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# Interventions to prevent obesity in children aged 12 to 18 years old (Protocol)

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[Intervention Protocol]

# Interventions to prevent obesity in children aged 12 to 18 years old

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## ABSTRACT

### Objectives

This is a protocol for a Cochrane Review (intervention). The objectives are as follows:

The overall aim of the review is to determine the effectiveness of interventions to prevent obesity in 12 to 18-year-old children and adolescents.

The four objectives are:

1. to evaluate the effects of interventions that aim to modify dietary intake on changes in zBMI score, BMI and serious adverse events among children and adolescents;
2. to evaluate the effects of interventions that aim to modify physical activity, sedentary behaviour, sleep, play and/or structured exercise on changes in zBMI score, BMI and serious adverse events among children and adolescents;
3. to evaluate the combined effects of interventions that aim to modify both dietary intake and physical activity/movement behaviours on changes in zBMI score, BMI and serious adverse events among children and adolescents;
4. to compare the effects of interventions that aim to modify dietary interventions with those that aim to modify physical activity/movement behaviours on changes in zBMI score, BMI and serious adverse events among children.

The secondary objectives are designed to explore if, how, and why the effectiveness of interventions on zBMI/BMI varies depending on the following PROGRESS factors.

- **P**lace of residence
- **R**ace/ethnicity/culture/language
- **O**ccupation
- **G**ender/sex

- **R**eligion
- **E**ducation
- **S**ocioeconomic status
- **S**ocial capital

The PROGRESS acronym is intended to ensure that there is explicit consideration of health inequity, the unfair difference in disease burden, when conducting research and adapting research evidence to inform the design of new interventions (O'Neill 2014). The PROGRESS acronym describes factors that contribute to health inequity. Recent work on race and religion in the UK suggested that consideration of these factors is critical to the design of new interventions (Rai 2019).

We will also collect, from RCTs, information about the costs of interventions so that policymakers can use the review as a source of information from which they may prepare cost-effectiveness analyses.

## BACKGROUND

Population levels of overweight and obesity have become a growing, major challenge throughout the world (WHO 2016; WHO 2017). The causes of this are complex: the 2007 foresight report mapped over 100 interconnected factors, all of which contribute to the population prevalence of obesity. These factors include macroeconomic drivers, biological factors, food supply and production, media, healthcare, built environment, transport and recreation, technology, early life experiences and education (GOS 2007). These factors can operate differently in different people, and partially explain inequalities in childhood obesity. A good example is the relative cost of healthy food such as fruits and vegetables, which may be prohibitive for families on a low income (Power 2021).

The global evidence suggests that the prevalence of overweight and obesity in children started to rise at the end of the 1980s (Ng 2014). By 2010, 43 million children under five years of age were categorised as having overweight or obesity, with approximately 35 million of these children living in low- and middle-income countries (de Onis 2010). Internationally, childhood obesity rates continue to rise in some countries (e.g. Mexico, India, China, Canada), although there is evidence of a slowing of this increase or a plateauing in some age groups in some countries (WHO 2016; WHO 2017). The World Health Organization Commission on Ending Childhood Obesity found that childhood obesity is reaching alarming proportions, including obesity in children of primary school age, in many countries and poses an urgent and serious challenge (WHO 2016; WHO 2017). The Sustainable Development Goals, set by the United Nations in 2015, also identify prevention and control of non-communicable diseases, including obesity, as core priorities (United Nations 2018).

Obesity in childhood and adolescence can be difficult to reverse through interventions (Al-Khudairy 2017; Mead 2017). Obesity tracks through to adulthood (Simmonds 2016), strengthening the case for primary prevention. Adult obesity is associated with increased risks for heart disease, stroke, metabolic syndrome, type 2 diabetes and some cancers (Bhaskaran 2014; Yatsuya 2010). Children and adolescents with obesity have poorer psychological well-being and elevated levels of a number of cardio-metabolic risk factors (Sommer 2018). Obesity comorbidities, including high blood pressure, high blood cholesterol and insulin insensitivity, are being observed at an increasingly early age. Childhood obesity may cause musculoskeletal problems, obstructive sleep apnoea, asthma and a number of psychological issues (NHS England 2014; Papoutsakis 2013; Paulis 2014; Rankin 2016). Childhood obesity is associated with type 2 diabetes and heart disease in adulthood and middle-age mortality (PHE 2022).

Estimates of the economic impacts of obesity (adult and child) as a percentage of gross domestic product (GDP) range from 0.13% in Thailand (Pitayatienanan 2014) to 9.3% in the USA (Waters 2018). However, the methods used to estimate these costs vary between studies, and most studies use a health system perspective rather than a societal perspective. Recently, Okunogbe 2021 estimated current and future national economic impacts of obesity across a sample of heterogeneous contexts globally. They estimated that obesity cost between 0.8% and 2.4% of GDP in 2019 in the eight countries in their study (Australia, Brazil, India, Mexico, Saudi Arabia, South Africa, Spain and Thailand). Their projections revealed an increasing trend in obesity costs as a percentage of GDP over time, estimated to reach 2.4% of GDP in Spain and up to 4.9% in Thailand by 2060. They concluded that economic impacts of obesity are substantial and reach a similar magnitude in low-income and middle-income countries as in high-income contexts. A separate projection for England reports that halving childhood obesity by 2030 could save the National Health Service GBP 37 billion and wider society GBP 202 billion (Hochlaf 2020).

Children aged 12 to 16 years attend secondary schools in most countries, and schools are seen as a key setting for obesity prevention as the majority of children have long-term and in-depth contact with them (WHO 2021a). However, the other environments (in real life and virtual environments) in which they live and play also provide opportunities for intervention. Adolescence may be a critical time for excess weight gain, in that this age group normally has more freedom in food and beverage choices made outside the home compared with younger children. This, alongside the fact that physical activity levels usually decline (and sedentary behaviours rise) during adolescence, particularly in girls, offers both opportunities and barriers for those developing interventions.

The potential for negative unintended consequences of obesity prevention interventions has received much attention. Whilst the risk of inducing or worsening eating disorders/disordered eating as part of an obesity prevention intervention remains small, when this does occur the results can be severe (Allen-Scott 2014). The shared aetiology of obesity and eating disorders has implications for the design of interventions to prevent childhood obesity. Researchers in both the obesity and eating disorder fields have proposed using an integrated approach to prevention that addresses the spectrum of weight-related disorders within interventions. The identification of risk factors that are shared between these weight-related disorders is an essential step in developing effective prevention interventions (Haines 2006)

Obesity prevalence is inextricably linked to the degree of relative social inequality, and being in lower social strata is associated with a higher risk of obesity in most high-income countries (even in infants and young children) (Ballon 2018). It is therefore critical that in preventing obesity we are also reducing the associated gap in health inequalities, ensuring that interventions do not inadvertently lead to more favourable outcomes in those with a more socio-economically advantaged position in society. Equally, there is a need to understand how to minimise obesity in more affluent groups in low-income countries. The available knowledge base includes limited evidence on which we can develop a platform for obesity prevention action and select appropriate public health interventions, whether for the whole population or for those at greatest risk of obesity (Hillier-Brown 2014).

