Published in final edited form as:

Child Health Care. 2013 ; 42(3): 198–213. doi:10.1080/02739615.2013.816590.

Strategies for Recruitment and Retention of Families from Low-Income, Ethnic Minority Backgrounds in a Longitudinal Study of Caregiver Feeding and Child Weight

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Abstract

Background—Children from low-SES and ethnic minority backgrounds are at heightened risk for overweight, yet are underrepresented in the pediatric obesity literature.

Methods—The current paper describes strategies employed to minimize barriers to recruitment and retention of African-American families receiving WIC services in a longitudinal study examining caregiver feeding and child weight.

Results—Seventy-six families enrolled in the study over 3.5 years, and 50% of the families completed the study.

Implications for Practice—Despite effortful planning, unanticipated barriers likely contributed to lengthy recruitment and a modest retention rate. Future research should incorporate *lessons learned* to modify and develop effective strategies for increasing engagement of low-SES and ethnic minority families in research.

In 2003–2004, the prevalence of overweight (BMI between 85th–94th percentiles) and obesity (BMI ≥ 95th percentile) among children in the United States reached its peak at 33.6% (Ogden et al., 2006), prompting the National Institutes of Health to declare the prevention and treatment of obesity in children a high priority for public health research (NIH, 2004). Researchers responded to this call, and resulting investigations of the behavioral mechanisms of excess weight gain in childhood have been influential in shaping pediatric obesity prevention and intervention efforts. Although the overall prevalence of pediatric overweight and obesity has decreased slightly to 31.8% according to 2009–2010 estimates (Ogden, Carroll, Kit, & Flegal, 2012), children from low-SES and ethnic minority backgrounds remain at heightened risk for excess weight gain (Ogden et al., 2012; Singh, Kogan, & van Dyck, 2010). One possible reason for these disparities is that children from low-SES and ethnic minority backgrounds have been underrepresented in pediatric obesity

studies. Increasing research participation among families from this demographic is imperative to addressing the pediatric obesity epidemic. More specifically, research with families from low-SES and ethnic minority backgrounds is necessary to understand factors that place children from these backgrounds at greater risk for overweight and to developing culturally appropriate obesity prevention and intervention programs.

An emerging literature suggests this goal may not be easily achieved unless studies are specifically designed to include strategies that decrease barriers to research participation for families from low-SES and ethnic minority backgrounds (Kennedy et al., 2010; Shavers-Hornaday, Lynch, Burmeister, & Torner, 1997; Yancey, Ortega, & Kumanyika, 2006). Both explicit logistical barriers to participation and implicit attitudinal barriers to participation must be addressed. For example, logistical issues such as difficulties securing transportation and childcare, time constraints, conflicting priorities, and frequent changes in contact information (addresses and phone numbers) have been found to impact recruitment and retention of low-SES and ethnic minority participants in clinical trials for adults (El-Khorazaty et al., 2007; Kennedy et al., 2010; Rdesinski, Melnick, Creach, Cozzens, & Carney, 2008). Implicit attitudinal barriers based on mistrust or differentiation must also be considered (Kennedy et al., 2010). Strategies such as diversity training for research staff, frequent interactions with participants to build rapport and ensure contact information is up-to-date, and providing multiple participant incentives all appear to minimize these barriers (Chang, Brown, & Nitzke, 2009). However, these strategies are also resource intensive, and whether they are sufficient to increase involvement of families from low-SES and ethnic minority backgrounds in non-clinical, family-based research remains unknown.

The purpose of this paper is to address this gap by describing strategies and techniques employed to increase engagement of African-American families receiving services from WIC in a longitudinal investigation of caregiver feeding practices and preschooler weight status. Specifically, we review the importance of establishing research partnerships with community organizations to achieving the study aims, outline approaches integrated within our study design to enhance recruitment and retention rates, present outcomes of our focused efforts, and discuss lessons learned.

Methods

Brief Overview of Study Procedure

Families attending a Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) clinic in Southern Ohio were eligible to participate in the study if they self-identified as African-American and had a preschooler between the ages of 36–59 months. If multiple children were eligible to participate, the caregiver selected one child to be the active participant in the study. Eligibility for WIC services in the state of Ohio requires that families have an annual household income $\leq$ 185% of the United States Poverty Income Guidelines. Exclusion criteria were a) caregiver $<$ 18 years old; b) non-English speaking caregiver; c) preschooler diagnosed with a chronic health condition; and d) caregiver or preschooler with allergies to foods served in the study protocol (i.e., nuts and milk). In compliance with policies for conducting research within WIC organizations in Ohio, Institutional Review Board (IRB) approval was obtained both from the governing county and the participating hospital.

