## Prevalence of overweight in Hunter primary school children – a pilot study

M Burgoyne<sup>1</sup> and CE Collins<sup>1</sup>

<sup>1</sup>Nutrition and Dietetics, School of Health Sciences, University of Newcastle, NSW, 2308

Australian children and adolescents are getting fatter. From 1985–1995, the prevalence of overweight in Australian children aged 7–15 years has doubled, whilst the prevalence of obesity has tripled (1). Using the 2000 International Obesity Task Force BMI for age cut points suggests that 20–25% of Australian children have a BMI indicating overweight or obesity (2).

Students were recruited from four Hunter primary schools of varying socio-economic status (SES) (2-low SES, 1-high SES, 1-mod SES). Anthropometric data was obtained from children who had parental consent to participate in the survey. The study was approved by the Hunter Area Health Service, the University of Newcastle and the NSW Department of Education Ethics Committees. Children were categorised, using the Cole BMI cut-points as either at a Healthy Weight (equivalent to an adult BMI < 25), 'At Risk' of becoming overweight (equivalent to an adult BMI > 25 to < 30) or Overweight (equivalent to an adult BMI > 30).

Of the 917 children who received an invitation to participate in the study, 290 children were weighed and measured. The average response rate across the schools was 31.6%. Of these 69% were identified as being in the healthy weight range, 19% in the 'at risk' group and 12% in the overweight group. The proportion of children in each category was not different across the four schools. The trends observed in this study suggest that childhood overweight and obesity in the 4 Hunter schools included in the study are similar to national statistics. However, due to the low consent rate of parents, it is difficult to determine if the children measured are truly representative of the schools' populations, therefore results cannot be generalised.

In conclusion, further studies are needed in the Hunter region to determine the true prevalence of overweight and obesity in school children. Methods of approaching parents and children need to address the low response rate to improve for future prevalence estimates.

## References

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