The WHO Commission on Ending Childhood Obesity states that progress in tackling childhood obesity has been slow and inconsistent, and obesity prevention and treatment requires a whole-of-government approach in which policies across all sectors systematically take health into account, avoid harmful health impacts, and thus improve population health and health equity (WHO 2016; WHO 2017). Indeed, it is now acknowledged that tackling obesity requires a systems approach and policy initiatives across government departments that are joined-up (Rutter 2017). The broader system that influences obesity has been elegantly described (GOS 2007), and is multi-level and complex in nature. Understanding this broader system allows us to identify points that could be reasonable targets for intervention development.

Some of these points are upstream (e.g. policy environment) and some downstream (e.g. individual-level education), and some points in the system are more modifiable than others. Downstream interventions rely on individuals actively making a choice to consume a healthier diet or have a more active lifestyle. These types of interventions often simply provide education and information on a healthy diet or healthy physical activity levels, and rely on the individual child and family being willing and able to make these changes. Upstream interventions change policy or the environment in which the child lives (home, school, the wider environment), which makes consuming a healthy diet and being physical activity the easy choice (sometimes the only choice). Examples include mandatory food standards and guidance on physical education for schools, policies around marketing of foods with a high level of fat, salt or sugar (HFSS foods) which are targeted at children (including in supermarkets), town planning policies on mobile food and beverage vans close to schools, and the number and locations of takeaways on walking journeys experienced by adolescents. There is evidence that downstream interventions are more likely to result in intervention-generated inequalities (Adams 2016; McGill 2015). The important point to note is that the most successful approach to tackling childhood obesity is to develop and implement both upstream and downstream interventions.

Experts have noted, in relation to Chapter 2 of the Childhood Obesity Plan for England, that the main focus of interventions relies on self-regulation at an individual level (downstream interventions), and that an equal focus on upstream interventions is also required if a step change in tackling childhood obesity is to be realised (Griffin 2021; Knai 2018). There is also evidence that the successful implementation of a whole-school approach, such as that used in the Nutrition-Friendly Schools Initiative (WHO 2021b), is a key factor in the effectiveness of interventions to promote healthy eating for children. However, careful consideration should be given to how school culture can and needs to be shifted, working with schools to tailor the approach and circumnavigate staff capacity issues, and building relationships within and outside the school gates to enhance sustainability (Daly-Smith 2020; Tibbitts 2021).

The aim of this Cochrane Review is to synthesise the evidence base for preventing obesity in children aged 12 to 18 years old, with particular regard to health equity. We will focus on the 12 to 18 years age group because this age range maps onto the 'secondary school' setting in most countries. We will update the Cochrane Review by Brown 2019, which included children from 0 to 18 years, with analyses split into three age groups of children 0 to 5, 6 to 12 and 13 to 18 years. This updated review will focus on children aged 12 to 18 years and is one of four linked update reviews that are based on the Brown 2019 review, but which each focus on a different age group of child or young person: 0 to 1, 2 to 4, 5 to 11 and 12 to 18 years, with a new protocol for each. Findings from our 2019 review suggested that different interventions might work differently in children of different ages (Brown 2019).

## Description of the condition

Overweight and obesity are terms used to describe an excess of adiposity (or fatness) above the ideal for good health. Current expert opinion supports the use of body mass index (BMI) cut-off points to determine weight status (as healthy weight, overweight or obese) for children, and several standardised BMI (zBMI) cut-offs have been developed that account for the child's age and gender (Adab 2018; Bell 2018). Population monitoring of overweight and obesity is best done through use of BMI, but this measure has limitations at an individual level and, in children, zBMI is deemed to be more useful. Despite this, there is no consistent application of this methodology by experts and a variety of percentile-based methods are also used, which can make it difficult to compare RCTs that have used different measures and weight outcomes.

Overweight and obesity in childhood are known to have significant impacts on both physical and psychosocial health (reviewed in Lobstein 2004). Indeed, many of the cardiovascular consequences that characterise adult-onset obesity are preceded by abnormalities that begin in childhood. Hyperlipidaemia, hypertension, abnormal glucose tolerance, and type 2 diabetes occur with increased frequency in children with obesity (Freedman 1999). In addition, obesity in childhood is known to be associated with cardiovascular disease risk factors in adults (Umer 2017), underpinning the importance of obesity prevention efforts.

## Health inequalities

Obesity results from a sustained positive energy imbalance, and a variety of genetic, behavioural, cultural, environmental and economic factors have been implicated in its development (reviewed in Lobstein 2004). The interplay of these factors is complex and has been the focus of considerable research. However, the burden of obesity is not experienced uniformly across a population, with the highest levels of the condition experienced by those most disadvantaged. In high-income countries there is a significant trend observed between obesity and lower socio-economic status e.g. in the UK, Office for National Statistics & NHS Digital (NHS Digital 2020). In the UK, body mass trends over adolescence were associated with local area deprivation in a large UK cohort, even when controlling for family socioeconomic circumstances (Staatz 2021). In a study of children aged six to nine years living in 24 countries in the WHO European region, an inverse relationship between the prevalence of childhood overweight/obesity and parental education was found in high-income countries, whereas the opposite relationship was observed in most of the middle-income countries (Buoncristiano 2021). In low-income countries the relationship is variable, and there appears to be a shifting of the obesity burden across socioeconomic groups and different patterns by gender (Jiwani 2019; Monteiro 2004). On this basis, we plan to explore the finding of this review by World Bank category high-, upper middle-, lower middle-, and low-income countries (World Bank 2021).

## Description of the intervention

This review involves assessing interventions aimed at preventing obesity (either the primary aim of the intervention or one of the key aims of the intervention), implemented in any setting, that have been assessed in a randomised controlled trial. Comparators may be any active intervention or no intervention (usual care).

Note that the 2019 Cochrane Review on preventing obesity in children included many more downstream (individual-level) interventions, compared with upstream (policy and environmental-level) interventions, that met their inclusion criteria (Brown 2019; Nobles 2021). Therefore, the evidence base for preventing obesity should encompass additional, high-quality reviews which focus on the upstream interventions and which include RCT studies and other study designs (e.g. Wolfenden 2016).

The insights from this new review of RCTs will help to refine future interventions that can operate within a whole systems approach; one that combines a range of upstream and downstream approaches.

