Systematic review of randomised controlled trials of interventions that aim to reduce the risk, either directly or indirectly, of overweight and obesity in infancy and early childhood

Sarah A. Redsell*, Barrie Edmonds†, Judy Anne Swift‡, Aloysius Niroshan Siriwardena§, Stephen Weng¶, Dilip Nathan** and Cris Glazebrook††

*Faculty of Health, Social Care and Education, Anglia Ruskin University, Cambridge, UK, †School of Health Sciences, Queen’s Medical Centre, University of Nottingham, Nottingham, UK, ‡Division of Nutritional Sciences, School of Biosciences, University of Nottingham, Nottingham, UK, §School of Health and Social Care, University of Lincoln, Lincoln, UK, ¶Division of Primary Care, University of Nottingham, Nottingham, UK, **Department of Child Health, Queen’s Medical Centre, Nottingham University Hospitals Trust, Nottingham, UK, and ††Institute of Mental Health, University of Nottingham Innovation Park, Nottingham, UK

Abstract

The risk factors for childhood overweight and obesity are known and can be identified antenatally or during infancy, however, the majority of effective interventions are designed for older children. This review identified interventions designed to reduce the risk of overweight/obesity that were delivered antenatally or during the first 2 years of life, with outcomes reported from birth to 7 years of age. Six electronic databases were searched for papers reporting randomised controlled trials of interventions published from January 1990 to September 2013. A total of 35 eligible studies were identified, describing 27 unique trials of which 24 were behavioural and three were non-behavioural. The 24 behavioural trials were categorised by type of intervention: (1) nutritional and/or responsive feeding interventions targeted at parents of infants, which improved feeding practices and had some impact on child weight (n = 12); (2) breastfeeding promotion and lactation support for mothers, which had a positive effect on breastfeeding but not child weight (n = 5); (3) parenting and family lifestyle (n = 4); and (4) maternal health (n = 3) interventions that had some impact on feeding practices but not child weight. The non-behavioural trials comprised interventions manipulating formula milk composition (n = 3). Of these, lower/hydrolysed protein formula milk had a positive effect on weight outcomes. Interventions that aim to improve diet and parental responsiveness to infant cues showed most promise in terms of self-reported behavioural change. Despite the known risk factors, there were very few intervention studies for pregnant women that continue during infancy which should be a priority for future research.

Keywords: infancy, prevention, obesity, overweight, intervention.

Introduction

Worldwide, more than 40 million children under the age of 5 were overweight or obese in 2011 (World Health Organization 2013). Over a fifth (22.6%) of UK children aged 4–5 years who were measured in 2012/2013 were either overweight or obese (Health and Social Care Information Centre 2013), with the highest rates found in children living in economically deprived areas and children from Black or Black British, Asian or Asian British ethnic groups (Health and Social Care Information Centre 2013). As a child’s weight at 5 years of age is a good indicator of future health (Gardner et al. 2009) and risk of obesity in adulthood (Dietz 1998), there is a strong case for early intervention that prevents or reduces the risk (National Institute for Health and Clinical Excellence 2006; Darzi 2008). The risk factors for childhood overweight and obesity are known and can be identified antenatally or during infancy. A systematic review identified significant associations between childhood overweight and maternal pre-pregnancy overweight,
smoking during pregnancy, high infant birthweight and rapid weight gain (Weng et al. 2012). Estimates vary, but between 25% (Ekelund et al. 2006) and 33% (Hui et al. 2008) of infants gain weight more rapidly than is desirable during the first 6 months of life and this is a strong risk factor for the development of childhood obesity (Baird et al. 2005; Monteiro & Victora 2005; Ong & Loos 2006). From the infant perspective, rapid weight gain may be modifiable with interventions targeting parental feeding practices. For example, a meta-analysis found breastfeeding decreased the odds of childhood overweight by 15% (Weng et al. 2012). There is no systematic review evidence regarding the protective effects of later introduction of solid foods (Sloan et al. 2008; Hawkins et al. 2009; Huh et al. 2011), shorter breastfeeding duration (Weyermann et al. 2006), higher energy intake (Ong et al. 2006), shorter sleep duration (Taveras et al. 2008), high maternal control over feeding (Farrow & Blissett 2006), sedentary lifestyle (Brophy et al. 2009) and the risk of childhood obesity. Responsive feeding (DiSantis et al. 2011) may be protective against childhood obesity.

