Childhood obesity: the guideline for primary care should form part of a whole-system approach

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See also pages 387 and 411 as well as www.cmaj.ca/lookup/doi/10.1503/cmaj.141285 and www.cmaj.ca/lookup/doi/10.1503/cmaj.150117

The guideline from the Canadian Task Force on Preventive Health Care on the prevention and management of childhood obesity in this issue has been developed with great care and rigour.[1] The guideline is published at a time when the problem of childhood obesity in Canada is a key public health priority. The problem does not appear to be "going away," and it is not restricted to Canada. The World Health Organization has recognized that this is a global problem and has set up a Commission on Ending Childhood Obesity.[2] The commission will review the science and evidence on implementation, monitoring and accountability for childhood obesity, and suggest a suite of interventions and options. The guideline from the Canadian Task Force will provide an important resource for the work of the commission.

The task force guideline is intended for those working in primary care, and it focuses on prevention and management. However, it is important to understand these recommendations in context. Because the efforts of the primary care workforce are just one part (and an integral part) of the "whole system," as outlined in a recent series of articles in the *Lancet*,[3–5] then this guideline is clearly relevant to other actors in that system.

It is worth stating up front that the task force guideline on prevention of obesity is not just about preventing overweight and obesity in children of ideal weight, nor should it be. The challenge of how we might adapt the current system to help prevent overweight and obesity includes our ability to provide universal and targeted interventions to groups of children who are a mix of ideal weight, overweight and obese (i.e., an average school class of children in most schools in Canada). In addition, the task force notes that these efforts must reach those most in need and must not increase inequalities.[6]

The guideline provides very useful guidance on how to perform continued growth monitoring of children within primary care. Accurate measuring of weight and height requires some attention to detail and adherence to protocols. There are many reports in the literature of sloppy measuring, even in primary care. The good news is that good monitoring is quick and easy to do, and provides invaluable data and useful feedback for the child and the child's family. Also, if these data are part of a longitudinal database used for formal record keeping, it can contribute to monitoring the prevalence of childhood obesity for the regions and country as a whole. There is another good reason for monitoring weight and height in children: this process can detect children who are underweight or underheight for their age and sex. A small percentage (but a substantial number) of children are undernourished, even in countries such as Canada.

The task force recommends that primary care practitioners do not get involved in public health programs that aim to prevent obesity in children. It is clear why this conclusion might be reached from the evidence base of randomized controlled trials in this area, but the task force should have been bolder and may have missed an opportunity to suggest that primary care services step up to be part of the network of people in a "systems-wide" public health approach to the prevention of childhood obesity.[4] The primary care team can play an important role in supporting, encouraging and advising the public health team. Tackling childhood obesity should not be seen in two halves — prevention and treatment. It is a continuum, and the grey area in the middle is actually where

Key points

- The primary care team can play a critical role in a "whole-system" approach to tackling childhood obesity.
- Routine measurement of height and weight is important, but to be useful, it must be done well.
- Children most in need are often most difficult to reach.
- Primary care practitioners must be able to work within systems where effective behavioural treatment interventions are readily available.

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many children lie for at least some time during their childhood.

Most of the recommendations by the task force relating to the treatment of childhood obesity are graded as weak. However, they offer the best possible advice given the evidence available. Many of the recommendations may seem obvious or could be considered common sense, but it is worth working through them in some detail. The first recommendation states that primary care practitioners should offer, or refer to, formal, structural behavioural interventions for weight management. But what does this mean for the medical doctor or nurse in a busy medical centre? The important point to take away is that the local health authority needs to translate these recommendations into useful guidance at a local level. For that to happen, local health departments need to scope what expertise and services are available and where. In some areas, this may mean that a dedicated nurse delivers these interventions. In other areas, referral to commercial weight-management programs that are specifically designed for children may be the best option. What we do know is that expertise in behavioural strategies is important in the delivery of the intervention, and the workforce delivering these interventions (even medical doctors and nurses) may benefit from relevant training in this area.

People cannot be blamed for looking for a quick fix to their problems with obesity. The task force recommends that the drug orlistat should not be given to children 11 years old or younger. The task force was less confident about making that strong a statement for older children; however, they do recommend that youths who are obese should not be routinely offered orlistat. In the same vein, the task force was confident that surgery should not be offered as a treatment for childhood obesity.

The treatment options suggested by the task force recommendations for the primary care workforce are limited, albeit evidence-based. It is important to consider the experience of primary care practitioners, seeing distressed children (and their families) who so desperately want to lose weight and "be normal." If practitioners are not able to offer drug treatments or bariatric surgery, they need to be confident in the behavioural interventions at their disposal. Because of this, it is key to understand that the primary care team is an integral part of a whole-system approach to tackling childhood obesity.

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