### How the intervention might work

Interventions that aim to prevent childhood obesity seek to maintain an energy balance that is ideal for the healthy growth and development of the child. All such interventions work either by limiting the amount of energy (calories) consumed or by increasing the amount of energy expended (which includes basal metabolic rate, physical activity and other movement including sleep, and energy required for child growth), or by both limiting the amount of energy consumed and increasing the amount of energy expended. If sustained energy expenditure (normal metabolic demands plus cost of growth) exceeds energy consumed, the child may become malnourished. A severe energy deficit over a prolonged period in childhood, particularly during rapid periods of growth, may have serious negative consequences for growth and development, and these effects are potentially irreversible. Getting the balance of short-term effectiveness versus a more moderate, safer and a more sustained energy deficit in the context of childhood obesity prevention interventions 'right' remains a key public health challenge (Emmett 2015).

The safest and most reliable way to ensure an ideal energy balance in growing children is for the child to eat a healthy diet (low in fat and sugar) and be physically active. Most countries have age-specific recommendations for daily food and drink intakes, and physical activity levels.

Most interventions that include a diet component promote a low fat or low sugar intake, or both, for example by replacing sugary drinks with water and high fat snacks with fruit and vegetables. Takeaways and fast food are particularly high in fat, and these are often the target of interventions to prevent obesity. Examples in children include town planning regulations that restrict the presence of mobile food vans close to schools, limiting vending machine content in schools and other environments where children frequent and play, and monitoring the content of packed lunches. Voluntary and mandatory school food standards are in place in many countries.

Interventions that include a physical activity component promote active play, active travel, healthy sleep or a reduction in sedentary behaviour, or a combination of these. Examples include the inclusion of bursts of physical activity during classroom time, the introduction of after-school dance or sport sessions, a limit on the time a child can watch TV or use a tablet/device in a day, and the introduction of safe cycling and walking routes to school. Most countries include physical education as part of the curriculum in schools.

### Why it is important to do this review

Governments internationally are being urged to take action to prevent childhood obesity and to address the underlying determinants of the condition. To provide decision makers with high-quality research evidence to inform their planning and resource allocation, this review aims to provide an update of the evidence from RCTs designed to compare the effect of interventions to prevent childhood obesity with the effect of receiving no intervention, or an active, comparator intervention. Previous work has highlighted that the current evidence base focusses mainly on individual-level interventions that are assessed via an RCT. Where possible, the totality of the evidence base should also capture studies that evaluate the effectiveness of upstream interventions (Nobles 2021), mindful of the fact that these types of interventions are not commonly assessed via an RCT because of the design challenges at scale.

There has been considerable growth in the number of studies in this field over the last five to 10 years. We aim to update the age-relevant (12 to 18 years only) data collected in the existing Cochrane Review of children aged 0 to 18 years (Brown 2019). From our scope of the literature, it is clear that the number of relevant studies that would be included in this review of 12 to 18-year-olds would approximately double the number of those included in the 2019 Cochrane Review. Importantly, many of the relatively recent studies we have identified have reported data on inequalities and new evidence that could affect the recommendations.

The burden of children with obesity has been exacerbated in most countries during the Covid-19 pandemic. Early indications in a number of countries show rising levels of childhood obesity (www.worldobesity.org/), and an increase in inequalities in childhood obesity. In some countries, particularly low-income countries, the double burden of malnutrition (obesity and undernutrition) has risen sharply during the pandemic (IFPRI 2020; Zemrani 2021). Those responsible for public health in all regions of the world, countries, and local communities are planning (and then implementing) their Covid-recovery strategies. As such, our public health policymakers' needs for cost-effective interventions to prevent childhood obesity that are scalable and feasible are more urgent than ever before. These interventions should then feed into a broader strategy that includes upstream interventions.

## OBJECTIVES

The overall aim of the review is to determine the effectiveness of interventions to prevent obesity in 12 to 18-year-old children and adolescents.

The four objectives are:

1. to evaluate the effects of interventions that aim to modify dietary intake on changes in zBMI score, BMI and serious adverse events among children and adolescents;
2. to evaluate the effects of interventions that aim to modify physical activity, sedentary behaviour, sleep, play and/or structured exercise on changes in zBMI score, BMI and serious adverse events among children and adolescents;
3. to evaluate the combined effects of interventions that aim to modify both dietary intake and physical activity/movement behaviours on changes in zBMI score, BMI and serious adverse events among children and adolescents;
4. to compare the effects of interventions that aim to modify dietary interventions with those that aim to modify physical activity/movement behaviours on changes in zBMI score, BMI and serious adverse events among children.

The secondary objectives are designed to explore if, how, and why the effectiveness of interventions on zBMI/BMI varies depending on the following PROGRESS factors.

- **P**lace of residence
- **R**ace/ethnicity/culture/language
- **O**ccupation
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- **R**eligion
- **E**ducation
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The PROGRESS acronym is intended to ensure that there is explicit consideration of health inequity, the unfair difference in disease burden, when conducting research and adapting research evidence to inform the design of new interventions (O'Neill 2014). The PROGRESS acronym describes factors that contribute to health inequity. Recent work on race and religion in the UK suggested that consideration of these factors is critical to the design of new interventions (Rai 2019).

We will also collect, from RCTs, information about the costs of interventions so that policymakers can use the review as a source of information from which they may prepare cost-effectiveness analyses.

## METHODS

### Criteria for considering studies for this review

#### Types of studies

We will include studies that:

- are individually-randomised, or cluster-randomised with at least three clusters/groups of individuals per intervention arm (including the first period only of trials with a cross-over design, due to important concerns about carry-over);
- measured BMI or zBMI (or weight and height from which BMI or zBMI can be calculated) at baseline and after the end of the intervention period (including collection of self-reported measurement); and
- included an active intervention period of any duration, provided that the studies reported follow-up outcome data at a minimum of 12 weeks from baseline.

Studies may be written in any language. We will exclude studies published before 1990, since global evidence suggests that the prevalence of overweight and obesity in children started to rise at the end of the 1980s (de Onis 2010; Ng 2014). Given the time lag between the conception, funding, and completion of RCTs, we considered a 1990 publication date as a pragmatic and reasonable starting point for the literature in the area.

#### Types of participants

We will include children and adolescents with a mean age of 12 years and above, but less than 19 years, at baseline. We will apply this rule if these results relate only to a subset of children from a trial that includes a much wider range of ages.