Recruitment occurred during WIC certification visits. WIC educators provided a brief overview of the study to caregivers and then introduced interested families to the research study staff. Caregivers who agreed to participate completed informed consent, a demographics questionnaire, and then a brief interview about family mealtime experiences. Families were then scheduled for two study visits (one year apart). Each visit lasted

approximately 2–3 hours and consisted of six components: a) obtaining anthropometric measures from caregivers and preschoolers, b) dyads being video-taped while consuming a standardized lunch, c) caregiver completion of questionnaires assessing feeding, preschooler diet, family functioning, and food security, d) caregiver completion of three 24-hour recalls (2 week days, 1 weekend day) of preschoolers diet (Guenther, DeMaio, Ingwersen, & Berline, 1995), e) preschooler completion of the Eating in the Absence of Hunger (EAH) Paradigm (Fisher & Birch, 1999) and f) preschooler completion of a Dual energy x-ray absorptiometry (DXA) scan. Families had the opportunity to earn up to \$140 dollars in gift cards to a local grocery store during their participation: \$10 for completion of the demographics form and interview, \$50 for each study visit, and \$30 for providing updated contact information at WIC certification visits between the research study visits (\$10 per WIC visit).

Establishing Research Collaborations with Community Partners

Conducting research with hard-to-reach populations, such as families from low-SES and ethnic minority backgrounds, is dependent upon establishing collaborations and partnerships with community organizations serving these populations (Wallerstein & Duran, 2010). The current study is one of multiple collaborations between our research group and WIC in a research partnership spanning almost a decade. Our partnership was formed due to mutual interests in promoting health and preventing childhood obesity among low-SES and underserved populations. Collaboration was evident in each stage of the current study, from its design to its execution. The WIC staff's contribution to the integrity of the research process was crucial to its success (i.e., introducing the study to potentially eligible families, and alerting study staff when participating families arrived for WIC follow-up clinic visits).

Pilot Study

A small pilot study ($N = 5$) was conducted to determine the feasibility of the current protocol, specifically our strategies for recruitment and the logistics of the study visit (Time one only). The primary modification resulting from the pilot study was to gather demographic information at the time families completed the informed consent process as this permitted examination of characteristics potentially associated with drop-out prior to completion of the Time One visit. Further, to facilitate personal identification with the project, we developed a study logo (Chang et al., 2009; Kennedy et al., 2010) and ensured it was on all study documents distributed to the family (e.g., magnets with study visit dates and times, letters, newsletters).

Strategies to Improve Recruitment and Retention

Recruitment—Potentially eligible families first learned about the research study from their WIC providers. The decision to have WIC providers introduce the study to families served two purposes: 1) to guarantee WIC providers had an active role in the research process, and 2) to increase the likelihood of family participation in the study by using a trusted source (Wallerstein & Duran, 2010). Our recruitment procedure included specific strategies to ensure that WIC educators could fulfill this role with minimal disruption to clinic flow and no interference in delivering mandated information covered during WIC certification visits (Chamberlin, Sherman, Jain, Powers, & Whitaker, 2002; El-Khorazaty et al., 2007). Specifically, we obtained IRB approval for the research study staff to review WIC clinic schedules and provide WIC educators with a list of potentially eligible families each week. Thus, the WIC staff time commitment comprised of paging research staff members when potentially eligible families arrived, providing a brief overview of the study to the families, and introducing interested families to research staff upon completion of WIC visits (all of which took approximately five minutes).

Informed consent documents are often cumbersome and, even after adjusting to a 4th-grade reading level, may be written in language that is not well understood by families with limited formal education and no previous research experience. A flip-chart including pictures and brief sentences was created to maximize caregiver understanding of the study purpose, procedures, and additional key information (e.g., participant rights and procedures to ensure confidentiality). We worked with an expert in research with African-American families to develop this chart and to ensure its contents were culturally relevant.

One challenge often encountered in conducting community-based research is that the research study staff, their community partners, and recruitment locations are not in close geographic proximity. A key logistical advantage in our study was that the WIC clinic was located within the same tertiary care center as the research team. This allowed ongoing face-to-face communication with the clinic staff as well as a quick response when eligible families arrived for certification visits. Two research study staff members were present during recruitment visits: one worked with the caregiver to complete the informed consent and initial data collection process and the second engaged the caregiver's preschooler and other children who were present in activities and games. The staff member who worked with the preschooler during the informed consent process also worked with the preschooler during study visits to facilitate consistency and increased comfort for the child in an unfamiliar setting. It was important for families to have a positive experience from the initial contact to help maintain their participation throughout the longitudinal study and to increase the likelihood of their participation in future studies. We considered building rapport with families, especially with the children, as crucial to achieving this goal.

