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# Developing School-Based BMI Screening and Parent Notification Programs: Findings From Focus Groups With Parents of Elementary School Students

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School-based body mass index (BMI) screening and parent notification programs have been advanced as an obesity prevention strategy. However, little is known about how to develop and implement programs. This qualitative study explored the opinions and beliefs of parents of elementary school students concerning school-based BMI screening programs, notification methods, message content, and health information needs related to promoting healthy weight for school-aged children. Ten focus groups were conducted with 71 participants. Parents were generally supportive of school-based BMI screening. However, they wanted assurance that student privacy and respect would be maintained during measurement and that BMI results would be provided to parents in a neutral manner that avoided weight labeling. They also believed that aggregate results should be disseminated to the larger school community to support healthy change in the nutrition and physical activity environments of schools. Implications for practitioners and researchers are discussed.

**Keywords:** *childhood obesity; BMI screening; schools*

In response to a burgeoning childhood obesity epidemic, the Institute of Medicine (IOM, 2004) recently released a report that lays out a “prevention-focused action plan to decrease the prevalence of obesity in children and youth in the United States.” The report includes goals for preventing obesity in children and a set of related recommendations for government agencies, industry and media, community organizations, parents and families, health care professionals, and schools. One of the recommendations for schools is to conduct annual assessments of each student’s height and weight and body mass index (BMI) percentile and make this information available to parents. Schools, with their access to most young people, are optimum settings to implement BMI screening programs. Historically, schools have provided height and weight screening as part of a health screening process that has also typically included hearing and vision screening (Brenner,

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Burstein, DuShaw, Wheeler, & Robinson, 2001). However, budgetary constraints in recent years have resulted in schools eliminating or reducing height and weight screening of students. As important, it has not been a school routine to report height and weight results to parents or to calculate and report students' BMI and age- and gender-adjusted BMI percentiles.

Little is known about developing school-based BMI screening and parent notification programs. Initial efforts in Arkansas and Pennsylvania, where schools are now required by state law (Arkansas Center for Health Improvement, Act 1220, 2004) or state health department mandate (Pennsylvania Growth Screening Program, 2004) to notify parents of their child's BMI, indicate that school communities have concerns about school-based BMI screening programs. In both states, parents and school staff expressed negative reactions to the notification process, as well as concerns with regard to the school resources required to oversee a measurement and notification process (Dishongh, 2003; Holzman, 2003). Furthermore, because two thirds of adults are overweight (Flegal, Carroll, Ogden, & Johnson, 2002) and 30% of youth are overweight or at risk of overweight (Ogden, Flegal, Carroll, & Johnson, 2002), it is reasonable to assume that weight and healthy weight control will be a sensitive issue for many, especially overweight children and their parents, many of whom will also be overweight. Indeed, consideration of the needs and concerns of parents and children, the primary program recipients, is likely to be a central factor in securing community support for BMI screening and parent notification programs.

During the development phase of a pilot study that implemented and evaluated a school-based BMI screening and parent notification program, a series of parent focus groups was conducted. The primary aim of the focus groups was to gather information with regard to parents' opinions and beliefs about height, weight, and BMI screening at school and how to develop notification programs in a sensitive manner and convey supportive messages to parents and children about weight and healthy weight control. Focus groups are an effective and recognized method for collecting qualitative data from relatively homogeneous populations about attitudes, perceptions, and opinions that may influence important outcomes, such as community acceptance of new, potentially controversial programs (Krueger, 1994). The purpose of this article is to describe what was learned from parents about program development and implementation and factors likely to foster parent support for programs.

## METHOD

### Study Sample and Research Design

*Sample Selection.* Parents of students attending two elementary schools (kindergarten through sixth grade) were eligible to participate in the focus groups; participants were also required to read and understand English. The two schools were among a convenience sample of four schools in one suburban school district in Minnesota that agreed to participate in the pilot study. The two schools participating in the focus group sub-study were similar in size and student characteristics and demographics. On average, each school enrolled approximately 700 students, 21% of students were minorities, and 21% qualified for the free and reduced school meals program.

