Council, state that infant formula with higher protein levels are associated with higher weight in the first two (2) years of life, but has no effect on length.³
- Infant formula has a different protein profile than breast milk, and often contains more protein. High protein infant formula has been associated with development of overweight or obesity, therefore, parents/caregivers should be encouraged to choose low protein formulations.³ The protein content in:
 - o human milk is 1.0 to 1.1 grams/100 ml
 - o cow's milk is 3.3 grams/100 ml
 - o infant formula (cow's milk) is 1.3 to 2.0 grams/100 ml (with goat's milk infant formula at the higher end of this range).
- If infant formula is given, it should be made up according to the instructions on the packaging to ensure correct concentration.³ Suggested quantities for various ages on the packaging are a guide only.

Solids timing and introduction

- Early introduction of solid food to an infant's diet has been related to obesity. Research has found that infants fed formula exclusively or in combination with breast milk were more likely to be introduced to solid food prior to 4 months than infants exclusively breastfed.^{17, 18}
- Infant temperament may determine when solid foods are introduced by parents. Parents may misinterpret the behavior of active or unsettled infants, and provide them with solid foods earlier than mothers of more sedate infants.¹⁹

Division of feeding responsibility

- It is a parent's role to offer a range of healthy foods, and a child's role to choose what, how much, and how often to eat. It is recommended that children over the age of 2 are
 - Offered 3 meals and 2-3 snacks
 - Offered water as the only drink.²⁰
- Allowing children to choose how much they would like to eat, allows them to listen to their own hunger and satiety cues, protective against the development of overweight and obesity.²⁰

Feeding style

- Parent feeding styles have been demonstrated to be influential on the development of overweight and obesity in young children.^{21,22}
- Monitoring children's intake, restricting foods, or food groups from children's diet and emotional feeding are all related to childhood weight gain and the development of obesogenic eating behaviours in young children.²³
- These practices, undertaken by parents/caregivers in an effort to improve children's health or weight, may actually lead to children seeking out restricted foods and overeating.

Movement opportunities

- It is recommended that children in this age group be physically active:
 - Children aged 1 to 5 should be active for at least 3 hours per day, spread over the whole day. From birth, children should be physically active, and parents/caregivers should be encouraged to allow infants to have supervised floor play throughout the day. Guidelines suggest that children should not be sedentary for more than one hour, with the exception of the time spent sleeping.²⁴
 - Screen time limits should be set for young children. Children under the age of 2 should not have any screen time, and children aged 2 to 5 years should be limited to less than one hour of screen time per day.²⁴

Appendix B: Primary school children

According to statistics from the *Longitudinal Study of Australian Children*, rates of obesity and overweight in middle childhood appear to be relatively stable.²⁵ However, children who are overweight in childhood are likely to remain so, and the likelihood of attaining a healthy weight in adulthood becomes more difficult.^{26, 27}

Early Detection

The National Health and Medical Research Council (which compiles evidence for screening programs) suggests that community health services have an important role to play in identifying children who are gaining weight too quickly.¹ Nurses may be able to conduct a weight assessment, provide brief intervention where appropriate, give information, and provide referral, liaison and support for students and their parents/carers.

Serial measurement

To monitor growth and the effect of the intervention on body composition, the length or height and weight of the child should be measured every 3 months, and his or her growth plotted on the age- and gender-specific BMI centile chart. A dramatic change in growth rate is cause for concern and further investigation is warranted. Both rapid increases and rapid decreases in BMI (even for children who are overweight or obese) can indicate a problem and relate to negative health outcomes. Once initial goals are achieved, less intensive monitoring may be appropriate.¹

Parental support

Parents/caregivers should be encouraged to seek help early for overweight and obesity in their child, as behaviours are more easily adapted in younger children.²⁶ Successful long term weight management for children is most likely to be achieved in families who adopt healthier lifestyle habits as a family unit.²⁸

Physical activity and sedentary behaviour

Children aged 5–12 years should accumulate at least 60 minutes of moderate to vigorous intensity physical activity every day.