Despite the epidemiological evidence and calls for prevention strategies targeting multiple risk factors that begin at birth (Dattilo et al. 2012), the majority of effective interventions are designed for older children (Waters et al. 2011). Hesketh & Campbell (2010) conducted a systematic review of obesity prevention interventions for children under 5 years of age. They identified five interventions for children under 2 years, all of which reported limited positive impact on feeding practices but not weight outcomes (Hesketh & Campbell 2010). This finding may be at least partially attributed to the focus of the review, which excluded some interventions that potentially modify rapid weight gain such as breastfeeding. It is clinically important to explore whether interventions exist that directly or indirectly address known risk factors (Weng et al. 2012) and to examine the impact of these interventions on the development of childhood overweight or obesity. This systematic review includes studies describing randomised controlled trials (RCTs) of interventions that aim to address the risk factors for childhood overweight and obesity identified in an earlier review by the authors (Weng et al. 2012). Interventions that commenced antenatally or during the first 2 years of life with outcomes reported from birth to 7 years of age are the subject of this review.

Methods

Inclusion/exclusion criteria

The inclusion criteria were:

Study design

Prospective studies that identified themselves as RCTs were considered for inclusion. No restriction was placed on geographical location or setting of the intervention programme.

Key messages

- The most promising obesity prevention interventions for children under 2 years of age are those that focus on diet and responsive feeding.
- Although the number of published studies on obesity prevention interventions for children under 2 years of age has risen exponentially since 2010, interventions for pregnant women with follow-up during early life are rare. This should be a priority for future research.
- Future interventions for obesity prevention in children under 2 years of age should consider the option of advising some families to offer lower protein formula milk together with behavioural change components.
- Future intervention development should explore the most appropriate behaviour change theory to use with parents of young children.
Participants
The participants were pregnant mothers, parents (carers, guardians) of infants <2 years old and healthy infants <2 years old.

Intervention
Behavioural and non-behavioural interventions were included in this review.

Comparison
Studies with any type of comparison group were eligible for inclusion.

Primary outcomes
The primary outcomes were infant/child body mass index (BMI), weight, weight gain velocity, weight-for-length and weight-for-age from birth to 7 years of age.

Secondary outcomes
Secondary outcomes were breastfeeding uptake and duration, timing of introduction of solid food, diet intake and quality, responsive feeding practices and physical activity from birth to 7 years of age.

Search strategy
A full electronic search was carried out in August 2012 and updated in September 2013. Six electronic databases (PubMed, Medline, CINAHL, PsychINFO, Cochrane, EMBASE and the Cochrane Library) were identified and searched for articles published from 1990 onwards. This was chosen as a cut-off because a scoping search could not identify trials of obesity prevention interventions in early childhood prior to this date. Full search terms are provided in Box 1.

Reference lists of articles identified using this strategy and of currently published systematic reviews were scanned to identify potential studies for inclusion in the review that may have otherwise been missed.

Two databases for the registration of clinical trials (http://www.clinicaltrials.gov/ and http://www.controlled-trials.com/) were searched to identify any ongoing or unpublished research trials. An advertisement was distributed to members of the Association for the Study of Obesity (UK) to identify ongoing and/or unpublished studies or those published in the grey literature.

Box 1. Search terms for review
1. child OR children OR infant OR newborn OR pediatric OR pre-school OR nursery OR nurseries or parent OR caregivers/education
2. ‘body mass index’ OR BMI OR ‘weight gain’ OR overweight OR obesity OR ‘body fat’ OR adiposity OR ponderal OR anthropometric OR growth OR ‘child development’ OR ‘body height’ OR ‘body weight’ OR weight-for-age OR weight-for-length
3. nutrition OR ‘complementary feeding’ OR baby-led OR ‘feeding interaction’ OR ‘formula feeding’ OR ‘formula fed’ OR ‘infant food’ OR ‘nutritional requirements’ OR ‘energy intake’ OR diet OR ‘diet therapy’ OR ‘feeding behavior’ OR ‘food preferences’ OR ‘breast feeding’ OR weaning OR parent OR ‘health education’ OR ‘health facilities’ OR ‘health promotion’ OR ‘physical activity’ OR exercise OR sedentary OR ‘tummy time’ OR sleep
4. prevention OR intervention
5. ‘randomized controlled trial’ OR RCT OR random OR ‘control group’
6. [1 AND 2 AND 3 AND 4 AND 5]
Quality assessment

The Jadad scale (Jadad et al. 1996) was used to assess the quality of published clinical trials based on the description and appropriateness of random assignment, blinding and the flow of patients.

Random assignment

Two points were awarded if assignment was explicitly stated as randomised (including the use of words such as randomly, random and randomisation) and the method to generate the sequence of randomisation was described and appropriate (table of random numbers, computer generated, concealed allocation, etc.). Otherwise, the trial scored zero points.