We will consider studies to have eligible children if they meet any one of the following criteria:

- targeted children or adolescents who are in the general population;
- included children or adolescents who are part of a family group receiving the intervention, if outcome data can be extracted separately for the children;
- targeted children who are 'at risk' for overweight or obesity, for example because a parent is overweight or obese; or
- targeted children and adolescents who are from specific place-based areas (e.g. of high deprivation) or specific settings (e.g. religious settings) where that population is known to have relatively low levels of physical activity, high levels of energy intake, high levels of obesity, or a combination of these factors.

In order to reflect a public health approach that recognises the prevalence of a range of weights within the general population of children and adolescents we will include RCTs that include participants with overweight or obesity, with the exception of RCTs that have an aim to treat obesity.

We will exclude:

- RCTs that recruit only children and adolescents with overweight or obesity at baseline, because we consider these interventions to be focused on treatment rather than prevention; and
- RCTs of interventions designed for children and adolescents with a critical illness or severe comorbidities.

#### Types of interventions

Eligible interventions will have a main aim of changing at least one factor from: diet, physical activity, sedentary behaviour, sleep, play or structured exercise to help prevent obesity in children and adolescents.

Examples of interventions that would be included in the review include the following.

- Interventions that provide opportunities for children to do more physical activity in school time (e.g. active lessons) so as to improve concentration in the classroom, and in the longer term, help prevent obesity.
- Interventions that alter the food environment within the school canteen (e.g. layout of food by kiosks) so as to make it easier to purchase healthier food items.
- Interventions that provide education to children and adolescents and their families on how to have a healthier diet and to do more physical activity.
- Interventions that regulate how HFSS foods are advertised to children within, and in close proximity to, educational settings.
- Digital interventions that are accessed by children and adolescents on their smartphones that use interactive games to educate on nutritional value of certain food types.

We will exclude studies:

- of interventions designed primarily to improve sporting performance (focused on strength and sport-specific fitness training);
- of interventions designed to prevent obesity in people who are pregnant.

##### *Setting*

We will include interventions in any setting, including the home, healthcare settings, childcare, schools and the wider community.

We will also include digital interventions. There is no single agreed definition of a digital intervention, and we are operationalising it here as one that employs software, hardware and digital services (e.g. example mobile health apps, wearable devices, telehealth and telemedicine, and personalised medicine) to help prevent childhood obesity.

#### *Comparators*

We will include studies that compared an eligible intervention with a non-intervention control group who received no intervention or usual care, or with another eligible intervention (i.e. head-to-head comparisons).

### Types of outcome measures

#### *Primary outcomes*

Our primary outcomes are:

- zBMI score, measured from weight and height of the children at least 12 weeks after randomisation and standardised to age-specific local or national tables for BMI; or (where zBMI is not available) BMI, measured from weight and height of the children at least 12 weeks after randomisation; and
- serious adverse events, defined as eating disorders, body dysmorphia disorder, body image disturbance or injuries sufficient to seek medical attention.

We consider zBMI to be a more useful proxy index of body fatness in children compared with BMI, so will consider zBMI above BMI. We will also present data for BMI because in some studies, particularly older studies and studies from some countries, only BMI is presented. In the event of presentation of multiple sets of data for zBMI orzBMI, we will follow the decision rules set out under Data extraction and management and Measures of treatment effect. We will present these main outcomes in the summary of findings tables.

Note that we will include zBMI and BMI taken from both measured and self-reported weight and height data, but we will make it clear where these measures are self-reported and conduct sensitivity analysis to address the impact of including these.

#### *Time points*

We will collect data from all reported postintervention time points at least 12 weeks from baseline. We will group data for analysis into three time periods: i) 12 weeks from baseline to < 9 months; ii) 9 months from baseline to < 15 months (corresponding to approximately one school year); and iii) long term (15 months or more).

Where included studies have collected relevant data on height and weight at the start and end of the intervention period but have not presented their findings using zBMI or BMI, we will report this information in tables, but not use the data in any summary.

#### *Secondary outcomes*

There are no secondary outcomes.

## Search methods for identification of studies

This is one of four linked protocols created to update the existing Cochrane Review on this topic (Brown 2019). The Brown 2019 review included children aged 0 to 18 years. This protocol covers children aged 12 to 18 years, with three additional, separate protocols in preparation for ages 0 to 2, 2 to 4, and 5 to 11 years. The search methods for this protocol (12 to 18 years) will build on, and be an update of, the literature searches and records screening previously undertaken in Brown 2019. We will isolate, at the screening stage, those records relevant to the age group 12 to 18 years. Details of the searches we are building on are available in Brown 2019. Because our eligibility criteria coincide with those of the Brown 2019 review, we will not repeat these searches.

### Electronic searches

For this update review we will search the following databases, from 2018 (the date of the last search in the Brown 2019 review):

- Cochrane Central Register of Controlled Trials (CENTRAL) in the Cochrane Library (Appendix 1);
- MEDLINE (Ovid);
- Embase (Ovid);
- PsycINFO (Ovid).

We will include additional search terms for topics around: marketing; beverages and sweetening agents; food labelling; school meals; after/out-of-school activities; parental interventions; public health; electronic apps and web-based interventions. These search terms will be run only in the Cochrane Library. The reason we chose to limit these terms to CENTRAL and the Cochrane Database of Systematic Reviews (CDSR) was a pragmatic one, as Cochrane's Centralised Search Service (CSS) uses a highly efficient search strategy to capture reports of RCTs from MEDLINE and Embase (for inclusion in CENTRAL) (Noel-Storr 2020). Also, our full search (run across all databases) includes several generic 'prevention' search strings, to capture any type of intervention. See Appendix 1 for an example of this search.

We will also run additional searches on the following education databases (1990 onwards):

- Australian Education Index (AEI) (EBSCOhost);
- British Education Index (BEI) (EBSCOhost);
- ERIC (Education Resources Information Center) (EBSCOhost).

We will examine adverse events only in the studies meeting the main eligibility criteria and will not perform an additional search focusing on adverse events.

### Searching other resources

We will search ClinicalTrials.gov with the filter 'Applied Filters: Child (birth–17)' and the WHO International Clinical Trials Registry Platform, search portal (ICTRP), using the filter for studies in children. In addition, we will look at the reference lists and references of included studies. We will run a pragmatic search for PhD theses (1990 onwards) using the following databases:

- Electronic Theses Online Service (EThOS) - British Library (ethos.bl.uk/Home.do);
- DART - Europe e-theses Portal (dart-europe.eu/basic-search.php);
- Networked Digital Library of Theses and Dissertations (NDLTD) (ndltd.org);
- Open Access Theses and Dissertations (OATD) (oatd.org);

- Proquest Dissertations & Theses Global (search.proquest.com/pqdtglobal/dissertations/).

