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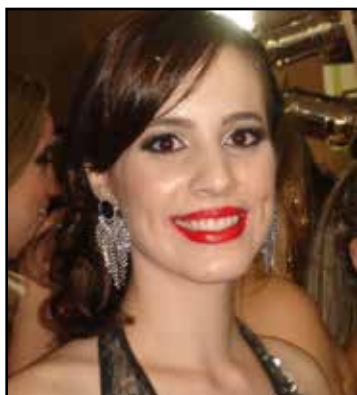
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Family perspective on childhood obesity and its forms of coping: a descriptive study

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ABSTRACT

Aim: to identify how the family perceives the health of the child with obesity and what strategies are used to cope with it. **Method:** descriptive research of qualitative approach. Data were collected between January and May 2014 through interviews with 14 mothers of obese children. The speeches were submitted to Content Analysis and Thematic Modality. **Results:** it was observed that some families did not recognize obesity as a health problem, while others identified complications. Encouraging healthy eating habits and practicing physical activities were the main coping strategies adopted by families. However, sometimes some practices harmed health. **Conclusion:** the family seems to recognize childhood obesity as a health problem when the child has complications and is now facing it. Health professionals should be aware of different ways of understanding and coping with childhood obesity so that they can act in a qualified manner.

Descriptors: Pediatric Obesity; Family Relations; Pediatric Nursing; Life Style; Public Health.

INTRODUCTION

Obesity is now a public health problem in the countries with high economic power and also in the less favored countries, where malnutrition and low weight were more evident⁽¹⁾. In addition, obesity has appeared more and more precociously, reflecting in the expressive increase of children with overweight and obesity⁽²⁾. For example, in 1990, there were 31 million (5%) of overweight children under five years of age and in 2012 they were already 44 million (6.7%)⁽¹⁾.

Obese children are more likely to become obese adults⁽²⁾. In addition, this health condition is associated with a variety of serious complications and an increased risk for premature diseases⁽¹⁾. With a view to fostering changes in the current scenario of childhood obesity, it is necessary to recognize it as a public health problem, develop preventive actions and develop effective treatments during childhood.

Thus, early detection of obesity, its control and treatment should encompass all social spaces in which the child is inserted, with emphasis on family involvement in this process⁽³⁾. In recent years, research has been conducted on the family's perception of the nutritional status of children⁽³⁻⁵⁾. However, there are still gaps in terms of the family's understanding of this disease and in terms of the actions developed within the family for coping with obesity.

In view of this, it was defined as the objective of the present research, to identify how the family perceives the health of the child with obesity and what strategies are adopted to face it.

METHOD

This is a descriptive research that uses a qualitative approach, performed in a medium-sized municipality in the southern region of Bra-

zil, through an interview with the main caregiver of the obese child. It was decided to carry out a qualitative research, since its focus is directed at the individual and society, with the purpose of deepening the knowledge about issues related to the daily life of the people, considering the interpretations about their experiences⁽⁶⁾. Thus, the phenomenon under study - understanding and coping with childhood obesity within the family - could be better understood through the qualitative approach.

For the selection of the subjects of the research, the database of the Food and Nutrition Surveillance System (SISVAN) of the municipality was used, thus allowing the identification of children aged between six and ten years old classified as obese. This system receives information from 63 teams of the Family Health Strategy (FHS), active in the 28 Basic Health Units (BHU) existing in the municipality, at the time of data collection.

From the information in this report, it was possible to contact those responsible for the child to be invited to participate in the survey. At this point, they were informed about the study's objectives and the form of participation desired. The initial contact with the family was by telephone, and with those who agreed to participate, a home visit was scheduled, according to their availability.

A questionnaire consisting of five questions was used in the interviews, which dealt with the perception of the child's current state of health, the family and child feeding routine, the attitudes that the family believed contributed to the reduction and/or increase of the child's weight and her knowledge about the topic of childhood obesity. We also used the visual scale of Tigge-man and Wilson-Barret⁽⁷⁾ with nine figures representative of the child's weight condition, figure one corresponding to low weight and figure nine to a child with the highest degree of obesity (Fi-

gure 01). The participants were asked to indicate the figure they believed corresponded to their child and the one who wanted it to correspond.