Blinding

Non-behavioural trials were awarded two points if they were double-blinded where neither the person doing the assessments nor the study participant could identify the intervention being assessed, or if in the absence of such a statement the use of ‘active placebos’, ‘identical placebos’ or ‘dummies’ were mentioned. Behavioural trials were awarded one point if single-blinded (as behavioural trials are not possible to double-blind) where the person(s) collecting and/or assessing outcome data were blind to participants’ group allocation, and the study assessed whether blinding had been a success. In all other cases, the trial scored zero points.

Flow of participants

One point was awarded if the number and reasons for withdrawal in each group were stated. If there was no statement on withdrawals or the description of withdrawals was incomplete, the trial was awarded zero points.

In addition, internal validity (i.e. was the intervention delivered as planned) and external validity (i.e. how generalisable is the delivery of the intervention to other settings) were examined in accordance with the evidence-based behavioural medicine (EBBM) guidelines (Davidson et al. 2003) for studies on behavioural interventions. Data were collected on whether trials on behavioural interventions reported (1) training of treatment providers; (2) supervision of treatment providers; (3) preferred treatment of choice of those investigating, providing and receiving the intervention; (4) treatment integrity; and (5) assessment of participants’ adherence to study treatment. Studies scored one point for each of these criteria.

Results

Figure 1 shows the flow diagram of the review process. Electronic searches identified 1784 titles and a further 27 were identified through other searches (see Fig. 1). Of these, 605 duplicate studies were removed. Two reviewers (BE and SR) screened 1206 titles and abstracts; of which, 1064 did not meet the eligibility criteria. The remaining 142 abstracts were eligible for full-text review. One full text study was translated from German to English (Jungmann et al. 2010). The 142 full-text studies were examined by at least two authors; of these, 107 did not meet inclusion criteria. The most common reason for exclusion was that the intervention was designed and delivered to a child older than 2 years of age. There were also a number of studies that met the inclusion criteria but on closer inspection it was revealed that the focus was on malnourished, underweight or low-birthweight infants rather than those with the potential to be overweight or obese. These studies were also excluded from the review. A total of 35 eligible studies were identified, describing 27 unique trials of interventions (24 behavioural and 3 non-behavioural).

Details of the main findings in relation to feeding and weight outcomes can be found in Supporting Information Table S2.

The interventions identified were heterogeneous and did not all directly target obesity risk during infancy. Interventions that met the inclusion criteria included those that tackled known risk factors, such as breastfeeding, but did not specifically focus on obesity prevention. Specific obesity prevention interventions and parenting interventions were identified and included in the review. The two reviewers proposed categorising the studies to reflect their intended outcomes. The proposed categories were discussed.
Trials of interventions that specifically addressed breastfeeding and lactation support were grouped separately from the diet and/or responsive feeding interventions. The reason for this was that these interventions emphasised improving uptake and duration of breastfeeding not obesity prevention. The diet and/or responsive feeding interventions included breastfeeding as a component but additionally addressed other aspects of infant feeding with outcomes focused on aspects of obesity prevention such as weight and parental feeding practices. The diet and/or responsive feeding interventions were considered distinct from the interventions that addressed general parenting and lifestyle. These interventions had some outcomes associated with obesity prevention, such as infant weight, but mainly measured aspects of parenting. Specific interventions addressing maternal health with outcomes reported during infancy were grouped separately. The non-behavioural studies reported weight but not feeding outcomes and were therefore assigned to a separate category.

**Nutritional and/or responsive feeding interventions**

Sixteen studies reported the findings of 12 trials of diet, nutrition and/or feeding behaviour...
interventions. These interventions were heterogeneous consisting of multiple components designed to improve energy intake and output and diet quality and/or feeding responsiveness. Four trials reported that the intervention had a significant impact on weight outcomes in the desired direction (Paul et al. 2011; Daniels et al. 2012; Wen et al. 2012; Verbestel et al. 2013). The most effective trials were either driven by behavioural change theory (Verbestel et al. 2013) or included diet, nutrition and parental responsiveness components (Paul et al. 2011; Daniels et al. 2012; Wen et al. 2012).