## Data collection and analysis

### Selection of studies

Two authors will screen titles and abstracts independently and in duplicate using Covidence systematic review software. They will retrieve full-text articles of records that potentially meet the eligibility criteria, and screen these independently and in duplicate. The two authors will resolve any differences in opinion or uncertainty through a process of discussion and, when necessary will involve a third author.

### Data extraction and management

We will modify a data collection form for study characteristics and outcome data that was used in the Brown 2019 Cochrane Review of interventions to prevent obesity in children. Two review authors will extract study characteristics and numerical data independently and in duplicate. We will extract the following study characteristics.

- Methods: study design (including number of clusters in cluster-RCTs); total duration of study; details of any 'run in' period; number of study centres and location; study setting; date of study.
- Participants: numbers randomised, lost to follow-up/withdrawn and analysed; age (mean and range); sex; inclusion and exclusion criteria.
- Baseline zBMI or BMI
- Interventions: description of intervention and comparator intervention or control group conditions, such as type of intervention, duration of intervention, setting, theory behind the intervention, unit of intervention (who is targeted), who delivers the intervention.
- Outcomes: zBMI (mean and SD); BMI (mean and SD); numbers of reported serious adverse events.
  - Time points: as described under Types of outcome measures;
  - Measurement: we will note if BMI and ZBMI are self-reported (by parent or child) or measured by researchers;
  - Effect estimates: we will collect BMI and zBMI data according to these preferences:
    - postintervention mean differences adjusted for baseline zBMI (or BMI) from analysis of covariance; in preference to
    - postintervention mean differences; in preference to
    - differences in change-from-baseline means.
  - Effect estimates from cluster-RCTs: we will collect BMI and zBMI data that are adjusted for clustering in preference to analyses that are not adjusted for clustering;
- PROGRESS factors;
- Information about the costs of interventions, for the purposes of secondary analysis by healthcare policymakers. We will not analyse costs in this review;
- Notes: funding for trial, and notable conflicts of interest of trial authors.

Where we cannot extract desirable statistics directly (e.g. standard deviations of BMI), we will compute or estimate these using the methods described in the *Cochrane Handbook for Systematic Reviews of Interventions* (Li 2019).

### Assessment of risk of bias in included studies

We will assess the risk of bias (RoB) for all results using the RoB 2 tool (Sterne 2019), in the following five domains: bias arising from the randomisation process, bias due to deviations from intended interventions, bias due to missing outcome data, bias in measurement of the outcome and bias in selection of the reported result. Judgements about risk of bias will be determined using the algorithms in the tool, based on answers we give to the relevant signalling questions, although if we feel there is sufficient reason to override the algorithm, we will do this and state a reason for it. An overall risk of bias for each result will be produced, based on the least favourable assessment of bias across the domains. Judgements reached could be low, some concerns or high risk of bias. For cross-over RCTs, as we are using only the first period of the RCT, we will use the main RoB 2 tool for parallel group trials. For cluster RCTs we will use the version of the RoB 2 tool designed for studies using cluster randomisation (Eldridge 2021), which has an additional domain 'bias arising from the identification or recruitment of participants into clusters', and modified signalling questions within the other domains.

We will assess the effect of assignment to the intervention for the outcomes zBMI (or BMI) and serious adverse events at all time points. We will assess risk of bias only for specific results that contribute to the meta-analyses. For studies with multiple intervention arms, we will assess risk of bias for each specific pairwise comparison contributing to meta-analyses.

For studies we identify through new searches, two authors will independently use the RoB 2 tool to carry out the assessments (ET, FS, JPTH, JS, TM). Bias for results included in either the Brown 2019 Cochrane Review or the Hodder submitted review have been assessed for risk of bias by two authors independently using the original Cochrane risk of bias tool (RoB 1) (Higgins 2011). We will transform these RoB 1 assessments into RoB 2 assessments as follows. One author (ET, FS) will first undertake an independent RoB 2 assessment (blind to the RoB 1 assessment). She will then compare this with the previous RoB 1 assessment. Differences or uncertainties will be resolved through discussion with a second reviewer (FS, ET) and, where necessary, by involving a third author (JPTH, JS, TM). To avoid conflict of interest, any authors that are also trialists for an included study in this review will recuse themselves from risk of bias assessment of their trials.

To draw an overall conclusion about the risk of bias in a synthesised result across included studies, we will use the methods set out in Table 14.2.a of the *Cochrane Handbook for Systematic Reviews of Interventions* (Schünemann 2019).

We will upload a copy of the agreed consensus risk of bias to a data repository such as Figshare or Dryad for submission with the completed review. We will use our overall risk of bias assessment for each result in the review to inform GRADE (see summary of findings section) and for sensitivity analysis (see Sensitivity analysis).

### Measures of treatment effect

We will measure intervention effects on zBMI using an unstandardised mean difference (MD) between intervention groups. For BMI, we intend to examine mean difference and will perform sensitivity analyses using a standardised version (standardising by pooled standard deviation) in case of high heterogeneity in MDs across studies in different age groups. For

serious adverse events we will measure intervention effects using risk ratios.

### Unit of analysis issues

We will examine each cluster-RCT to determine whether the analysis accounted for clustering. For results that were not adjusted for clustering, we will create an approximate analysis by inflating the standard error of the estimated intervention effect according to an estimated 'design effect' (Higgins 2019a). This requires an estimate of the intra-cluster correlation coefficient (ICC), describing the relative variability within and between clusters. Where a study does not report this, we will use external estimates from (in preferential order): (i) other cluster-RCTs in the review with similar types of cluster; or (ii) published resources of previously identified cluster-RCTs (Ukoumunne 1999). We will run sensitivity analyses using 1) no adjustment, 2) adjustment for clustering assuming an ICC of 0.02, and 3) adjustment for clustering assuming an ICC of 0.04. We will report all values of unadjusted and adjusted standard errors plus data used to calculate them in Appendices or supplementary data files.

We will address RCTs with more than two intervention groups according to guidance in the *Cochrane Handbook for Systematic Reviews of Interventions* (Higgins 2019a). For RCTs with more than two experimental (or comparator) arms relevant to the same meta-analysis, we will combine the arms to create a single pairwise comparison. Where this precludes planned investigations of heterogeneity, we will keep the arms separate and halve the number of participants in the control arm. For factorial RCTs, we will include each main intervention effect as if they were distinct trials.

### Dealing with missing data

We will examine the extent and reasons for missing data as part of the risk of bias assessment of each included RCT. We will write to authors of trials to seek missing data for RCTs published in the last 15 years. We will not impute missing data.

### Assessment of heterogeneity

We will use the $I^2$ statistic to quantify the degree of inconsistency across results, supplemented by a P value from a test of homogeneity to measure the strength of evidence of statistical heterogeneity (Deeks 2019).