Figure 01. Set of Silhouettes for the evaluation of the Body Image



Source: Tiggemann and Wilson-Barret (1998)⁽⁷⁾

The interviews were recorded after obtaining the consent of the relatives. Then, they were transcribed in full and were submitted to content analysis, thematic modality⁽⁶⁾, involving three stages. In the first, the one of pre-analysis, the organization of the material occurred from the exhaustive reading of the reports obtained in the interviews. In the second stage, the exploration of the material, the registration units were cut out with the use of colored pens to identify the subjects worked. Finally, in the third stage, interpretation of the results, the discourses were confronted with the scientific literature to broaden the understanding of the phenomenon.

The study was carried out in accordance with the prerogatives established by Resolution 466/12 of the National Health Council and was approved by the permanent committee on research ethics involving human beings of the signatory institution (opinion no. 500.380). All participants signed the informed consent form. To preserve their identities, the discourses were identified by the order of the interview followed by the ages of the mother and child, according to the example: mother 1, 28 years - child, 9 years.

RESULTS

From contact with the child's primary caregiver, 13 mothers and one grandmother, ranging in age from 28 to 63 years, were informants in the study. In the identification of the speeches, all respondents were considered mothers, since the only grandmother participating in the research also performed this function for the child. The analysis of the discourses allowed the identification of two thematic categories: "recognizing the health state of the child and the consequences of childhood obesity"; and "development, maintenance and treatment of childhood obesity: family coping".

Recognizing the child's health status and the consequences of childhood obesity

Some mothers did not perceive obesity as a health problem, and in these cases, they referred to the presence of other pathologies as an obstacle to attain the desirable state of health. Others were able to recognize the condition of obesity and its influence on the health status of their children.

She's fine, thank God, except for the thyroid problem. But, it is under control. She had a rhinitis problem, but she also had surgery three years ago and the tonsils too (Mother 3, 42-year-old / Daughter, 9 years old).

She has always been healthy. Now she has diabetes, but she has always been a healthy child, though. She never had anemia and did not get sick (Mother 12, 30 / Daughter, 7 years old).

Mother 5, justified that, because the treatment of obesity is behavioral, it is not considered

as a disease. For her, the illness disease requires pharmacological treatment, medical follow-up or surgical intervention.

I don't consider [obesity] a disease, but it is critical. It is not normal to say that it is nothing. But I don't think it's a disease, because if you have a change in behavior you lose weight. Now the disease is not only a change of habit; you have to take medicine, make treatment, surgeries... (Mother 5, 31 years / Son, 9 years).

Childhood obesity was considered an illness only when it reached a morbid degree, especially when some consequences were already present or in cases in which the complications began to manifest.

I don't consider obesity a disease. Honestly, there are cases and cases. I know a child of her age who is like this [she demonstrates it by putting both arms away from the body], in this case, it's becoming a disease (Mother 12, 30 years / Daughter, 7 years).

In the study presented here, most of the children did not yet have negative physical reflexes due to overweight, and this made it difficult for the family to recognize it as a health problem. In the family's conceptions, the child presented good health, because he had appetite, performed physical activities without difficulties and did not present acute or chronic illness associated.

On the other hand, with the use of the visual scale, one can identify that the mothers recognized the excess weight. When questioned about which of the figures best represented the child's body, nine of them selected figure

seven, and five figures six. In relation to which of the figures the mother would like the child to resemble, four pointed to the previous figure selected as representative of current body status, four were anxious for the child to decrease two figures, four aimed at three figures prior to the selected one and two others that wanted the child to remain as he was.

These results showed that most of the mothers in the study, although they denied obesity as a disease, aspired to the weight reduction of the child, and some even aimed for a great decrease in body weight. Among the 14 mothers included in the study, 12 nodded at the child's overweight in the scale visualization. The reports of the other two mothers showed their tendency to minimize the problem of obesity in childhood and, at the same time, the reluctance to accept that the child is obese, even after the warning of health professionals.

She's a few pounds overweight, but I don't consider her fat. I don't see her as obese as they say. Because I take her to the post to weigh and say, "Mother, she's obese!", But I never saw my obese daughter (Mother 12, 30 / Daughter, 7 years).