Seven interventions focused on parent education around diet and feeding practices (Lapinleimu et al. 1994, 1995; Watt et al. 2009; Scheiwe et al. 2010a; Wen et al. 2011, 2012; French et al. 2012; Jonsdottir et al. 2012; Campbell et al. 2013; Verbestel et al. 2013). In addition, these interventions included components to improve early physical activity (Wen et al. 2011, 2012) and reduce sedentary behaviours (Campbell et al. 2013; Verbestel et al. 2013). Only one of these interventions (Healthy Beginnings) was successful at improving the duration of breastfeeding (Wen et al. 2011, 2012), whereas most of the specific breastfeeding interventions reported this as a successful outcome (Morrow et al. 1999; Kramer et al. 2001, 2002, 2007; Bhandari et al. 2003; Agrasada et al. 2005; Bonuck et al. 2005; Agrasada & Kyllberg 2009). The Healthy Beginnings home-visiting trial reported positive intervention effects on children’s fruit and vegetable intake, along with others (Watt et al. 2009; Scheiwe et al. 2010a; French et al. 2012), and an increase in an aspect of physical activity known as tummy time (supervised infant laid prone on mat) (Wen et al. 2011, 2012). The Healthy Beginnings trial also reported that parents delayed the introduction to solid food following their intervention (Wen et al. 2011, 2012). The Melbourne Infant trial reported reductions in television watching (Campbell et al. 2013) and a trial by Verbestel reported reductions in screen time following their intervention (Verbestel et al. 2013). The Melbourne Infant trial reported a reduction in sweet snack intake (Campbell et al. 2013) and a trial by French reported a reduction in juice intake (French et al. 2012). Healthy Beginnings included an educational component around parent–child interaction and the authors report a significant reduction in parents giving food as a reward (Wen et al. 2011, 2012).

Three of these studies report outcomes in contrast to the desired direction. Watt et al. (Watt et al. 2009; Scheiwe et al. 2010a) reported that the intervention group infants were heavier when compared with controls at follow-up. Although Verbestel et al. (2013) reported that their intervention had a positive impact on weight outcomes, dietary-related behaviours became less healthy in both groups over the study period.

Three interventions included components to help parents understand about responsiveness to infant cues as well as teaching them about diet and feeding. Infants receiving the NOURISH intervention (Daniels et al. 2012, 2013) had a significantly lower BMI-for-age z-score than those in the control group (intervention, 0.23 ± 0.93; control, 0.42 ± 0.85) at 9 months of age. The control group was also more likely to show rapid weight gain from birth to 9 months of age [odds ratio (OR) = 1.6, 95% confidence interval (CI) = 1.1 to 2.4]. Mothers in the control group were more likely to use non-responsive feeding practices that overrode child satiety signals ($P < 0.001$). Although there were no significant differences in anthropometric measures between the groups at aged 2, the intervention group mothers had significantly fewer controlling feeding practices and exhibited more instrumental feeding and parental encouragement to eat (Daniels et al. 2013).

Black et al. (2001) also provided education around (1) recognition of infants’ cues; (2) non-food strategies for managing infant behaviour; and (3) mother–grandmother negotiation strategies. Mothers in the intervention group were nearly four times more likely to adhere to the American Academy of Paediatrics guidelines on infant feeding (OR 3.8: 1.6–9.1) compared with mothers who did not receive the intervention. Kavanagh et al. (2008) delivered a behavioural intervention to formula-feeding caregivers in the Special Supplemental Nutrition Programme for Women, Infants and Children. The intervention, comprised information about infant satiety cues and formula milk preparation, only had a positive impact on parents’ knowledge about feeding. Infants’ growth
in the intervention group was greater than in the control group.

The SLIMTIME intervention (Paul et al. 2011) was delivered to 160 first-time mothers who intended to breastfeed. This intervention focused on responsive feeding rather than diet. A significantly slower rate of weight gain was reported for infants receiving ‘soothe/sleep’ intervention suggesting that educating parents of infants about responsive feeding may be more beneficial than dietary advice alone.

Finally, a unique study by Fewtrell et al. (2012) compared the weights of infants receiving one of two different types of bottle design with a breastfed reference group and found no significant differences in anthropometry at 2, 3 and 4 months post-partum.

**Breastfeeding promotion and lactation support interventions**

Seven studies reported the findings of five trials of breastfeeding promotion and lactation support interventions (Morrow et al. 1999; Kramer et al. 2001, 2002, 2007; Albernaz et al. 2003; Bonuck et al. 2005; Chapman et al. 2013). The majority of interventions demonstrated highly significant improvements in the outcomes assessed, which included uptake, duration and exclusivity of breastfeeding (Morrow et al. 1999; Kramer et al. 2001, 2002, 2007; Bhandari et al. 2003; Agrasada et al. 2005; Bonuck et al. 2005; Agrasada & Kylberg 2009), with two studies reporting significant improvements only in some of the outcomes assessed (Albernaz et al. 2003; Chapman et al. 2013). The PROBIT (Kramer et al. 2001, 2002, 2007) trial reported that infants in the intervention sites weighed significantly more at 1 month of age but this difference was not significant by the age of 12 months.