Removing Barriers to Participation

Based on research detailing strategies for improving retention in low-SES, ethnic minority families (Chang et al., 2009; Nicholson et al., 2011; Rdesinski et al., 2008), and our previous research (Jain, Sherman, Chamberlin, & Whitaker, 2004; Powers, Chamberlin, van Schaick, Sherman, & Whitaker, 2006; Whitaker, Sherman, Chamberlin, & Powers, 2004), protocol modifications were developed to limit the barriers encountered in recruitment and retention. To minimize transportation barriers, all participants were offered taxi service to and from each study visit. Additionally, although families were encouraged to bring only their preschooler to the study visit, they were told other children could attend if no other options for childcare existed. If other children attended the visit, they were provided with the same lunch as their caregiver and sibling. However, non-participating children consumed this meal with a research study staff member in a separate room. This accommodation was used by a number of families who needed assistance with childcare.

Due to the numerous responsibilities, life stressors, and limited resources often experienced by families from low-SES and ethnic minority backgrounds, the need to reschedule study visits at the last minute was anticipated. We included several strategies to provide families with an opportunity to reschedule visits rather than "no showing." Specifically, all families were contacted the night before and the morning of the scheduled visit. Families were informed that research study staff would not be present for study visits if no confirmation was made the morning of the scheduled appointment. Families who expressed interest in the taxi service were told that taxis would not be sent unless they confirmed attendance on the morning of the scheduled study visit.

Retention Efforts

Many efforts were made to stay connected to families in the 12-month period between study visits. Families who completed the Time One visit received a quarterly newsletter detailing study progress regarding recruitment, the number of families who had completed Time One

and Time Two visits, and seasonal activities for preschoolers. The purpose of the newsletter was to communicate to families that their participation was valued and to emphasize that they were part of a community doing something for the betterment of other families and preschoolers. In addition, birthday cards were sent to preschoolers to maintain a personal connection with each child and family. A postcard containing a photo of caregivers and preschoolers taken at the first study visit was also sent to families at the halfway point, which included a reminder that their next and final study visit would be in six months. Finally, families were sent a letter two weeks prior to the date of their Time Two visit. The letter indicated the appointment time and date and encouraged them to contact the research study staff to reschedule if they could not attend. Time One procedures for confirming study visits were repeated for Time Two visits.

Multiple approaches were included in the protocol design to increase the likelihood that participant contact information was up to date. First, the demographic form included a section for names and telephone numbers of two relatives or friends who did not live with the family who could be contacted if the family could not be reached. Second, research study staff reviewed contact information with families enrolled in the study when they attended WIC clinic visits. Families complete four certification visits per year as part of their participation in the WIC program, which provided three opportunities to meet with families between their two research study visits. The research study staff worked closely with the WIC nutrition staff to identify dates of upcoming WIC clinic visits to assure personal contact with the families between the two study visits. If families consistently missed WIC certification visits, or mail was returned by the postal service, the study staff would contact families via phone or consult with the WIC clinic to update contact information.

Study Resources

Funding for this study came from three different grant sources: a mid-career grant and research training grant (both to SWP) as well as a center-wide, translational research grant. Collectively, these grants ensured sufficient resources for employing a full-time research assistant, two postdoctoral fellows, DXA services, 24-hour dietary recall analysis, supplies for implementation of the EAH paradigm (e.g., food), and costs associated with strategies to promote increased recruitment and retention among our targeted population (e.g., taxi service and multiple mailings). The research assistant was responsible for identifying eligible families, responding to pages for recruitment visits, scheduling study visits, completing food recalls, maintaining supplies (i.e. groceries, incentives), contacting families, maintaining the database, and distributing retention materials between study visits. Post-doctoral fellows worked with the research assistant to complete recruitment and study visits and provided supervision.

Results

A total of 76 families were consented for participation over the span of approximately three and one-half years. Fifty (65.8%) of these families completed the Time One visit and of those who completed the initial study visit, 35 (70%) completed Time Two (see Figure 1). Fifty percent of enrolled families completed both study visits. Families who completed all study visits did not differ significantly from those who completed only the Time One visit or only the informed consent visit on any demographic variables (i.e., income, employment, marital status, education; all p 's > .05; see Table 1).