In both schools, annual health screening of students has occurred every fall and includes height and weight screening of students in all grades and vision and hearing

screening in selected grades. Schools inform parents about the screening in a number of ways that include a notice on the school Web site and in the school newsletter and a health services pamphlet that is distributed to parents of newly registered students. Active parent consent for students to participate in the screening is not required. However, both parents and students may forgo screening by notifying the school nurse about their preference. Screening is completed on most students. Parents of children who do not meet a standard "pass" criteria for hearing and vision screening are notified about results; results of height and weight screening are not routinely reported to parents.

*Focus Group Recruitment.* From October 2004 to January 2005, a parent recruitment advertisement was included in each school's newsletter (sent home with students) and posted on each school's Web site. Parents were invited to participate in a 60- to 90-minute group discussion about their opinions and beliefs concerning the health screening of students conducted at school, especially the height and weight screening. Focus groups were held at a school facility that was centrally located, conducted in the early evening, and offered on several weekdays between November 2004 and January 2005. Parents who participated received a complimentary light dinner and \$50 after completion of the focus group.

*Focus Group Format.* Focus group questions were developed by the study investigators and designed to solicit information about parents' opinions and beliefs concerning (a) school-based height, weight, and BMI screening programs, (b) a preferred BMI notification method, (c) message content, and (d) health information needs related to promoting healthy weight for school-aged children. Introductory questions asked parents to share thoughts about "schools providing health screening for students" and the need for "continuing height and weight screening of children in district elementary schools." Key questions focused on whether schools should "notify parents about the results of children's height and weight screening," and parent interest in "receiving information about your child's BMI," as well as information that would be "helpful when considering ways to promote and support a healthy weight for your child." A semistructured questioning route was used to ensure consistency across groups while allowing flexibility for parent participation level. Probes were used to elicit further discussion on responses. Each focus group was facilitated by a trained moderator (the lead author), with assistance from a co-moderator, and were audiotaped. The study was approved by the University of Minnesota Committee on the Use of Human Subjects in Research.

### **Data Coding and Analysis**

Audiotapes were transcribed verbatim to ensure systematic analysis of focus group discussions. Data were then analyzed using a thematic analysis approach described by Miles and Huberman (1994), with parent as the unit of analysis. Trained research staff reviewed each transcript and abstracted and organized data to facilitate data categorization. A coding template was developed that allowed data to be organized by topics and issues relevant to implementing a school-based BMI screening and parent notification program, using the structured framework provided by the moderator's questioning guide, described above. Once coded, participant responses were categorized into pertinent themes, such as "parent concern regarding the screening process" and "uses for BMI data other than parent notification." A matrix was created that allowed for the tabulation of themes both within and across focus groups. Results were then compared, contrasted, and

rank ordered to create a textual summary of focus group findings. To control for possible bias during the data abstraction and reduction process, each focus group transcript was independently reviewed by two trained research staff. Any differences between abstractors were discussed and resolved and data abstraction was amended accordingly.

## RESULTS

### Sample Characteristics

Seventy-one parents agreed to participate in focus group discussions. Ten focus groups were conducted and the average group size was 7 (range = 5-9). Most participants were female (90%) and Caucasian (96%). The average age was 39 years (range = 27-49). One half of the parents had a college degree. A similar proportion of parents worked part-time and full-time, 42% and 41%, respectively, whereas 17% reported not working outside the home. About one half of the parents had one child enrolled in a study school, whereas 42% had two children and 8% had three. The proportion of parents with a child in a specific grade was as follows: kindergarten (17%), first grade (10%), second grade (9%), third grade (20%), fourth grade (11%), fifth grade (17%), and sixth grade (16%).