**Parenting and lifestyle interventions**

Four trials were identified that delivered broad parenting and health interventions, with infant feeding components, via home visiting. These interventions had a significant impact on feeding behaviours but overall, this type of intervention reported fewer improvements than those focusing exclusively on diet feeding. Johnson et al. (1993) provided peer mentoring for first-time mothers via home visiting. Cow’s milk was introduced significantly later to infants in the intervention group and they consumed significantly fewer inappropriate foods. The Miller Early Childhood Sustained Home-Visiting (MECSH) intervention also provided sustained and structured nurse home-visiting to improve parenting and family health (Kemp et al. 2011). Intervention infants were breastfed for significantly longer duration than controls. The MOMENTS trial (Cupples et al. 2011) delivered a home-visit intervention which aimed to reduce health inequalities for women living in socio-economically deprived communities of Northern Ireland. The intervention did not have an impact on breastfeeding or weight outcomes. PROKIND (Jungmann et al. 2010) found no effect of a home-visiting intervention to improve maternal mental health and child health on infant weight at 12 months of age.

**Maternal health interventions**

Three trials were identified where an intervention was delivered to a woman either antenatally or postnatally with outcomes that potentially had an impact on the infant. However, none of these interventions led to significant improvements in the infant’s weight in the desired direction. Dewey et al. (1994) delivered an aerobic exercise intervention to breastfeeding women which had no impact on the volume or content of breast milk or on infant weight at 12 weeks. The INFAT trial (Hauner et al. 2012) found that the intervention resulted in prolonged gestation and that infants in the intervention group had higher birthweight ($P = 0.019$), weight-for-length ($P < 0.01$) and BMI ($P < 0.01$) than infants in the control group. However, no differences in body weight were found at 6 weeks of age. Laitinen et al. (2009) evaluated an intervention starting in the first trimester of pregnancy which focused on counselling around a balanced healthy diet containing plant stanol ester products (e.g. soft margarine). There was no effect on infant weight at birth or over the first 12 months of life.

**Formula milk interventions (non-behavioural)**

Three studies (one trial; Koletzko et al. 2009; Socha et al. 2011; Escribano et al. 2012) investigated the
effects of providing infants follow-on cow’s milk formula with lower or higher protein contents on weight gain. Weight gain velocity was significantly greater in the infants fed higher protein milk from birth to 6 months. Group differences were greatest at 12 months of age; infants fed with lower protein content formula had a significantly lower mean weight-for-age z-score, mean weight-for-length z-score and mean BMI z-score than infants who received higher protein content formula. At 24 months of age, infants who received formula with lower protein content had a weight-for-length z-score 0.2 lower (95% CI 0.06 to 0.34) than infants who received formula with higher protein content.

Two further trials investigated the impact of infant formula containing hydrolysed protein on growth (Rzehak et al. 2009; Mennella et al. 2011). Both found infants grew more slowly when fed hydrolysed protein formula. Infants who received the extensively hydrolysed casein formula in the GINI trial had significantly slower sex-adjusted BMI gains from 8 to 48 weeks of age, but not beyond (Rzehak et al. 2009). Mennella reported that infants fed with hydrolysate formula had significantly lower weight-for-age z scores from 3.5 to 7.5 months and significantly lower weight-for-length z scores from 2.5 to 7.5 months. The weight-gain velocity of infants fed with hydrolysed protein formula conformed to the World Health Organization (WHO) norms, whereas the weight gain velocity of infants consuming the cow’s milk formula exceeded the WHO growth norms over the study period. This study was predominantly non-behavioural but some behavioural aspects were reported. In particular, infants fed with protein hydrolysate formula were satiated with less formula that those fed cow’s milk (Mennella et al. 2011).

Quality assessment

Quality assessment was undertaken by two reviewers (SR and BE). Each reviewer initially scored the papers separately and then they met to agree the ratings. Where there was disagreement, the two reviewers re-read the paper and justified their rating to each other. The final ratings were agreed through further discussion. Full details about the quality assessment ratings can be found in Supporting Information Table S3.

Unsurprisingly, non-behavioural interventions scored higher on the Jadad scale than behavioural studies; but clearly, it is not possible to conduct double-blind behavioural studies. Thirteen trials were considered to have used an appropriate method of randomisation for the allocation of participants to experimental groups. Of the remaining trials, the method of randomisation was not described in enough detail in the study protocol or associated research articles to determine whether the method of randomisation was appropriate. Five trials were considered to have used an appropriate method of blinding and, where appropriate, had evaluated the success of blinding. All of these trials were of non-behavioural interventions. Behavioural interventions trials usually did not report if the blinding process had been evaluated, nor if it had been successful. Thirteen trials reported participants flow adequately. The remaining studies failed to provide adequate descriptions for study attrition. Quality problems were inconsistent between papers and the majority of trials had some limitations.