In addition to not recognizing the condition of obesity as a health problem, one of the mothers revealed that she believed that excess weight was related to good health and that this condition is characteristic of a phase of the child's life, which tends to regress with the onset of puberty.

He was born skinny, weighing three pounds. But, I gave those vitamins to him, that's when he started getting fat. My mother and grandmother told me: "This boy is very skinny!". I began to give

[the vitamins] to him and began to gain weight (Mother 13, 29 / Son, 9 years).

Although some mothers did not consider childhood obesity a disease or had doubts about it, they were able to assume that certain complaints and embarrassments in the development of everyday activities could be derived from being overweight:

I don't know if obesity is a disease, but I know it causes a lot of diseases, that's right. Because I think if she was not as chubby as she is, maybe her little problem of not being able to sleep and her snoring would improve. She is fatigued (Mother 4, 34 / Daughter, 10 years old).

Sometimes he complains: "Mom, come help me put on my shorts, because I can't do it!" But why? I tell him that he is chubby, and it gets harder to wear his shorts, because his clothes get stuck on his curves (Mother 14, 31 / Son, 7 years old).

Other mothers went further and could glimpse the possibility of health damage in adulthood due to childhood obesity:

I know that obesity can lead to diabetes, cholesterol, high blood pressure [...] and he can have psychological or physical problems in the future (Mother 1, 28 years / son, 9 years).

It was observed, therefore, that many mothers in this study did not consider childhood obesity as a disease, although some believe that it may be responsible for the development of other diseases. Some mothers can even recognize the losses that excess weight may bring

on the child's quality of life and in the future, considering not only the physical but also the psychological and social sphere.

Development, maintenance and treatment of childhood obesity: coping with the family

When referring to the behaviors and strategies used by the family to deal with childhood obesity and to control the child's weight, attempts were made to change habits, especially in relation to eating and practicing physical activities. However, it was found that these transformations were incipient, punctual and were limited to the inclusion in the child's diet of foods considered healthy and the exclusion of those unhealthy, in addition to reducing the amount of each food served at the meal.

When he dines it is only once, I don't let him repeat. Now, sometimes, as I know he will want to repeat, I put a little less on the plate. I never ask him what he wants to eat; I put it on the plate and he eats it (Mother 14, 31 years / Son, 7 years).

The search and implementation of alternatives that could contribute to weight reduction were frequent, however, it was observed that strategies adopted by families were not always correct or beneficial, such as skipping or replacing the main meals.

Today, after I picked him up at school, he ate three small chicken drumsticks. So today he's not going to have dinner, if he wants to eat something, he'll eat a banana. There are other days when he doesn't have dinner as well (Mother 1, 28 years / Son, 9 years).

When the strategies of food change were not mentioned by the mothers it was because they did not recognize the fragilities in the feeding of their children. In these cases, they believed that the foods offered were healthier when compared to the diet of other children.

Where does this [obesity] come from? ...Because there is no such silly food in my house. There are kids who drink soft drinks every day, who eat sweets, chocolate, pastries; here he doesn't have it (Mother 8, 33 years old - 8 years old son).

In this direction, the following report shows that, in general, households had some knowledge about which foods are healthy and which should be consumed in moderation, but often did not have the financial conditions to enable them to purchase the most appropriate foods.

When we have fruits, she eats. We've only been eating white rice for two weeks now. The sausage and the carrot that my daughter told you about, it was because our neighbor gave us. But fruit, greenery, these things, only when we can buy it (Mother 3, 42 / Daughter, 9 years old).

Besides the search for a healthy diet, when possible, another strategy used by the families to promote weight reduction was the incentive to practice physical activities that motivated the child and thus facilitated their development. However, they made reference to some difficulties for their realization, such as financial or due to the lack of structure in the neighborhoods.

The hard part is that it's a long way from home to play sports here. I know there

are groups of children downtown, but how do we get there? It's complicated (Mother 6, 28 years old / Son, 6 years old).

It is worth mentioning that changes in routine were mentioned by mothers who recognized the complications of childhood obesity as a health problem, and especially in cases where the child already showed some difficulty due to overweight.

Fragilities in family habits were mentioned, especially in relation to feeding, which, in addition to not contributing to the weight reduction of the child, still competed to worsen their condition.