### Assessment of reporting biases

We will assess risk of bias arising from (non)reporting bias using the ROB-ME tool (Page 2020), which is based on the framework described in the *Cochrane Handbook for Systematic Reviews of Interventions* (Page 2019). For meta-analyses with more than 10 studies this will include examination of contour-enhanced funnel plots.

### Data synthesis

We will undertake meta-analyses of zBMI scores and BMI using the generic inverse variance method with a random-effects model (Deeks 2019). Our main comparisons are:

- dietary interventions versus no intervention/control;
- physical activity interventions (including those targeting sedentary behaviour, sleep, play and exercise) versus no intervention/control;
- intervention with both dietary and physical components versus no intervention/control;
- intervention with both dietary and physical components versus dietary intervention alone;
- intervention with both dietary and physical components versus physical activity intervention alone; and
- dietary intervention versus physical activity intervention.

Our intention is to analyse postintervention mean differences adjusted for baseline zBMI (or BMI) from analysis of covariance in preference to postintervention mean differences, and postintervention mean differences in preference to differences in change-from-baseline means. We will analyse differences that are adjusted for clustering (including our own approximate adjustments) in preference to analyses that are not adjusted for clustering.

If data are presented in the primary reports that are not immediately useable in our meta-analysis we will transform them, where possible, using methods described in Chapter 6 of the *Cochrane Handbook* (Higgins 2019b). Decision rules regarding which effect measure to extract and analyse, when multiple measures are presented, are described in the Data extraction and management section.

### Synthesis if data cannot be combined with meta-analysis

We expect most studies to contribute to meta-analyses, because measurement of BMI is an eligibility criterion for this review, and we will make extensive efforts to estimate intervention effects from diversely reported results (e.g. from regression coefficients, from P values and from analyses based on dichotomised BMI scores (Higgins 2019b)). We will supplement the meta-analyses with two additional analyses so as to include studies that cannot be included in the meta-analyses. First, we will extract exact one-sided P values from studies that provide them and perform a meta-analysis of P values (Becker 1994; McKenzie 2019a). Second, we will collate the direction of effect (favouring the experimental intervention or the control intervention), and perform a simple test for overall direction of effect (McKenzie 2019b). We will examine the impact of adding additional studies by repeating these analyses including (i) only the studies in the meta-analysis and (ii) all studies for which the statistic can be derived.

### Serious adverse events

We will undertake meta-analyses of serious adverse events if there are sufficient numerical data. Since events are expected to be rare, we plan to use the Mantel-Haenszel method for this, and will also perform a random-effects meta-analysis using the generic inverse variance method as a sensitivity analysis. We will use a synthesis without meta-analysis approach if insufficient data are available (Becker 1994).

### Subgroup analysis and investigation of heterogeneity

We will explore heterogeneity in the primary analyses by performing the following pre-planned subgroup analyses according to study-level characteristics and (where possible) participant-level characteristics:

- main setting of the intervention (childcare/preschool, school, other educational settings, health service, wider community, home);

- duration of active intervention period: (i) 12 weeks from baseline to < 9 months; (ii) 9 months from baseline to < 15 months (corresponding to approximately one school year); and (iii) long term (15 months or more from baseline);
- income status of country (using World Bank criteria);
- socioeconomic status; (low vs high vs mixed, based on categorisations as described by the trial authors); and
- sex (if the predominance of studies present subgroup analyses by sex).

Tests for subgroup differences will be based on standard heterogeneity tests as described in Chapter 10, section 10.11.3.1 of the *Cochrane Handbook* (Deeks 2019).

### Sensitivity analysis

We will perform sensitivity analyses to examine the robustness of our findings to inclusion of results assessed as being at high risk of bias, by repeating analyses with such results omitted. We will investigate the impact of imputing ICCs in cluster-RCTs, as described in the section Unit of analysis issues. We will repeat analyses of BMI using standardised mean differences as described in the Measures of treatment effect section.

### Summary of findings and assessment of the certainty of the evidence

We will prepare summary of findings tables for each of our main comparisons for the time point 12 weeks to < 9 months. Each summary of findings table will summarise the size and certainty of effects of the interventions for the three outcomes BMI; zBMI and serious adverse events. We will base our assessments of certainty on the five GRADE considerations (risk of bias, consistency of effect, imprecision, indirectness and publication bias). We will use GRADEpro software (GRADEpro ), and follow methods described in the *Cochrane Handbook for Systematic Reviews of Interventions* (Schünemann 2019).

Two authors will work independently to make GRADE judgements, resolving any disagreements by discussion or, where necessary, by consulting with a third author. All decisions to rate down certainty in the results will be justified using footnotes, with comments added to aid readers' interpretation of the tables. We will document and incorporate the GRADE judgements into reporting of results for each outcome.

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# APPENDICES

## Appendix 1. Search strategy for Cochrane CENTRAL

**Search-1 (rolling search, 2018 onwards)**

#1 MeSH descriptor: [Obesity] explode all trees

#2 MeSH descriptor: [Body Weight Changes] explode all trees

#3 (obes*):ti,ab,kw

#4 (“weight gain” or “weight loss”):ti,ab,kw

#5 (overweight or “over weight” or overeat* or (over next eat*)):ti,ab,kw

#6 (weight next change*):ti,ab,kw

#7 ((bmi or “body mass index”) near (gain or loss or change*)):ti,ab,kw

#8 {OR #1-#7}

#9 MeSH descriptor: [Behavior Therapy] explode all trees

#10 MeSH descriptor: [Social Support] explode all trees

#11 MeSH descriptor: [Psychotherapy, Group] explode all trees

#12 ((psychological or behavio?r*) near (therapy or modif* or strateg* or intervention*)):ti,ab,kw

#13 (“group therapy” or “family therapy” or “cognitive therapy”):ti,ab,kw

#14 ((lifestyle or “life style”) near (chang* or intervention*)):ti,ab,kw

#15 counsel?ing:ti,ab,kw

#16 “social support”:ti,ab,kw

#17 (peer near/2 support):ti,ab,kw

#18 (children near/3 parent* near/3 therapy):ti,ab,kw

#19 {OR #9-#18}

#20 MeSH descriptor: [Obesity] explode all trees and with qualifier(s): [diet therapy - DH]

#21 MeSH descriptor: [Diet Therapy] explode all trees

#22 MeSH descriptor: [Fasting] this term only

#23 (diets or diet or dieting):ti,ab,kw

#24 (diet* near (modif* or therapy or intervention* or strateg*)):ti,ab,kw

#25 (“low calorie” or (calorie next control*) or “healthy eating”):ti,ab,kw

#26 (fasting or (modified next fast*)):ti,ab,kw

#27 MeSH descriptor: [Dietary Fats] explode all trees

#28 (fruit or vegetable*):ti,ab,kw

#29 (high next fat*) or (low next fat*) or (fatty next food*):ti,ab,kw

#30 (formula next diet*):ti,ab,kw

#31 {OR #20-#30}

#32 MeSH descriptor: [Exercise] explode all trees

#33 MeSH descriptor: [Exercise Therapy] explode all trees

#34 exercis*:ti,ab,kw

#35 (aerobics or “physical therapy” or “physical activity” or “physical inactivity”):ti,ab,kw