Internal and external validity of 24 behavioural intervention trials was assessed using the EBBM criteria. Descriptions of the training received by intervention providers in the delivery of the intervention varied considerably in the trials reviewed. Five trials (Kramer et al. 2001, 2002, 2007; Albernaz et al. 2003; Jungmann et al. 2010; French et al. 2012; Campbell et al. 2013) reported that the intervention was delivered by health care professionals (HCPs) (e.g. nurses, dieticians, consultants) who received additional training in intervention delivery. Two trials (Watt et al. 2009; Scheiwe et al. 2010b; Cupples et al. 2011) stated that the intervention was led by peer supporters or other voluntary workers after receiving training in the intervention. The intervention was delivered by HCPs without further training in four trials (Lapinleimu et al. 1994, 1995; Wen et al. 2011, 2012; Daniels et al. 2012, 2013; Jonsdottir et al. 2012). Two trials reported intervention delivery by trained personnel, but offered no details of their training or professional
status (Kavanagh et al. 2008; Hauner et al. 2012). Three trials did not state if treatment providers had been trained (Dewey et al. 1994; Laitinen et al. 2009; Paul et al. 2011).

Two trials (Albernaz et al. 2003; Cupples et al. 2011) reported on the level of supervision received throughout the study period by staff delivering the interventions. Intervention provider or participant preference for allocation to the intervention or control group was not specified explicitly in any of the trials reviewed. Dewey et al. (1994), however, reported the number of women who declined participation to avoid being assigned to the control group.

Adherence (i.e. whether or not the intervention was received by participants) was reported in 11 trials (Dewey et al. 1994; Lapinleimu et al. 1994, 1995; Kramer et al. 2001, 2002, 2007; Albernaz et al. 2003; Watt et al. 2009; Jungmann et al. 2010; Scheiwe et al. 2010b; Cupples et al. 2011; Paul et al. 2011; Wen et al. 2011; Daniels et al. 2012, 2013; Campbell et al. 2013). Adherence was typically monitored by recording the number of classes attended or home visits received. Five trials (Kavanagh et al. 2008; Watt et al. 2009; Scheiwe et al. 2010b; Cupples et al. 2011; Daniels et al. 2012, 2013; Campbell et al. 2013) indicated that attempts had been made to monitor whether the intervention had been delivered as planned. The majority of behavioural interventions lacked theoretical underpinnings and where theory was used this tended to focus on individual behaviour change rather than change at the environmental or system level. One trial used social learning theory (Black et al. 2001); one used social support (Watt et al. 2009; Scheiwe et al. 2010a); one used the health belief model (Wen et al. 2011, 2012); one used Kolb’s experiential learning cycle (Kavanagh et al. 2008) and one used an information-processing, elaboration-likelihood, precaution-adoption process model (Verbestel et al. 2013).

Discussion

Main findings

This review identified interventions designed to reduce the risk of overweight and obesity from birth to 7 years of age which included those that commenced antenatally and/or during the first 2 years of life. A wide range of heterogeneous interventions were identified, the majority of which were multi-component. Behavioural (n = 24) and non-behavioural (n = 4) interventions were tested in 27 trials and reported in 35 articles dating from 1994 to 2013. Twenty of these articles were published since Hesketh and Campbell’s review in 2010 (Hesketh & Campbell 2010).

The finding that specific interventions that promote breastfeeding and lactation support were effective in improving the uptake and duration of breastfeeding has been previously established. There is strong evidence from systematic reviews that any antenatal breastfeeding education (peer counselling, lactation counselling and formal breastfeeding education) can increase uptake of breastfeeding and duration (Morrow et al. 1999; Lumbiganon et al. 2011). Epidemiological evidence suggests that any breastfeeding may be protective against the risk of childhood obesity (Weng et al. 2012) but none of the breastfeeding trials identified in this review reported a positive effect of the intervention on infant weight in the first 2 years of life. Nevertheless, breastfeeding-support interventions should be available to all women, particularly those whose infants may be at greater risk, e.g. those mothers who are overweight/obese.