### General Opinions About Health Screening

Nearly one half of the parent participants were unaware that annual health screening (hearing, vision, height, and weight screening) was done at school. Among parents familiar with the screening process, most were supportive of height and weight screening and all were supportive of the hearing and vision screening. Many parents questioned why height and weight screening was done if results were not shared with parents or used for a purpose, such as surveillance. Similarly, most felt that if schools were conducting height and weight screening, results should be reported to parents. Several parents felt that height and weight screening was important because it would aid in the early detection of important health conditions, such as eating disorders, diabetes mellitus, and obesity.

- "It [height and weight screening] just seems like useless information if no one's going to communicate it to anybody." (FG-4; Page 3; Participant 1)
- "If they're going to be doing this [height and weight screening], instead of just collecting data, or just some poll or whatever they're doing, they need to inform the parents so that parents are aware of what's going on with their children, if they may be at risk or if they may not be at risk." (FG-7; Page 2; Participant 7)
- "I think that screening for weight and height is great, because you can catch so many problems as kids that you can nip in the bud before they become adults. You know, like, diabetes or obesity in general." (FG-3; Page 2; Participant 4)

### Concerns About the Screening Process for Height and Weight

Parents expressed several concerns about height and weight screening at school. A primary concern was the location of the screening and the privacy of students during the measurement process. There was also concern about children's behavior during the screening, especially teasing among children. Several parents, who had volunteered to assist with health screenings, reported that children often had a tendency to share screen-

ing results with each other. A few parents were concerned about the accuracy of the results and only a very few were concerned with the out-of-classroom time required to conduct the screening. There were a few concerns about the use of parent volunteers, which involved the training needs of volunteers and privacy concerns, as parent volunteers had access to private health information of other children.

- “And I’m thinking, for the weight thing, my kid’s a little heavy. You know, if he steps on the scale, if there’s any other kids around they’re like, ‘Oh, look what he weighs.’” (FG-2; Page 3; Participant 1)
- “I have seen kids comment on ‘you’re so short,’ ‘you’re so tall,’ ‘you’re so fat.’ You know, I’ve heard it all there. And I think from very early on they’re very in tune to those things. So maybe to make it more confidential if it’s going to continue.” (FG-1; Page 5; Participant 5)
- “And then I would also say that it is a matter of the kids’ confidentiality. These kids need to be respected and give them the privacy that they need. . . . I’m not saying just pull out the heavy kids. Treat them all the same and have it be a private matter.” (FG-3; Page 6; Participant 3)

### **Indications for Height and Weight Screening at School**

Several parents felt that school-based height and weight screening was more important for children and families who were without health insurance or had limited access to health care. Others indicated their children did not need height and weight screening done at school because they see a health care provider regularly. Others felt that screening during elementary school was not necessary, as overweight usually resolves as children age. A few participants felt that parents “know” if their child is overweight. However, more participants believed parents might be unaware of a child’s emerging weight problem, whether underweight or overweight. Several parents believed that school-based height and weight screening was beneficial because older children and healthy children do not routinely visit a health care provider.

- “I pay a lot of money to go to the pediatrician of my choosing, I don’t need them [schools] to do this [height and weight screening]. . . . I understand that there are kids who don’t get it, but so, is there a way of identifying kids who need it?” (FG-3; Page 4; Participant 5)
- “But don’t you think that as a parent, looking at your child, you’d be able to tell if they were overweight or not and you don’t need the school necessarily to weigh them in front of their classmates and tell them they’re overweight.” (FG-3; Page 2; Participant 3)
- “Because usually, once your kids get to a certain age, past kindergarten, they’re only going in every, what, they go in at 7 and then again at 12 for immunizations, and unless they’ve got a chronic problem, they’re not seen for height and weight. So some parents would go, ‘Wow, I didn’t know.’” (FG-8; Page 6; Participant 3)

### **Reporting Body Mass Index**

Many parents felt that BMI was a more meaningful indicator of a child’s weight status than height and weight alone: “It kind of makes the information useful.” Some felt that BMI and age- and gender-adjusted BMI were valuable because they were not measures they could easily calculate themselves. Others thought parents could use BMI to assure a child overly concerned about weight issues that he or she is within a normal weight range. Several parents thought BMI would be a “wake-up call” or “warning sign” for many parents, alerting them about an emerging weight problem that needs attention.