In addition to the aforementioned strategies to minimize common barriers, our research team also spoke frequently about recruitment and retention at regularly scheduled study progress meetings, included in which was a content expert at another university who provided important insights and suggestions. However, our lengthy recruitment period and moderate

retention rate reflect unanticipated barriers we were not able to successfully overcome. Specifically, these barriers included time constraints (family and staff) related to recruitment, attendance at study visits, and keeping family's contact information up to date.

Recruitment Challenges

Some families who were approached about the study were interested in participating, but were not able to stay after their WIC certification visit to complete the consent procedure due to transportation limitations (e.g., would miss bus or friend who provided transportation) and time constraints (i.e., work, school, doctor appointments). Additionally, there were times that the WIC staff members were unable to page the research study staff due to high clinic volume. Likewise, there were times when research study staff members were not able to respond to pages from the WIC staff due to conflicting work obligations.

Retention Challenges

To be consistent with the original EAH paradigm (Fisher & Birch, 1999) study visits were scheduled over the noon hour. Due to difficulties with coordinating room availability and the availability of staff to complete the DXA scan, we were only able to offer two choices to families regarding the days on which they could schedule study visits. Scheduling limitations may have contributed to the 66% completion rate at the Time One study visit and an overall attrition rate of 50%.

Time One Visit—Of the 26 families consented for the study who did not complete the Time One visit, 12 (46.2%) could not be reached by phone (i.e., numbers disconnected, no answer, no opportunity to leave a message) and were unable to be rescheduled, and 14 (53.8%) did not attend after rescheduling two or more times. Protocol modifications were implemented early in the project to limit the number of rescheduled visits to two in recognition of the time cost to prepare for a session (i.e., approximately 45 minutes for the research assistant and one postdoctoral fellow to prepare food and set-up the room for the experimental paradigm and approximately 10–20 minutes for DXA technicians to calibrate their machine).

Time Two Visit—Of the fifteen families who did not complete the Time Two visit, eight did not attend any follow-up WIC visits. For families that did complete both study visits 51% (n=18) were seen by the research staff during at least one of the family's WIC visits. Thus, increased personal contact between study visits may have had a positive impact on retention. Additional barriers to retention were encountered despite our efforts to update contact information. A number of families did not have a home telephone in service, had no minutes on their prepaid cell phone, or the phone was unable to accept voicemail messages. Although families provided the study staff with contact information of two family members, the same issues were sometimes encountered reaching these contacts. Occasionally families would move without notifying the research staff, limiting our ability to maintain contact with families via retention mailings.

Implications for Practice and Lessons Learned

Increasing research participation among families of low-SES and ethnic minority status is imperative to decreasing the pediatric obesity epidemic. Specifically, it is important to understand and identify what modifiable behaviors place children from these backgrounds at higher risk for becoming overweight and obese and subsequently to develop culturally-specific prevention and intervention programs. The extant literature has documented the unique challenges researchers face in engaging this demographic within adult-based clinical trials (i.e., childcare, unstable contact information, mistrust, transportation, mobility;

(Kennedy et al., 2010; Nicholson et al., 2011) and also strategies that appear to aide in minimizing these barriers (database tracking system, taxi transportation, recruitment materials reflective of the targeted population). The purpose of this manuscript was to describe strategies and outcomes of techniques employed to increase recruitment and retention of African-American families receiving services from WIC in a longitudinal investigation of caregiver feeding practices and preschooler weight status.

Our recruitment (66%) and retention rates (50%) were modest but consistent with studies in the adult literature that have targeted individuals from low-SES and ethnic minority backgrounds (El-Khorazaty et al., 2007; Nicholson et al., 2011; Rosal et al., 2011). We believe four strategies contributed to our relative success: community involvement, budgeting resources for strategies to minimize unique barriers to research participation for families from low-SES and ethnic minority backgrounds, careful planning and organization, and building rapport.

Community Involvement

A recent review compared the most effective methods for recruitment of ethnic minority participants in research and indicated that the universal strategy was collaboration within a community organization. Our recruitment rate is indicative of the success in working within this setting. Studies that utilized face-to-face recruitment techniques and provided recruitment materials culturally consistent with the targeted population observed recruitment rates of 90% and 34%, respectively (El-Khorazaty et al., 2007; Nicholson et al., 2011). Our retention rate of 50% was comparable to retention rates reported for other studies of low-SES mothers (41% & 64%) and ethnic minority populations (79%) (El-Khorazaty et al., 2007; Nicholson et al., 2011; Rosal et al., 2011). Studies that proactively sought to engage families from low-SES and ethnic minority backgrounds included community advisory boards, recruitment materials that were reflective of the targeted population, and a coordinator embedded in the clinic (Katz et al., 2001; Nicholson et al., 2011; Yancey et al., 2006).