The majority of multi-component interventions showed positive effects in relation to an aspect of infant diet or responsive feeding behaviours (Black et al. 2001; Paul et al. 2011; Wen et al. 2011; French et al. 2012; Campbell et al. 2013; Daniels et al. 2013). However, the NOURISH (Daniels et al. 2012, 2013) and Healthy Beginnings trials (Wen et al. 2011, 2012) appear to be more effective than the Melbourne Infant Trial (Campbell et al. 2013) and other trials that focused on diet and dietary practices (Lapinleimu et al. 1994, 1995; Watt et al. 2009; Scheiwe et al. 2010a; French et al. 2012; Jonsdottir et al. 2012; Verbestel et al. 2013). It is possible that the inclusion of components around parent interaction and responsiveness and adherence to behavioural change theory enhanced the positive impact for these trials. Future intervention developers may
wish to place more emphasis on these aspects par-
ticularly because the experimental psychology litera-
ture reports strong associations between maternal
responsiveness and control over infant feeding in the
development of childhood obesity (Farrow & Blissett
2006). Interventions specifically designed to build
maternal self-efficacy around infant feeding, which
combine behavioural components, such as responsive
feeding and soothing strategies with specific dietary
advice and anticipatory guidance around feeding
behaviours, may lead to more sustainable changes.
Further work is needed around the theory of
behavioural change that might underpin the devel-
opment of educational interventions for parents in
this area.

Four trials reported that the intervention had a
significant impact on weight outcomes in the desired
direction (Paul et al. 2011; Daniels et al. 2012; Wen
et al. 2012; Verbestel et al. 2013) but this effect was not
present at later follow-up for one trial (Daniels et al.
2013). These small intervention effects may be due to
sampling strategy rather than sample size. All the
trials randomised groups of parents or prospective
parents, whose infants may or may not have been at
risk of developing childhood obesity, to preventative
interventions. The consequence of this is that inter-
vention effects may not translate to demonstrable
changes in anthropometry in samples where many
infants have a low risk of obesity.

Three non-behavioural interventions were identi-
fied which tested different types of formula milk. One
trial reported that infants given higher protein cow’s
milk formula feed grew more rapidly, when compared
with infants fed lower protein formula (Koletzko et al.
2009; Socha et al. 2011; Escribano et al. 2012). The
authors have subsequently published a further paper
which, although outside the remit of this review, dem-
onstrates that infants fed with lower protein formula
maintain their lower BMIs at school age (Weber et al.
2014). Although the formulas used in this trial were
all within the normal prescribed formulation range,
the higher protein formula milk was at the upper end
of an infant’s requirements. Two further trials
reported slower infant weight gain in infants fed
hydrolysed formula (Rzehak et al. 2009; Mennella
et al. 2011). One trial reported infants had better
satiation with less formula when fed hydrolysed
protein (Mennella et al. 2011).

All of the non-behavioural trials were all high
quality and blinded both researchers and participants
(parents) to intervention group. However, the issue of
‘blinding’ parents to different types of infant formula,
where there is evidence that consumption could lead
to higher or lower risk of obesity, is ethically question-
able. Parents, as health care consumers, have a right to
information about risk, however small, to enable
them to make an informed choice about their infant’s
diet (Have et al. 2013).

Clinical implications

There have been a number of calls for early preven-
tion of childhood overweight and obesity (Institute of
Medicine 2011; Laws et al. 2014). The findings of this
review could potentially support the development of
an early childhood obesity prevention strategy. The
review identified a number of interventions some of
which contained successful components. These com-
ponents could form the basis of a multifaceted
approach to obesity risk which has the potential to be
individually tailored by the health professional and
parent.

The findings of the non-behavioural trials suggest
that there is merit in further exploring the option of
recommending lower protein formula milk. However,
the formula milks used for these trials are not the
standard milks that are available for parents to pur-
chase over the counter. Of those that are available to
parents, ‘follow-on’ formula milks tend to have higher
protein content than first-stage milks. Raising
parents’ awareness of the different constituents of
formula milk and advising them to refrain from
upgrading their infants onto follow-on or toddler
milks may be prudent interventions in terms of reduc-
ing obesity risk. Although the evidence suggests that
recommending hydrolysed protein may be beneficial
for infants at risk of rapid weight gain, caution is
needed. The authors of this review suggest that using
formula derived from hydrolysed protein in the
absence of medical need may have adverse implica-
tions, i.e. allergies. Furthermore, hydrolysed protein
formula has a different taste from normal formula
and unless there is a medical need, parents may not wish to expose their infant to this.