#36 (fitness near (class* or regime* or program*)):ti,ab,kw

#37 (“physical training” or “physical education”):ti,ab,kw

#38 “dance therapy”:ti,ab,kw

#39 (sedentary next behavio?r*):ti,ab,kw

#40 {OR #32-#39}

#41 MeSH descriptor: [Complementary Therapies] explode all trees

#42 ( “alternative medicine” or (complementary next therap*) or “complementary medicine”):ti,ab,kw

#43 (hypnotism or hypnosis or hypnotherapy):ti,ab,kw

#44 (acupuncture or homeopathy or homoeopathy):ti,ab,kw

#45 (“chinese medicine” or “indian medicine” or “herbal medicine” or ayurvedic):ti,ab,kw

#46 {OR #41-#45}

#47 (diet* or slim*) near (club* or organi?ation):ti,ab,kw

#48 (weightwatcher* or (weight next watcher*)):ti,ab,kw

#49 (correspondence near (course* or program*)):ti,ab,kw

#50 ((fat or diet*) next camp*):ti,ab,kw

#51 {OR #47-#50}

#52 MeSH descriptor: [Health Promotion] explode all trees

#53 MeSH descriptor: [Health Education] explode all trees

#54 (“health promotion” or “health education”):ti,ab,kw

#55 (“media intervention*” or “community intervention*”):ti,ab,kw

#56 (health next promoting next school*):ti,ab,kw

#57 ((school or community) near/2 program*):ti,ab,kw

#58 ((school or community) near/2 intervention*):ti,ab,kw

#59 ((family next intervention*) or (parent* next intervention*)):ti,ab,kw

#60 (parent* near/2 (behavio?r* or involve* or control* or attitude* or educat*)):ti,ab,kw

#61 {OR #52-#60}

#62 MeSH descriptor: [Health Policy] explode all trees

#63 ( (health next polic*) or (school next polic*) or (food next polic*) or (nutrition next polic*)):ti,ab,kw

#64 {OR #62- #63}

#65 MeSH descriptor: [Obesity] explode all trees and with qualifier(s): [prevention & control - PC]

#66 MeSH descriptor: [Primary Prevention] explode all trees

#67 (“primary prevention” or “secondary prevention”):ti,ab,kw

#68 (preventive next measure*) or (preventative next measure*):ti,ab,kw

#69 (“preventive care” or “preventative care”):ti,ab,kw

#70 (obesity near/2 (prevent* or treat*)):ti,ab,kw

#71 {OR #65-#70}

#72 (#19 OR #31 OR #40 OR #46 OR #51 OR #61 OR #64 OR #71)

#73 #8 AND #72

#74 MeSH descriptor: [Child] explode all trees

#75 MeSH descriptor: [Adolescent] this term only

#76 (child* or adolescen* or pediatr* or paediatr* or boys or girls or youth or youths or teenage* or "young people" or "young person*" or "young adult*" or schoolchildren or "school children"):ti,ab,kw

#77 {OR #74-#76}

#78 #73 AND #77

**Search-2 (new, 1990 onwards)**

#79 MeSH descriptor: [Marketing] explode all trees

#80 MeSH descriptor: [Persuasive Communication] this term only

#81 MeSH descriptor: [Communications Media] explode all trees

#82 (marketing or advert* or campaign* or "mass media" or "social media" or blog* or vlog*):ti,ab,kw

#83 (persuasive or persuasion or persuader*):ti,ab,kw

#84 MeSH descriptor: [Food Packaging] this term only

#85 MeSH descriptor: [Food Labeling] this term only

#86 ((food? or drink? or product? or nutrition* or diet* or carb* or sugar* or fat? or calori* or warning) NEAR/3 (label* or packag*)):ti,ab,kw

#87 "traffic light*":ti,ab,kw

#88 {OR #79-#87}

#89 MeSH descriptor: [Artificially Sweetened Beverages] this term only

#90 MeSH descriptor: [Beverages] this term only and with qualifier(s): [adverse effects - AE]

#91 MeSH descriptor: [Sweetening Agents] explode all trees

#92 (artificial* near/3 sweeten*):ti,ab,kw

#93 ((sugar* or sweeten* or unsweeten* or diet or "low calorie" or fizzy or carbonated) NEAR/3 (beverag* or drinks or juice? or cordial? or pop or smoothie? or snack?)):ti,ab,kw

#94 (((fizzy or carbonated) near/3 (beverag* or drinks)) or soda?):ti,ab,kw

#95 ("low sugar" or "high sugar" or "high fat" or HFSS):ti,ab,kw

#96 ((sugar or fat or food) near/2 (literacy or education)):ti,ab,kw

#97 {OR #89-#96}

#98 MeSH descriptor: [Food Services] explode all trees

#99 MeSH descriptor: [Dietary Services] this term only

#100 (school* near/3 (breakfast? or catering or diet* or dinner? or dining or lunch* or meal? or food? or snack?)):ti,ab,kw

#101 ("breakfast club?" or "catering service?"):ti,ab,kw

#102 (mealtim* or "meal tim*" or "meal environment?"):ti,ab,kw

#103 ("packed lunches" or "tuck shops" or "snack shops"):ti,ab,kw

#104 "vending machine?":ti,ab,kw

#105 {OR #98-#104}

#106 ("after school" or out-of-school):ti,ab,kw

#107 MeSH descriptor: [Non-Medical Public and Private Facilities] explode all trees

#108 MeSH descriptor: [Leisure Activities] explode all trees

#109 MeSH descriptor: [Physical Education and Training] this term only

#110 MeSH descriptor: [Sports and Recreational Facilities] explode all trees

#111 ((youth? or communit* or holiday* or vacation* or activit* or fitness or sport* or recreation* or leisure) near/3 (center? or centre? or camp? or club?)):ti,ab,kw

#112 ((youth? or communit* or holiday* or vacation* or leisure) next based):ti,ab,kw

#113 MeSH descriptor: [Movement] this term only

#114 MeSH descriptor: [Fitness Trackers] this term only

#115 (((movement or activit* or fitness) near/2 (app or based or chang* or monitor* or measur* or track*)) or recreation* or sport* or play):ti,ab,kw