- “I think if you’re going to take the time to screen them you should add the BMI, because that puts it in context and takes away the ‘you’re fat,’ ‘you’re short,’ the ‘you’re whatever.’” (FG-1; Page 19; Participant 5)
- “I think that BMI would really be helpful. So there are a number of kids that are, well, slightly overweight, but you think, well, they’re just a little overweight. But if you got their BMI and found out, oh, this is a bigger deal than I thought, I think there’s a number of parents that would act more on it than parents that wouldn’t.” (FG-1; Page 15; Participant 2)
- “For normal weight children it would be like, gosh, you’re exactly where you should be. And if your BMI was right on it wouldn’t matter if you weigh 10 pounds more than your friend because you’re 3 inches taller.” (FG-1; Page 16; Participant 2)

### Notification Process

Most focus group participants felt that all parents should be notified about the results from the height and weight screening and provided BMI information. Because of budgetary concerns, some felt that only parents of children with BMI values outside a healthy weight range should receive notification. Most believed the information should be mailed directly to parents. Mailed information was perceived as more confidential; it would also allow parents the flexibility to decide whether and how to share the information with the child and family. Other ideas for conveying BMI information to parents included having teachers deliver the information to parents at teacher-parent conferences and having parents who desired the information call the school nurse. Some reported being comfortable with their child bringing the information home in a sealed envelope. Only a very few were okay with receiving an e-mail or including the information on a child’s report card. Alternatives to mailing were viewed by many as less costly, however, most were concerned about maintaining confidentiality, children’s access to the information without parental guidance to interpret results, and burden to school staff.

- “I was going to say, if you’re going to take the time to do all kids, all parents should know. I mean, that might be the only screening that some of these kids get. And then the parent, at least, maybe will be a little bit relieved to know that their child is fine. But I know you’re talking financially, for all the stamps.” (FG-9; Page 9; Participant 2)
- “You’d have to do everybody [notify about results], because otherwise, I think you would just feel, I think it might make people defensive more.” (FG-10; Page 14; Participant 3)

### Message Content

Focus group participants felt that BMI would be an unfamiliar concept for some parents and not well understood by others, so whatever the method of notification, it was important to include a simple, easy-to-understand explanation of BMI and how to interpret results. Many parents felt that an impersonal “nuts and bolts” message, containing a child’s measurement and BMI information and a recommendation to follow-up with a health care provider if concerned would be better accepted by parents than a message “labeling” a child as overweight (as determined by the BMI percentile ranking) and “prescribing” a specific plan of action. Some felt that regardless of how the message was presented, there would be parents “offended by hearing that *their child* has a potential health problem.” However, most participants felt that “the majority of parents want to know [about child’s BMI] so they can take care of their kids” and that it would ultimately be “up to the parents to decide what they want to do with the information.”

- “If I were to get the information, I would not want them stating on there that your child is overweight. I would want it to be, here is the information, you make the decision, we’re giving you the information, you take it from there.” (FG-7; Page 14; Participant 1)
- “It might just be me, but as far as being sensitive to what comes about the kids, I don’t think that I would be. Like I said, any information that’s going to come, if I think it’s relevant I’ll use it how I think it’s best. . . . But at least I’ve got the information as quickly as I can have it, to do what I have to do for one of my children.” (FG-10; Page 15; Participant 4)

In addition to BMI information, participants believed the notification process should also include healthy eating and activity recommendations that are appropriate for all family members, not solely the child who is the subject of the notification. Indeed, several felt that the general focus of the letter should be on family and family change to foster healthy lifestyle habits. There were also recommendations to include addresses for Web sites with diet and activity suggestions, as well as a BMI calculator so parents could check their own BMI and/or “double-check” the BMI calculations of their child/children.