Focusing support for obesity prevention on vulnerable families at greatest risk is another option. However, health professionals may find this difficult as they may perceive it to be stigmatising and fear it may jeopardise their relationship with parents (Redsell et al. 2010, 2013c). A debate is needed about the feasibility and acceptability of targeted vs. generic parental behaviour change interventions. Several tools are available that can identify infant obesity risk (Santorelli et al. 2013; Weng et al.; Weng et al. 2013), although these require feasibility testing prior to implementation in clinical practice. The team has developed the Infant Risk of Obesity Checklist (IROC) (Weng et al. 2013a) which, together with the findings from this review, has been incorporated into clinical guidelines for Public Health Nurses (UK health visitors) (Redsell et al. 2013a,b). The IROC tool and intervention strategies have been developed into an interactive, education programme for UK health visitors to use to facilitate discussions about obesity prevention with parents during routine home visits. The Proactive Assessment of Obesity Risk during Infancy (ProAsk) programme is delivered via digital technology and is currently being subjected to a feasibility trial, the results of which will be delivered in late 2016. Funding for this has been awarded by the UK Medical Research Council Public Health Intervention Development Scheme (MRC-PHIND PH01/14-15).

Limitations

The majority of behavioural interventions were not underpinned by a theory of change and where a theory was applied, this tended to be social-cognitive in nature targeting the individual and/or family rather than the environment or health system. This approach is appropriate where individuals might be at higher risk but this was not the case for the majority of studies which recruited general samples. Trial quality (Jadad et al. 1996) was an issue for the behavioural interventions and whilst lack of blinding is inevitable for this type of intervention, it was disappointing that many studies failed to adequately describe their randomisation method or attrition rates. Davidson et al. described five categories (training, supervision, preference, adherence and integrity) for assessing internal and external validity of trials of behavioural interventions (Davidson et al. 2003). Furthermore, although the interventions have been delivered by both trained volunteers and health practitioners, the majority of studies lacked sufficient detail to make valid conclusions about which might be most effective (Davidson et al. 2003). Reporting of participant adherence and fidelity of intervention delivery was variable and problems in these areas might explain the small effect sizes. Although not part of the EBBM criteria, this review also examined the application of behaviour change theory in the trials identified; for most interventions, this was underexplored and/or underreported. Intervention development for behavioural change in this area could benefit from greater attention to theory, supported by a robust trial design that includes the use of a checklist to ensure internal and external validity.

Two high-quality, systematic reviews of obesity prevention interventions delivered during early years have been published (Hesketh & Campbell 2010; Laws et al. 2014), one fairly recently (Laws et al. 2014). Both reviews broadly concluded that further research in this area is urgently needed. Although our review can only report the findings of completed intervention studies, there were a number of protocols of interest, e.g. Brambilla et al. (2010). Thirty-two ongoing RCTs that appear to have fitted the inclusion criteria were identified via the clinical trials registers (see Supporting Information Table S4). The findings of these studies may better inform strategies to prevent childhood obesity during infancy.

Conclusions

This systematic review was broad in range in order to identify any important interventions which have the potential to prevent childhood obesity. Interventions that aim to improve parental feeding practices, including infant diet and parental responsiveness to infant cues, showed most promise in relation to behaviour change but not weight. The option of advising some
families to offer lower protein formula milk is worthy of further exploration if imbedded into a multi-component intervention together with behavioural change components. Despite the known risk factors for child obesity, there were very few intervention studies for pregnant women that continued during infancy. Further research by the team will explore the feasibility of intervention to prevent obesity during infancy.

Acknowledgements

We would like to thank Pippa Atkinson and Vicki Watson (Nottingham City Care Partnership) for their contributions.

Source of funding

This work was funded by a grant from the Burdett Trust for Nursing.

Conflicts of interest

The authors declare that they have no conflicts of interest.

Contributions

SR (Reviewer 2) led the study, drafted the original protocol, screened 1206 abstracts, read the full-text papers, checked the Jadad and EBBM scores, identified the ongoing trials and drafted the paper. BE (Reviewer 1) refined the original protocol, undertook the searches, screened 1206 abstracts, read the full-text papers, undertook data entry, checked the Jadad and EBBM scores, drafted the Supporting Information tables and drafted the results. SW advised the team about review procedures and helped with data presentation. JAS, CG, DN and ANS refined the protocol, screened abstracts where there was disagreement between the two reviewers, read the full-text papers and co-wrote the paper.

References


vention to promote protective infant feeding practices to prevent childhood obesity: outcomes of the NOURISH RCT at 14 months of age and 6 months post the first of two intervention modules. *International Journal of Obesity* 36, 1292–1298.


Redsell S., Edmonds B., Nathan D., Siriwardena A.N., Swift J., Weng S.F. et al. (2013a) Guideline for UK Midwives/Health Visitors to Use with Parents of Infants at Risk of Developing Childhood Overweight/Obesity. Edited by Institute of Health Visiting. Available at:

Supporting information

Additional Supporting Information may be found in the online version of this article at the publisher’s web-site:

Table S1. Data extraction sheet.
Table S2. Main findings in relation to weight and feeding outcomes.
Table S3. Quality assessment and process evaluation.
Table S4. Ongoing registered trials.