First, developing a community partnership was imperative for the success of engaging low-SES, ethnic minority participants in research. Although some studies have low rates of families from low-SES and ethnic minority backgrounds, the low numbers in other studies (Kennedy et al., 2010; Wendler et al., 2006) suggest problems in implementing the best methods to recruit families of low-SES and ethnic minority backgrounds. Collaboration with community agencies requires gaining insight about how community residents and hospital and clinic staff perceive the research team and how to identify potential problems early in the outreach efforts. Additionally, building community partnerships involves working within the infrastructure of the agency and can be time consuming. For example, our partnership was developed over a ten-year period. Our WIC collaborators were highly supportive of the project, which may have increased participants' willingness to speak with the research team and enroll in the study. Our collaboration with the WIC clinic provided invaluable assistance in developing rapport and securing participation from families. Other researchers similarly attribute their retention success largely to coordinated efforts between the research team and the infrastructure support of community clinics (Nicholson et al., 2011).

Unique Budgetary Considerations

Researchers conducting research with families of low-SES, ethnic minority status need to plan a substantial portion of their budget for recruitment and retention efforts that may not be necessary for families with more socioeconomic resources. For example, we budgeted \$30 per visit to transport each family (\$3,000 total) and an additional \$30 for updating

contact information (\$1500 total). This totaled \$4,500 in extra expenses beyond the \$5,500 budgeted for participation reimbursement.

Time and Labor Considerations

Recruitment and retention of families from low-SES backgrounds is not only resource intensive but extremely time demanding for research study staff. Recent research indicated an average of 6 contact-attempts was needed to reach families from low-SES backgrounds, which not only requires organization but also translates into increased cost for the labor involved. A longitudinal study examining contraception use in a community sample reported an average of \$325 for recruitment and retention via phone contact which equates to a full-time position (Rdesinski et al., 2008). Oftentimes we needed to contact families in the evening or on weekends to accommodate schedules. Consistent with previous research (Rosal et al., 2011), we developed a database for the current study that tracked all staff contacts with families, updated contact information, and the dates of WIC certification visits. This type of tracking system may have allowed us to stay in better contact with families and to schedule study visits to coincide with other clinic appointments at the hospital. Despite our pro-active efforts to minimize barriers, our moderate rates of recruitment (66%) and retention (50% at Time 1) suggest that additional or alternative steps may be helpful in designing future family-based studies with low-SES, ethnic minority populations. The current project enrolled 50 families over three and one half years, indicating that the recruitment of families from low-SES and ethnic minority backgrounds takes a substantial amount of time (La Rosa, Parron, & Alvarado, 1997).

Rapport Building

Building rapport is imperative for successful recruitment and retention and was achieved through showing sensitivity to the barriers and challenges of each individual family and highlighting the important contributions of families to the research aims (Nicholson, 2011). Researchers working with families of low-SES and ethnic minority status should make every effort to minimize staff turnover throughout the research study to enhance continuity in the relationships between staff members and program participants (Yancey et al., 2006). Researchers should allot funding for one permanent staff member whose sole responsibility is study coordination. Good relationships are critical for participant retention (Nicholson et al., 2011), the overall success of the program, and maintaining strong ties with collaborative research partners (i.e. WIC, DXA, Taxi Company). We included several strategies to facilitate rapport, including plain language descriptions of the study, a staff member available to engage the children, and providing immediate incentives. Finally, steps were taken throughout the study to keep families engaged by reminding them of our appreciation for their participation. To maintain rapport, families worked with the same research staff member at each study visit and follow-up assessment.

Future Research

While proactive steps were taken to minimize barriers, additional strategies documented in the literature as well as lessons learned may increase recruitment and retention efforts in a low-SES, ethnic minority population. We instituted a paging system within our recruitment procedures to minimize the disruption in the WIC clinic flow and to alert research staff when families arrived for certification visits. However, other studies have approached recruitment differently by having research staff members in clinic waiting areas, a strategy that is hypothesized to facilitate increased visibility and retention efforts (Nicholson et al., 2011).