The food is not very healthy. We eat lots of bread, chips, stuff. And sweets! We eat lots of sweets (Mother 2, 28 years old / Son, 6 years old).

On the other hand, in addition to recognizing the failures in family eating habits that could help triggering childhood obesity, some mothers also identified factors that helped maintain this morbidity. Cases in which the family had a stressful bond or even families in which the child was suppressed and discouraged by the parents were revealed in the speeches:

Her father is very ignorant, he likes to deal with things just screaming. It's kind of complicated here. Sometimes he calls her fat, or, when she puts some clothes on, he says "Disgusting!". She gets upset (Mother 3, 42 years old / Daughter, 9 years old).

Moreover, the attitudes that the mothers considered to support the children were evidenced; however, the way in which they were

performed were in line with the child's current state of obesity. In one case, for example, the mother sought her daughter accept obesity as a genetic and irreversible condition, which did not contribute to the change in the family lifestyle.

I tell her that being chubby does not mean health, but neither is it illness; that she does not have to feel worse than her friends, because she's not the only fat girl; there are a lot of people who are like that. The problem is that the father and the grandmother are also obese, it is hereditary; there is no other way, unfortunately. No matter how much she closes her mouth, she'll never be skinny. That's what I try to pass on to her (Mother 9, 41 / Daughter, 8 years).

Reports from this category showed that most families were involved with changes in lifestyle and control of childhood obesity. However, in some cases, misunderstandings about diet, financial conditions and resignation in accepting obesity were obstacles to coping with the disease and improving the standard of living of children.

DISCUSSION

Admitting child overweight is not a simple task for parents, as identified in this and in other studies^(3,5,8). In a study carried out with the mothers of children attending the Basic Health Units in a municipality in southeastern Brazil, it was found that mothers of children with extreme nutritional status - malnutrition or overweight - were five to eleven times more likely to classify the child's nutritional status incorrectly⁽⁵⁾.

A qualitative study with parents of eight obese children showed that five of them saw the child as being thinner than she really was⁽⁹⁾. In addition, research in the United States of America has shown that obese children themselves had difficulty recognizing this condition⁽¹⁰⁾.

Blockages in considering overweight are often related to the non-recognition of obesity as a disease or health problems that it may cause (8). And considering the increase in the prevalence of obesity worldwide and in all age groups, it is possible that mothers consider the overweight of the children as a normal condition, mainly because they believe that obesity is spontaneously resolved at the time of early adolescence⁽¹¹⁾.

Similar perceptions were also observed in the present study, and the negative repercussions of obesity experienced by some children served as an alert to parents and made them recognize obesity as a problem. Now, they perceived the need to face the situation, which led them to seek alternatives for weight reduction, especially the changes in diet and the incentive to practice some physical activity.

The negation or lack of knowledge about the deleterious effects of obesity on health are factors that may postpone the search for professional help and the beginning of treatment^(4,9). Obviously, such help is necessary because obesity can cause breathing difficulties, orthopedic dysfunctions, increased risk for fractures, hypertension, insulin resistance, among others⁽¹²⁾.

It should be noted that the increasing incidence of obesity among children has made it possible for these pathologies to be diagnosed in younger age groups^(13,14). An example of this is the increase in cases of hypertension among overweight and obese schoolchildren^(15,16).

The fact that the mother is able to associate the child's excess body weight with

the health problems that the child already presents or the possibility of presenting, is a motivating for the beginning of the transformations in the lifestyle of the family, mainly in relation to the routine⁽⁹⁾. Health professionals should identify these skills and empower them for the appropriate treatment of obesity, as well as the health service in partnership with the school and the family should identify effective strategies. However, in this study, it is observed that families act according to their empirical knowledge for the management of childhood obesity; intersectoriality and integrality are inherent aspects in the health care of the child and should be considered in relation to obesity.

However, the change in the family is not always the most appropriate. An example of this is the incentive to substitute meals or even not to eat a meal, an attitude not recommended for the treatment of obesity, as this can cause harm to children's health and development⁽¹⁴⁾. The substitution of meals for snacks when requested by the child also establishes a common error and, once given, it will tend to repeat this strategy⁽¹⁷⁾.