- “And it shouldn’t be just focused on the kid. . . . Maybe it could be a wake up call to the parents, too. Gosh, my child’s a little bit heavier. Maybe I am too. Just to change the lifestyle of the whole household. I mean that’s ideally what I would like to see.” (FG-1; Page 17; Participant 2)
- “I’m a single parent. I work two jobs . . . the health thing is always an issue. Having a child that’s overweight, having him get picked on is just such a big thing. Yet, trying to have him eat healthier . . . nothing has really worked. I don’t know if I haven’t tried hard enough. But just to get some feedback and maybe some resources that can help me with our lifestyle today, with getting on track.” (FG-2; Page 11; Participant 3)

### Uses for BMI Other Than Parent Notification

In addition to parent notification, focus group participants identified several other uses for school-collected BMI data. Among these, the most frequently mentioned was the use of data to improve the school food environment, which primarily included providing healthier school meals, but also allowing students more time to eat meals, limiting a la carte choices to healthier foods, and eliminating the use of candy and sweets as rewards and incentives for students. Many parents also felt that data could be used to justify increased “gym time” and “more recess” for students. Several parents identified the need for schools to “partner” with parents to provide a consistent message of support for healthy eating and physical activity. Many parents also favored reporting prevalence data of overweight among school children to both the school and the general community and local and state policy makers in order to justify and procure budget support for a healthy school meal program and more physical education. Several parents recognized that annual BMI screening provided a method for following or tracking the weight status of individual students, as well as groups of students over time. For a few parents, these other uses of school-collected BMI data were viewed as more valuable than parent notification alone.

- “I think having it published, too, is helpful. It’s going to get the school board members, the legislators, all aware that . . . Whoa, look at this. What are we doing? What do we need to change? Oh, the lunches, maybe. . . . I think that would be great because then we would have more firepower to go to the school board and say this needs to be changed. You’re making our kids unhealthy.” (FG-3; Page 21; Participant 3)

- “I think that if I had a child that had a high BMI and they would tell me that risk and that maybe I should consult the physician and here are some suggestions of what you can do. I might think, well, what are you [the school] going to do? Are you going to let them have recess? Are you going to improve the school lunches? Yes, I’m the parent and I’m ultimately responsible, but don’t be a hypocrite.” (FG-4; Page 8; Participant 2)
- “Because if we’re going to go through this whole process of weighing them and figuring out where they fit with all the other kids, then we’ve got to get the schools to work with them too. I mean, my daughter’s in third grade and if your desk is clean you get a candy bar, and if you turn in all your homework on Friday you get a sucker.” (FG-6; Page 11; Participant 1)

## DISCUSSION

Prevention of childhood obesity has been identified as a “national public health priority” (IOM, 2004) requiring concerted action by many different sectors and at multiple levels if effective approaches to halt and ideally reverse the childhood obesity epidemic are to be developed, implemented, and sustained. Because schools offer access to the majority of U.S. children and youth, they are requisite participants in any plan that aims to reduce the incidence and prevalence of overweight among young people. Annual assessment of students’ height, weight, and gender- and age-specific BMI percentile and notifying parents of results is one school-based obesity prevention strategy advocated by the IOM (2004). Several schools and school districts across the United States have or are planning to implement BMI assessment programs, yet little is known about what parents think of programs and how to develop programs that will be parent-supported. Our findings suggest that parents of elementary school students are likely to support programs if careful and deliberate attention is given to how screening is conducted, how parents are notified of results, and whether outcomes are shared with important others, such as school administrators and state legislators, and used to support a healthy school environment. Indeed, our parent sample recognized that school-based BMI screening programs have the potential to effect change at both an individual or parent and child level, by providing personalized information that supports healthy individual and family change, as well as at a school level, by disseminating prevalence data that can be used to support school improvements that include more nutritious school meal programs and increased funding for physical education.

