Author's response to reviews

Title: Barriers to successful recruitment of parents of overweight children for an obesity prevention intervention: a qualitative study among youth health care professionals

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Version: 4 Date: 6 April 2012

Author's response to reviews: see over
Dear editor,

Please find enclosed the second revision of the manuscript entitled ‘Barriers to successful recruitment of parents of overweight children for an obesity prevention intervention: a qualitative study among youth health care professionals’ (MS: 6177660156144866). We would like to thank you for giving us the opportunity to revise our manuscript and have made every effort to address the given comments. Changes in the manuscript are highlighted.

With regard to the reviewers’ comments, the following revisions have been made.

**Reviewer: Anthea Magary**

_Overall the authors have addressed the comments by the reviewers appropriately but now several matters are clarified I have some further comments._

We thank the reviewer for this compliment.

**Minor essential revisions**

**Methods:**

1. _Child obesity intervention: please identify the age range the intervention targets._

   The intervention aims at parents of overweight children aged 4 years. We have added this information in the Methods on page 5.

2. _I have problems with this explanation on page 5_  

   ‘and according to the physicians’ clinical judgement (based on their experience, expertise and the course of the weight pattern over time (phase 2), Children are identified as overweight using IOTF cut-points the internationally accepted (although statistical) definition. However clinicians make their own decision whether to classify the child as overweight. What experience and expertise are they bringing to this decision. I can understand the weight pattern over time (if that is available) and if the child is just above the cut-point. Also did the physicians assess potential risk factors such as parent weight status and child-family eating and activity behaviours._
I would like a clearer explanation. It seems to me that physicians made somewhat subjective assessments. Later a comment is made about weight over time. It would be interesting to know to what degree clinicians adhered to the IOTF cut-points.

We thank the reviewer for this critical observation. The usual procedure in the Dutch Youth Health Care is: 1) measuring child’s weight and height, and calculating BMI, 2) in case a child’s is slightly above the overweight cut-off, YHC professionals use their clinical view in order to assess weight status. This is also described in the Methods on Page 5 and 6 and in the Figure on Page 21. Indeed, ‘clinical judgement’ is a subjective procedure of YHC professionals that may have an influence on the selection procedure. However, we decided not to implement changes in the existing assessment protocols, in order to minimize pressure of work of YHC professionals.

We also did not cross-check their judgements with the IOTF cut-offs. Nevertheless, we do agree that this would be an interesting topic for future clinical studies, also in order to provide feedback to YHC professionals with the goal to optimize their clinical judgement skills. We added this in the Discussion on P. 14.

The following statement on page 10
‘the children who were overweight according to the guidelines were not always overweight according to their clinical judgement’
alerts me to think that physicians do not understand the derivation of the cut-points. And that a child will be classified differently according to whom they are assessed by. This should have been an issues discussed at the plenary sessions. It would be really helpful to know what criteria those making these comments use to identify a child with growth outside the healthy range. If a child is just overweight according to IOTF cut-points it is an alert, it is reasonable that no action is taken but suggest the child be measured again in 6 months. A child well into the overweight range runs the risk of increasing levels of fatness.

I wonder what language the physicians used when talking to parents about the child’s weight – it is well known this is a sensitive issue and it is important to use language such as health growth.

We feel that some additional explanation is needed regarding our role in defining the criteria for the assessment by YHC professionals and regarding the goal of our study. Clinical judgment is the diagnostic procedure that YHC physicians need to perform when a child’s weight is slightly above the IOTF overweight cut-off point. In these
cases, a physician determines whether the child is overweight based on their experience, expertise and the course of the weight pattern over time. In doing so, the YHC professional takes into account children’s build, pubertal stage, ethnicity, and distribution of fat throughout the body (Bulk-Bunschoten et al., 2004). We completely follow the reviewer’s idea that a child may be labeled as overweight by one physician and as normal weight by another. This potential lack of consistency was, however, not the topic of our study but this might be an interesting topic for future studies. Starting at the point where a child was labeled ‘overweight’ by the physician, we were interested in the extent to which the physician managed to refer the parents to an obesity prevention intervention. This process is therefore studied, in-depth, in contrast to a critical appraisal of the clinical judgement procedure. As indicated in our previous comment, we do however feel that this issue warrants further clinical studies. This recommendation is added in the Discussion on Page 14.

3. Page 6: reword as follows:

Based on YHC records and a national overweight prevalence rage in the age group of 14%, it was estimated that approximately 230 children were eligible…

However by the end of the referral period only 10% of eligible children had been referred, considerably less than expected.

How many exactly were referred and what proportion was expected (25%, 50% and based on what)

About 20 children were referred (approximately 10% of 230 eligible children). We expected this percentage to be at least double this percentage, based on Veldhuis et al. 2009. This information has been added to the revised manuscript (Page 7).