School aged children should:

- Limit use of electronic media for entertainment (e.g. television, seated electronic games and computer use) to no more than two hours a day.
- Break up long periods of sitting as often as possible.
- Between 9–11 hours of sleep per night is recommended for school-aged children (ages 6–13 years).²⁹

Health promoting schools

Since overweight and obesity in middle childhood has serious long-term consequences for children's health, nurses should raise awareness about obesity and overweight in the school community and advocate for parents/caregivers and the whole school community and advocate for positive lifestyle being involved in anti-obesity interventions.²⁸

School Health Service policy and the *Memorandum of Understanding* for provision of school health services outlines the importance of health promotion and endorses the Health Promoting Schools Framework. Ideally, nurses working in the school setting should seek opportunities to work collaboratively with teachers, health committees and others in the school community to promote health. Specifically in relation to addressing obesity

among school age children and young people, broad health promotion approaches would include influencing school policy and ethos in relation to physical activity, healthy eating, the discouragement of food-related rewards and positive mental health including anti-bullying and positive self-esteem. Obesity prevention strategies need to be consistent and long term (over several years) in the school setting to reach intended obesity reduction goals. This broad approach combined with more intensively supporting individual families in need has been suggested to have positive outcomes in reducing the development of obesity and preventing the progression of obesity where it already exists.^{30, 31}

For more information about school health promotion activities in the field of healthy eating, physical activity, healthy lifestyles and body image, refer to the *Health Promotion in Schools Resources* on the *CACH intranet/resources/school health*.

Appendix C: Adolescents

Puberty is a time of great change biologically, physically and psychologically, and is marked by changes in body composition, changes in physical activity, and eating behaviours.³² Young people are vulnerable to societal pressures and can often feel insecure and self-conscious about their bodies. Poor body image has been listed by young people as a top concern over several years, above depression, family conflict and drugs,³³ and can have long term physical and psychological influences on health.³⁴

Focus on healthy behaviours

There is extensive research on the role of stigma and anti-fat bias on the health of those who are overweight or obese³⁵ reinforcing the importance of the promotion of positive mental health in schools. Interventions with a whole school approach may be successful in overweight and obesity prevention³¹ It is beneficial to promote healthy lifestyle changes, such as having a healthy varied diet and adequate exercise, where health is not tied exclusively to weight loss.³⁶

Eating behaviour

Disordered eating behaviours, such as bingeing, extreme dieting, purging and starvation, are often practiced by overweight and obese youth³⁷, therefore it is imperative that nurses understand the dangers of such disordered patterns of eating. Unhealthy and extreme weight control behaviours are strongly associated with depression, anxiety, and higher levels of obesity due to the propensity for extreme dieters to gain back any weight lost, as well as additional weight.³⁷⁻³⁹

Prevention messages and programs should be similar to those undertaken in relation to eating disorders, i.e. they need to be sensitive, non-judgmental, discourage dieting and encourage young people to have a positive relationship with their bodies.³⁷

Health promoting schools

School Health Service policy and the Memorandum of Understanding for provision of school health services outlines the importance of health promotion and endorses the Health Promoting Schools Framework.

Ideally, nurses working in the school setting should seek opportunities to work collaboratively with teachers, health committees and others in the school community to promote health. Specifically in relation to addressing obesity among school age children and young people, broad health promotion approaches would include influencing school policy and ethos in relation to physical activity, healthy eating, and positive mental health including anti-bullying and positive self-esteem.

Obesity prevention strategies need to be consistent and long term (over several years) in the school setting to reach intended obesity reduction goals. This broad approach combined with more intensively supporting individual families in need has been suggested to have positive outcomes in reducing the development of obesity and preventing the progression of obesity where it already exists.^{30, 31}

Provide young person with support

Involve the young person's family if possible but be aware of their growing independence.¹ If the family and significant others are involved, encourage them to avoid talking about weight and to positively support a healthy body image, healthy eating and physical activity.