As schools consider implementing BMI screening programs, parent opinion and parent involvement in program development is viewed as critical to program success (Byrd, 2003). The concerns and suggestions voiced by parents participating in our study provide one template for a parent-informed school-based BMI screening program. According to study participants, parents want advance notice that health screening is being offered at school, what screening encompasses, and the option to decline participation. Parents desire confirmation that height and weight measurement is done in a private, respectful, and standardized manner, and steps are taken to minimize weight-related teasing among children. Preferably, the notification would be mailed to all parents, include BMI information, be presented in a neutral manner that avoids weight labeling, and provide family-oriented healthy eating and physical activity suggestions. Aggregate school-level data describing overweight prevalence would be shared with school, community, and state decision makers.

In contrast to media reports that describe parental response to school-based BMI screening programs as primarily negative (Byrd, 2003; Dishongh, 2003; Holzman,

2003), our results suggest that many parents view programs positively and believe they will benefit children, families, and schools. It is important that our parent sample believed that school-collected BMI information should be shared with both parents and the school community. Study participants felt that informed parents would be better prepared to assess a concern about weight changes in their child, whether the concern was overweight, underweight, or the need to reassure a child overly concerned about weight that he or she is a healthy weight. They believed parents informed about school-level prevalence of overweight among children would be better positioned to advocate for change at school that would improve their school's nutrition and physical activity environment. Finally, they felt that school, community, and state officials informed about overweight prevalence among children would be more likely to approve funding that supports healthy school change.

Our focus group participants also offered some important cautionary notes for those considering developing school-based BMI screening and parent notification programs. It is important to note that parents desired assurance that the measurement process would be private and respectful and that deliberate steps would be taken by school staff to minimize any weight-related teasing among children. Weight-related stigmatization is a reality for many overweight children (Neumark-Sztainer, 1999) and the negative psychosocial consequences associated with overweight, such as poor body image and low self-esteem, are well recognized (Ebbeling, Pawlak, & Ludwig, 2002). Student privacy during screening is therefore a requisite component of a school-based BMI screening program. Mass screening in a corner of the gymnasium should no longer be acceptable practice. Instead, screening should occur in a setting that provides both visual and auditory privacy. Recognizing that this may be difficult in many schools that are already space-challenged, it should nonetheless be a standard of practice for schools offering BMI screening programs.

There is also a need to consider who is collecting the measures. For example, is it appropriate to have teachers and parent volunteers collecting private, potentially sensitive health data from students or should measurement be provided by health services staff and, specifically, school nurses and the health assistants and/or nursing students they supervise? Furthermore, have those conducting screening received appropriate training that addresses both accurate data collection and potential psychosocial implications of screening, including guidance on how to address students questions about weight? Similar to space, adequate health services staffing is an issue for many schools and school districts. Nevertheless, appropriate staffing, preferably by health services staff, and staff training should also be considered a required component of a BMI screening program.

Another equally important issue is the potential for parents of overweight children to experience "victim-blaming." This possibility may be further compounded for parents who themselves are overweight or obese. Because parental obesity is a risk factor for childhood overweight, this is likely to be the case for many (Whitaker, Wright, Pepe, Seidel, & Dietz, 1997). It is critical, then, that those developing notification programs recognize the potential for parents of overweight children to feel blamed for their child's weight and strive to communicate weight-related information to parents in a supportive and neutral manner. Although there is potential for students, families, and schools to benefit from school-based BMI screening and parent notification programs, it is critical that schools considering or already offering such programs carefully attend to these important details if programs are to be constructive and supportive of students and parents.