4. How many professionals in total were invited? 16 participated, it is possible to indicated the response rate but bearing in mind it would not be expected that all professionals from the 14 clinics would participate

All professionals working in the child health clinics in south Limburg (49 nurses and 25 physicians) were invited to participate in the current study. Of these, 16 professionals responded and were interviewed (22%). We noted that within these 16 interviews the saturation point was reached. We have added the response rate in the Methods (Page 7).
5. As described it appears it was only the physicians who attended the training, so why were other professionals invited to participate in the interviews? What impact does this have on the validity of the results? Did all the physicians who appeared to be responsible for the recruitment attend the training?

Although physicians have the main responsibility in referring children aged 3 years and 9 months, nurses are also responsible for signaling overweight in children in the age group of 0-4 years but see the children at other ages. Therefore, nurses were able to provide useful information in our study, in addition to the contextual information that was provided by the YHC managers. We have added this information in the Methods on Page 7. With respect to the contents of the training, we refer to our response to the next remark by the referee.

6. Was there an opportunity for attendees at the training to raise issues such as identifying an overweight child (eg the apparent distrust of cut-points), how to discuss overweight with parents. Suggesting parents attend a parenting intervention is potentially confronting and parents may take offence, was language suggested on how the intervention might be ‘sold’ to parents. The comment ‘intervention intense and time consuming’: suggests to me lack of understanding of the problem with respect to behaviour change and the change needed in family – it takes time and cannot be achieved through a single consultation. I’m thinking that there was probably scope for exploring some of these issues in the training which may have then resulted in physicians being better advocated for the intervention – its more than just better communication skills.

We think there is a misunderstanding here. We did not organize a training, but only a plenary information session, or introducing presentation, in which we informed professionals about the referral procedure. As stated before, we did not change existing procedures with regard to the assessment of child’s weight status. We fully agree with the reviewer that a training would be a suitable option to address potential problems on how to motivate parents for behaviour change. We therefore recommend in the Discussion to provide them with a training based on the results of our study (see Page 16).
7. Limitation is that many of those interviewed did not receive the training recruitment and so were not implementing the strategy but providing their views. A comment is recruited

We agree with the reviewer that the YHC nurses were not present at the plenary information session. The reason for this was that nurses were not involved in referring children to our intervention, because they do not have consultations with children aged 3 years and 9 months. They are however responsible for signaling overweight at other ages and therefore we decided to involve them in the interviews (see point 5).

8. I think the issue of social norms is important and warrants a comment in the discussion about how this might be addressed. This underlies the lack of awareness of parents which is a major barrier to recruitment and should be mentioned in the abstract conclusion.

We agree with the reviewer that the issue of social norms is important. In the discussion we mentioned that we expect that social norms towards participation in child overweight programs might change when evidence-based interventions are more prevalent and easily accessible. Indeed, the lack of awareness of parents was a major barrier and this underlines the issue of social norms. In the Discussion (Page 16) and in the Abstract (Page 2), we argued that parental awareness towards their child’s overweight should be addressed in future studies.

Discretionary revisions

1. Interviewees ‘perceived prevention of overweight and obesity as an important task of the YHC organization’

Is it possible to say what these interviewees considered their role to be in this process? It seems to me they have been given an excellent opportunity to identify children who would benefit from an intervention which is readily available but have not made a lot of effort to advocated for parents to support healthy behaviours in their children.

We agree with the reviewer that the YHC physicians were given an excellent opportunity to identify and refer overweight children. Although all interviewed professionals perceived prevention of overweight and obesity as an important task of the YHC organization, a range of barriers impeded the optimal referral. We added this information in the Discussion on Page 12.
Reviewer Karin Hannes

Dear editor, authors,

I feel that all of my comments have been addressed, accept the one on the type of design used (1st query). I have the feeling that the author team may not be fully aware of what design that have used, if any. They describe an interview technique, instead of describing the design. This is similar to stating that you have used questionnaires but then don’t specify whether you have conducted a cross-sectional or a longitudinal study. From the information added to the paper it is my guts feeling that the actual design used is an embedded mixed methods design, of which the results of the embedded qualitative part in the trial are reported in a separate paper. But I am not sure of what the actual design intention was and I can only make a rough guess. This is important methodological information, which should have been added as a way of showing that there was some epistemological reflexivity within the team on the qualitative part.

We apologize for our misunderstanding of the reviewers request for additional information. The reviewer is correct in that we used a mixed methods design (Polit & Beck, 2012). The present qualitative study was initiated to investigate hindering and stimulating factors for recruitment, based on disappointing referral numbers during a pilot study on a parenting intervention to prevent excessive weight gain in 4-year-old children. Quantitative results are part of an ongoing RCT. We added the information on which design we chose in the Methods on P. 7.