Thus, it is necessary to consider the influence of parents on their children's eating practices in the long term. The family is considered the main environmental influence for the child, and their knowledge about food does not come only from their experiences, but also from the observation of the other's food behavior, and in these cases, given the proximity, the food choices of the family stand out⁽¹⁸⁾.

The reports also showed that the obstacles to establishing a healthy feeding routine for the child can extrapolate the disciplinary issues and involve the financial conditions of the family. Thus, the impediments to obtaining food had already been reported in another study, in which the mothers described the high price

of fruits and vegetables as a hindrance to the acquisition of these products⁽¹⁹⁾.

Extrapolating food issues, another important aspect to be considered in the development and maintenance of obesity is the lack of physical activity in quantity and quality. This turns out to be a vicious circle, because with the lack of physical activity, body weight increases, thus triggering obstacles that make the child feel unmotivated to practice physical activity, further aggravating obesity. Indeed, overweight children are notoriously those with the lowest levels of motor coordination when compared to eutrophic children, thus discouraging the practice of regular physical activities⁽²⁰⁾.

The adversities faced by the children during the practice of physical activities are, in some cases, recognized by the mothers, who mentioned, in addition to the lack of motor coordination, fatigue. However, mothers who acknowledge the importance of physical exercise for their children's health seek alternatives to motivate and encourage them. However, as mentioned by the participants, there are no regular physical activity programs available in the neighborhoods, that is, even if families recognize this need, the obstacle is access to this service due to lack of provision of these services.

The family can also intervene in the development and continuity of childhood obesity in other ways, such as the type of bond established between family members and the child. When conflicting relationships in the family are exposed, with fragile and stressful links, emotional insecurity is transmitted to children, so that the family is no longer recognized as a welcoming and safe environment^(8,20). Thus, there is a gap in the parental function, which can negatively affect the development of the child and reflect on the emergence of food diseases^(8,19).

It is also necessary to consider the genetic characteristics of the child that may predispose to obesity. In this sense, one of the mothers recognizes the daughter's genetic predisposition to obesity and encourages the child to accept it in this way. Although it is a positive attitude in which the mother values the child's well-being, at the same time, it can discourage her to seek alternatives for weight reduction, believing that, as a hereditary factor, there will be no regression.

Finally, for the success of interventions aimed at reversing childhood obesity, it is necessary to effectively participate and involve the entire family, especially parents, who are the primary caregivers and educators of the child in the early years of life^(8,19). Besides the family, the participation of the other contexts in which this child is inserted is important, starting with the school and in the last years, from the Health in the School Program, it is necessary that the articulation between health and education become effective, together with the family, to draw strategies that break with the mechanism of obesity. Thus, the influence exerted by parents and society is significant for the child to adopt healthier practices⁽⁵⁾, but also the support that the family transmits so that the child feels safe and encouraged to face obesity. Thus, it is necessary that family relationships be solid, constituting a warm and safe environment⁽⁸⁾.

CONCLUSION

The results of the research revealed that the majority of mothers recognize the excess weight of the children; however, this surplus is not always considered a problem capable of interfering in their health-disease process. Obesity, therefore, in general, is perceived as a disease only when it triggers complications, which

is worrying, since this delays the diagnosis of the disease and the beginning of treatment. It is also noticeable that some children already face the negative effects of obesity, mainly in the execution of simple tasks of the day and during the sporting practices and, in these cases, the families recognize more easily the obesity as a health problem when compared with those children in which the negative reflexes have not yet manifested.

Thus, the results of this study are expected to be able to sensitize health and education professionals, as well as their managers, by supporting the practice of those who deal with children and with families that coexist with childhood obesity. And it is suggested to professionals to ask the family about the possible changes already made to the problem of obesity, thus contributing to the elaboration of new and creative strategies for coping with childhood obesity within the family, considering the psycho-emotional and social aspects that involve the problem.

Finally, it is important to emphasize that, because it is a qualitative study, it is not feasible to generalize of its results and comparability should be proceeded with caution. Therefore, it is suggested that new, broader investigations and other methodological approaches, including other family members, obese children, health professionals and educators, be carried out to provide a better understanding in terms of how the family and the child understand and address the issue of childhood obesity.

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