Transportation limitations and conflicting priorities also precluded some families from being able to stay after their WIC clinic visit for the time needed to complete the informed consent

procedure and initial data collection. Previous studies within the literature and our own research group (Baughcum et al., 2001; Jain et al., 2001) have conducted recruitment by contacting families ahead of their visits to discern interest, potentially improving recruitment rates where families often needed an additional 10–15 minutes to complete demographics and the brief interview in addition to the 10–15 time for the informed consent process. Modification of the recruitment procedure in this way might increase enrollment by allowing families to learn about the study on their own time and minimize the number of interested families who could not complete due to competing demands. Contacting families in advance and attending clinic also require substantial time investment by the research staff, the cost-benefit of which must be thoughtfully evaluated. Researchers should consider instituting recruitment strategies such as focus groups to provide potential families the opportunity to provide additional strategies for overcoming common barriers. Additionally, members of the community agency could also provide information about the best means to contacting families, and can provide insight on what barriers may arise that were not previously accounted.

Previous research has suggested that employing researchers and staff reflecting the ethnic and/or cultural make-up of the study population can also improve participant satisfaction and adherence to study visits (Moreno-John et al., 2007; Steinhauser et al., 2006). The current study employed researchers of Caucasian and Latina descent, which could have impacted the ability of the staff to build trust with the African American families identified for research. A number of studies have included diversity training to improve recruitment and retention of minority populations with some success (Kennedy et al., 2010). The purpose of this type of training is to articulate to research staff the best approach for interacting with families in a genuine way, communicating within the culture, and being sensitive to the potential unique demands of the families.

In sum, increasing research participation among families from low-SES and ethnic minority backgrounds is crucial as we strive to understand the factors that place children from these backgrounds at greater risk for being overweight and ultimately to address the pediatric obesity epidemic. Families from low-SES and ethnic minority backgrounds are underrepresented in the pediatric obesity literature, which may stem largely from failure of researchers to proactively design study protocols to minimize barriers to research participation for families from this demographic (Kennedy et al., 2010; Nicholson et al., 2011; Yancey et al., 2006). Future research is needed to more systematically evaluate strategies to increase engagement of families from low-SES and ethnic minority populations in family-based, longitudinal studies.

Acknowledgments

We would like to thank the families for their participation in this study. We would also like to thank the WIC staff, without their collaboration this project would not have been possible.

This study was supported by grants K24 DK059973 and T32 DK063929 (both SWP) from the National Institutes of Health as well as UPHS grant UL1 TR000077-04 from the National Center for Research Resources and the National Center for Advancing Translational Sciences of the National Institutes of Health.

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Figure 1.
Recruitment and Retention Based on Rescheduled Visits.

Table 1

Demographic Characteristics [Mean(SD)/Percent(n)] for the sample as a whole and by Retention Group

	All Enrolled Families (N=76)	Families Lost-to- Follow-Up (n=26)	Families Completing T1 visit only (n=50)	Families Completing T1 and T2 visits (n=35)
Age (years)				
Preschooler	3.36 (.51)	3.21 (.41)	3.89 (.57)	3.81 (.59)
Caregiver	28.34 (9.27)	27.07 (7.42)	28.33 (7.34)	27.3 (5.10)
Education				
Junior High School	1.3% (1)	-	4% (1)	3% (1)
<High School diploma	31% (23)	36% (9)	28% (14)	26% (9)
High School diploma	35% (26)	36% (9)	34% (17)	32% (11)
Some college	27% (20)	28% (7)	26% (13)	29% (10)
Standard College	5.3% (4)	-	8% (4)	9% (3)
Marital Status				
Single	88% (66)	96% (25)	88% (44)	88% (31)
Married	6% (5)	4% (1)	6% (3)	6% (2)
Separated	6% (5)	-	6% (3)	6% (2)
Employment Status				
Unemployed	64% (48)	64% (16)	64% (32)	69% (23)
Part-time	16% (12)	12% (3)	20% (9)	17% (6)
Full-time	19% (14)	24% (6)	16% (8)	14% (5)
Annual Income				
<\$10,000	67% (51)	76% (20)	62% (31)	59% (20)
\$10,000–\$19,000	25% (19)	24% (6)	26% (13)	32% (11)
\$20,000–\$29,999	2.6% (2)	-	4% (2)	2% (1)
\$30,000–\$39,999	2.6% (2)	-	4% (2)	5% (2)
\$40,000–\$49,999	2.6% (2)	-	4% (2)	2% (1)