BMI and age- and gender-specific BMI percentile are recognized as important tools in the prevention of childhood obesity (American Academy of Pediatrics [AAP], 2003;

Dietz & Robinson, 1998; Himes & Dietz, 1994; IOM, 2004; U.S. Department of Health and Human Services, 2001). Indeed, the AAP (2003) advocates the use of BMI in the assessment and early identification of excessive weight gain in children and recommends that health providers in pediatric ambulatory care settings calculate and plot BMI once a year in all children and adolescents. However, factors such as health insurance coverage, clinic access, and busy parent schedules limit the number of children receiving BMI screening in a health care setting. National data indicate that almost 9 million or 12% of U.S. children younger than 18 years of age have no health insurance coverage and 13% of these children reported no contact with a health care professional in more than 2 years (Blackwell, Vickerie, & Wondimu, 2003; National Center for Health Statistics [NCHS], 2004). Hispanic and non-Hispanic Black persons are more likely to lack health insurance than non-Hispanic White persons (NCHS, 2004), an especially worrisome finding given that overweight prevalence is disproportionately higher among Mexican American and non-Hispanic Black youth (Ogden et al., 2002). Even when health care access is not an issue, data suggest that few health providers assess a child's BMI and BMI percentile (Barlow, Dietz, Klish, & Trowbridge, 2002). School-based BMI screening and parent notification programs are not intended to displace the role and responsibility of health care providers in assessing and treating childhood overweight. Instead, programs can provide screening access to all school-aged children, regardless of insurance coverage and an opportunity for health care settings and schools to work together with parents to address obesity prevention and promote healthy weight among children.

This study has several strengths. It is one of the first to examine the opinions and beliefs of parents concerning school-based BMI screening and parent notification programs. Study participants represented parents with children in kindergarten through sixth grade. College-educated parents and those less than college-educated were equally represented and most parents worked outside the home. Standardized data collection procedures and analysis techniques were used to minimize bias and enhance internal validity.

This research is also subject to limitations, especially in the sample composition. The study represents the self-reported views of a convenience sample of primarily female, Caucasian parents from two elementary schools in one suburban metropolitan school district in the Midwest, thus limiting generalizability of study findings. Because some participants in the focus groups knew each other, they may have been less forthcoming in sharing their true beliefs and opinions. It is possible that the opinions and beliefs of parents who chose not to participate in the study differ significantly from those of participants. Study participants were limited to parents of elementary school-aged children and their opinions and beliefs about school-based BMI screening programs may not be relevant to programs targeting older youth attending middle and high school.

## IMPLICATIONS FOR PRACTITIONERS

Schools are logical settings to implement obesity prevention strategies that target children. School-based BMI screening and parent notification programs, one school-based obesity prevention strategy advocated by the IOM, are already in place in some schools and school districts and are being considered by many more. Program success is likely to be influenced by parent support, and parent support is likely to be fostered if parents are involved in program development. Our findings provide guidance for schools and school staff as they consider developing and implementing BMI screening programs. Study results indicate that program support will be enhanced by attending to issues that are

important to parents, such as assuring student privacy and respect during the measurement process and instituting a dissemination plan that informs both parents and the school community. Although parent support is a critical and core component of a successful program, factors such as financial support and competent oversight of the screening logistics will also influence program success. Our study does not address these issues. Furthermore, it remains to be seen if school-based BMI screening and parent notification programs will be an effective obesity prevention tool. This is an important hypothesis that merits testing and school communities, health care professionals, and researchers are encouraged to consider and include evaluation in program development plans.

School-based programs focused on reducing obesity prevalence are few, and fewer still have targeted the primary prevention of obesity. Although some of these studies have reported positive albeit short-term results, most agree that the efficacy of school-based interventions to prevent obesity has not been established (Centers for Disease Control and Prevention, 2005; Dietz & Gortmaker, 2001; Story, 1999). There is strong support for school-based obesity prevention programs, however, assessing weight among children in the school setting (whether as part of a screening program or as a component of research evaluation) has been identified as a possible barrier to school-based programming because of the stigmatization and discrimination that may occur as a result of the measurement process (Centers for Disease Control and Prevention, 2005; Neumark-Sztainer, 1999). Although this is a relevant concern, it may also be an opportunity for schools and those interested in school-based research to carefully evaluate how height and weight measurement is conducted at school and develop a measurement process that is respectful and considerate of students and fosters a school environment where weight stigmatization and discrimination is not tolerated. Findings from our focus group study with parents of elementary school students suggest that parents would support such an approach.

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