- Speak to the young person with and without his or her parent or caregiver

- Treat the young person as responsible and capable of contributing to decision-making
- Use language that is clear and easily understood, and avoid jargon
- Check regularly that what you are saying has been understood
- Avoid being judgemental by showing empathy and tolerance while still expressing concern for the young person's wellbeing
- Overweight or obese adolescents may experience bullying or low self-esteem, therefore provide mental health support as required
- Engagement might wax and wane, and requires attention throughout care. ¹

Physical activity and sedentary behaviours

- Young people aged 13–17 years should accumulate at least 60 minutes of moderate to vigorous intensity physical activity every day. ²⁴
- Young peoples' physical activity should include a variety of aerobic activities, including some vigorous intensity activity. ²⁴
- On at least three days per week, young people should engage in activities that strengthen muscle and bone. ²⁴
- Young people aged 13–17 years should minimise the time they spend being sedentary every day. To achieve this:
 - o Limit use of electronic media for entertainment (e.g. television, seated electronic games and computer use) to no more than two hours a day.
 - o Break up long periods of sitting as often as possible. ²⁴
 - o To achieve additional health benefits, young people should engage in more activity – up to several hours per day.
 - o Between 8-10 hours of sleep per night is recommended for young people (ages 14-17 years) ²⁹

For more information about school health promotion activities in the field of healthy eating, physical activity, healthy lifestyles and body image refer to the *Health Promotion in Schools Resources* on the *CACH intranet/resources/school health*.

Appendix D: Risk and Protective Factors for Childhood Obesity

GENETIC MAKEUP	CHILD DIETARY INTAKE	FAMILY ENVIRONMENT	PARENTING
<p><i>Risk Factors</i></p> <ul style="list-style-type: none"> Parental Obesity Ethnicity Conservative metabolism (tendency to store energy) Certain rare endocrine disorders (eg. Prader-Willi Syndrome). <p><i>Protective Factors</i></p> <ul style="list-style-type: none"> 'Active' metabolism (tendency to expend energy) 	<p><i>Risk Factors</i></p> <ul style="list-style-type: none"> Infant formula volume and composition High intake of energy dense, nutrient poor foods (e.g. fast foods, soft drinks) Early introduction of solids. <p><i>Protective Factors</i></p> <ul style="list-style-type: none"> High intake of low GI foods (e.g. whole grains, legumes) High intake of dairy foods (e.g. low fat milk, yoghurt) Eating a healthy breakfast 	<p><i>Risk Factors</i></p> <ul style="list-style-type: none"> Family has few economic resources <ul style="list-style-type: none"> Parent lacks nutritional knowledge Living in a regional or remote area.¹⁰ Parent does not recognise childhood obesity or is not concerned about it Parent has unhealthy eating habits (e.g. regular dieting, or overeating) <ul style="list-style-type: none"> Screen time Parent works long hours Parent uses the car for all transport. <p>Energy dense foods are available and easily accessible in the home.</p> <p><i>Protective Factors</i></p> <p>Parent has an active lifestyle Meals are eaten as a family Fruit and vegetables are available and easily accessible in the home</p> <ul style="list-style-type: none"> Child has access to safe outdoor playing areas Parent and child engage joint physical activities Parent offers transport to sporting venues 	<p><i>Risk Factors</i></p> <ul style="list-style-type: none"> Restrictive child-feeding practices (i.e. parent rarely gives child choices about what to eat and how much) Permissive child-feeding practices (e.g. parent accommodates child's dislike or avoidance of new foods) Coercive parenting style (e.g. parent shows anger when child misbehaves) Inconsistent parenting style (e.g. parents fails to follow through with discipline) Low self-efficacy (i.e. parent lacks confidence in managing child's weight related behaviour) <p><i>Protective Factors</i></p> <ul style="list-style-type: none"> Parent monitors child food intake and activity patterns Parent reinforces healthy behaviours (e.g. through praise and modelling) Parent sets firm limits about food and activity
EARLY GROWTH & DEVELOPMENT	CHILD ACTIVITY PATTERNS		
<p><i>Risk Factors</i></p> <ul style="list-style-type: none"> High birth weight Early adiposity rebound <p><i>Protective Factors</i></p> <ul style="list-style-type: none"> Exclusive breastfeeding for 6 months 	<p><i>Risk Factors</i></p> <ul style="list-style-type: none"> High levels of sedentary activity (e.g. >2hrs screen time per day) Poor sleep patterns (e.g. poor routines or sleep apnoea) <p><i>Protective Factors</i></p> <ul style="list-style-type: none"> Regular physical activity (e.g. >60 minutes moderate-vigorous organised activity or energetic play per day) 		

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