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Title	Childhood obesity prevention interventions in primary care: a qualitative study of perspectives of primary care clinicians and parents of 2-5 year old children
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Reviewer 1	Hasanain Ghazi
Institution	Kuala Lumpur, Malaysia
General comments (author response in bold)	1. Why the task force recommended against offering prevention at primary health level? **RESPONSE:** Thank you for this question. One of our authors (PB) was also a member of the Task Force which put forth this recommendation. Their recommendation against routinely offering structured prevention interventions was due to a lack of evidence in the literature for clinically important benefits for children at this time. In this guideline, the Task Force also identified a need for additional research into how primary care settings can best support obesity prevention efforts, and a need to explore parent preferences. We have highlighted this gap in knowledge as a rationale for our research in our introduction (pdf proof pg 5, lines 22-31). 2. It is unknown how many clinicians refused to participate? How many emails had been send out to see the response rate? **RESPONSE:** Thank you for this question. Our team had recruited clinicians with the help of a contact person at each study site; this was usually another clinician or clinic administrator, who forwarded the invitation to their respective teams. Because of this, we are unable to know for sure how many of those approached formally or passively declined to participate (no change in the manuscript). 3. Why phone interview? Why not face-to face interview like in-depth interview? **RESPONSE:** Thank you for this question. We recognize that there are distinct advantages to conducting interviews in person, however there were a couple of reasons why we chose to perform the interviews over the phone. The primary reason is that our study sites are relatively dispersed geographically, and it would have been infeasible to travel for the number of interviews that were conducted. We have added a sentence in the "Data Collection & Analytic Approach" section on page7 (lines 33-37) which reads: "All but one parent interview was held over the phone (one interview was done in person at the clinic), and ranged from 20-40 minutes; phone interviews were chosen due to the geographic dispersion of study sites." 4. Sampling method unclear? Is it purposive? **RESPONSE:** Thank you for this suggestion. Both clinician and parent participants were purposively recruited through several mechanisms described in the "Recruitment of Participants" on pages 6-7. While we did mention purposive sampling for clinicians (pg 6, line 42), the sampling method for parents is notably absent. We have edited wording in this section on pdf proof page 7 (line 9) to clarify that parents were purposively recruited as well: "At each site, parent participants were purposively recruited through several mechanisms…" 5. Why the three groups representations is not equal? 2-12 is a big range. **RESPONSE:** Thank you for this question. For focus groups, it is preferable to have 5-10 participants. Unfortunately we were unable to confirm attendance numbers in advance, since recruitment of clinicians was primarily through promotion of the study via our site contact persons. In fact, many clinicians made the decision to participate on the day of the focus group. While we did try to recruit a minimum of 5 participants for each clinician focus group, it was at times not feasible due to clinician availability on the day of the focus group. We were quite surprised when 12 clinicians arrived at our rural site focus group, however we felt it would be inappropriate to turn them away. We have edited our results section under "Participant Characteristics" and "Clinicians" (pdf proof pg 9, line 35) to reflect that attendance depended on clinician availability on the day of the focus group: "Seven clinician focus groups were held across the three sites (n = 40); attendance ranged from 2-13 participants, based on clinician availability on the day of the focus group." 6. Why all parents were females? **RESPONSE:** Thank you for this question. Our recruitment methods and materials were inclusive of males; all posters and flyers were worded to recruit "parents" which is gender-inclusive. However we had very few males approach us to participate; of two males who initially contacted us, neither completed an interview. This is an important limitation to our findings, and we have expanded our "Limitations" section on pdf proof page 14 (lines 39-43) to better highlight this. It now reads: "Our sample size for parent participants was relatively small, and parents were not diverse with respect to age, gender or ethnicity despite an extended recruitment phase, which limits the generalizability of our findings."
Reviewer 2	Jabir Jassam
Institution	Merrickville District Community Health Centre, Family Medicine, Merrickville, ON
General comments (author response in	1. What program you can apply in this age group? I might be more interested if the age is between 5-10 **RESPONSE:** Thank you for this question. Our team acknowledges that in order to be

bold)	effective on a population level, childhood obesity prevention interventions are needed for all age groups. In the current study, our target population focused on families of 2-5 year old children, given that obesity is observed this early, and that there are few preventative interventions specifically designed for this age group. We explored the perspectives of clinicians and parents through the lens of an existing obesity prevention intervention, which was designed specifically for families with children 2-5 years of age; behaviours addressed within the intervention are designed to be developmentally appropriate for this age group. 2. The authors are not MDs except one which makes their experience in the primary care setting is limited **RESPONSE:** Thank you for this comment. While only one of the authors is a primary care MD, the first author (NB) is a primary care registered dietitian, and second author's primary research area involves nutrition services in primary care settings (PB). In order to enhance reflexivity with respect to the research team, additional information on NB's role has been added under "Data Collection & Analytic Approach" (pdf proof pg 7, lines 41-51; pg 8, lines 9-13). 3. The number of primary MDs who participated is very low **RESPONSE:** Thank you for this comment. In our study, we had 6 MD participants in our focus groups; as a group, they were second most common participants. Our setting and sites represent one model of primary care which is team-based and interprofessional. In these settings, it is common for RNs as well as NPs to be highly involved in the provision of well-child care, and obesity prevention efforts. As such, adequate representation from RNs and NPs is essential to understand the context and setting of our results. We agree that it is important to note the limitations of conceptual generalizability of our results, in that they cannot be applied to understand other models of primary care (i.e., solo family MDs). We have added some content to our "Limitations" section to identify the limits to generalizability of our results (pdf proof pg 14, lines 33-39). It now reads: "While we engaged a variety of primary care clinicians from three different settings (urban academic, urban, and rural), we only recruited from the FHT model, which does not reflect the diversity of practices in Canada, and limits the generalizability of our findings.