#116 MeSH descriptor: [Sleep] explode all trees

#117 sleep*:ti or ((sleep near/3 (duration or efficienc* or hygiene or problem* or quality)) or actigraph*):ti,ab,kw

#118 {OR #106-#117}

#119 ((parent* or family or families or guardian?) near/2 (advice or advisory or (behavi* near chang*) or coach* or educat* or focus* or intervention* or program* or project* or psychoeducat* or strateg* or study or support* or therap* or train* or trial)):ti,ab,kw

#120 ((parent* or family or families or guardian?) next (based or centred or centered or focus* or tailored or target*)):ti,ab,kw

#121 {OR #119-#120}

#122 MeSH descriptor: [Religion] explode all trees

#123 MeSH descriptor: [Culture] explode all trees

#124 (religi* or church or spiritual or faith?):ti,ab,kw

#125 ((cultur* or multicultur* or race or racial*) near/2 (adapted or appropriate or based or center* or centre* or competent or focus* or tailored or translat* or target*)):ti,ab,kw

#126 {OR #121-#125}

#127 MeSH descriptor: [Public Health] this term only

#128 "public health":ti,ab,kw

#129 ((complex or co-ordinated or comprehensive or factorial or interdisciplinary or inter-disciplinary or multiple or "multi component?" or multicomponent? or multidisciplin* or "multi disciplin*" or multidimension* or "multi dimension*" or multifactor* or "multi factor*" or multifacet* or "multi facet*" or multilevel* or "multi level*" or multimodal* or "multi modal*" or multiparamet* or "multi paramet*" or multiecological or "multi* ecological") near (intervention? or program* or project? or strateg* or study or support* or system? or therap* or train* or trial)):ti,ab,kw

#130 {OR #127-#129}

#131 MeSH descriptor: [Computer Communication Networks] explode all trees

#132 MeSH descriptor: [Telecommunications] explode all trees

#133 MeSH descriptor: [Mobile Applications] this term only

#134 MeSH descriptor: [Cell Phone] explode all trees

#135 MeSH descriptor: [Therapy, Computer-Assisted] this term only

#136 digital*:ti,kw OR (digital near/3 (assist* or based or deliver* or intervention? or pilot or platform? or program* or project? or strateg* or study or support* or system? or technolog* or therap* or train* or trial)):ab

#137 (android or app or apps or avatar* or blog* or CD-ROM or "cell* phone*" or cellphone* or "chat room*" or chatroom* or cyber* or DVD or eHealth or e-health or "electronic health" or e-Portal or ePortal or ePsych* or e-Psych* or eTherap* or e-therap* or "electronic forum*" or gaming or "information technolog*" or "instant messag*" or ipad or i-pad or iphone or i-phone or ipod or i-pod or podcast or "smart phone" or smartphone or "social network* site*" or "social networking" or mHealth or m-health or multi-media or multimedia or "personal digital assistant" or PDA or SMS or smartwatch* or "smart watch*" or "social medi*" or telehealth* or tele-health* or telemed* or tele-med* or telemonitor* or tele-monitor* or telepsych* or tele-psych* or teletherap* or tele-therap* or texting):ti,ab,kw

#138 (internet or technolog* or tele* or web):ti,kw or ((computer or e-mail* or email* or messaging or internet* or mobile or online* or on-line or software or technolog* or telecomm* or tele-comm* or "text messag*" or virtual* or web or WWW) near/3 (assist* or based or deliver* or intervention? or pilot or platform? or program* or project? or strateg* or study or support* or system? or technolog* or therap* or train* or trial)):ti,ab,kw

#139 (gaming or gamification or "wearable device?" or wearables or videogame or "video game" or videoconferenc* or "video conferenc*"):ti,ab,kw

#140 (synchronous or asynchronous or (electronic near/2 deliver*) or eLearning or e-learning or "blended learning"):ti,ab,kw

#141 (screentime or "screen time"):ti,ab,kw

#142 ("self care" and (computers or internet or software)):kw

#143 {OR #131-#142}

#144 (#88 OR #97 OR #105 OR #118 OR #121 OR #126 OR #130 OR #143)

#145 (#8 AND #144 AND #77)

#146 (#145 NOT #78)

#147 (BMIz or (BMI* near/2 (z-scor* or zscor*))):ti,ab

#148 ((bmi or "body mass index") near/3 (assess* or calculat* or change? or changing or differ* or increas* or decreas* or reduc* or post-intervention* or "follow* up*" or followup*)):ti,ab

#149 ((bmi or "body mass index") near/3 outcome?):ti,ab

#150 ((adiposity or fat or weight) near/3 (goal? or outcome?)):ti,ab

#151 #147 OR #148 OR #149 OR #150

#152 #151 AND (#72 OR #44) AND #77

#153 #152 NOT (#78 OR #145)

**********

Note.

Rolling search – additional terms 2015 onwards

#1 MeSH descriptor: [Body Weight Changes] explode all trees

#20 MeSH descriptor: [Obesity] explode all trees and with qualifier(s): [diet therapy - DH]

#24 (diet* near (modif* or therapy or intervention* or strateg*)):ti,ab,kw

#30 (formula next diet*):ti,ab,kw

#65 MeSH descriptor: [Obesity] explode all trees and with qualifier(s): [prevention & control - PC]

## CONTRIBUTIONS OF AUTHORS

Developed concept of the review: CS, JPTH, TM, RJ, DC
Drafted the protocol: CS, RH, TM, SD, YG, FS, ET, JPTH, SI, LW, JN, JS, DC, SP, FHB
Drafted and developed the search strategy: SD

## DECLARATIONS OF INTEREST

- **Theresa HM Moore:** reports being employed by Cochrane as a Methodology Editor.
- **Eve Tomlinson:** declares that they have no conflict of interest.
- **Francesca Spiga:** declares that they have no conflict of interest.
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- **Luke Wolfenden:** reports research grants to undertake trials likely to be included in the review; paid to University of Newcastle. LW reports that he benefited financially from these payments and/or has access to or control of the funds. LW reports involvement in conducting a study (or studies) that is (are) eligible for inclusion in the work. LW has received funding, via grants awarded to his institution, for his time to undertake research, and to conduct research trials including activities from study development, conduct, analysis and reporting from NSW Ministry of Health, Nib Foundation, Heart Foundation and National Health and Medical Research Council. LW reports that he has published numerous opinions, commentary or editorial on topics pertaining to chronic disease prevention, healthy eating, physical activity and obesity. LW reports working as a health promotion program manager at Hunter New England Local Health District, a government funded health service. LW is Co-ordinating Editor of Cochrane Public Health; however, he was not involved in any stage of the editorial management or assessment of this protocol.
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- **Sophie Phillips:** declares that they have no conflict of interest.
- **Frances Hillier-Brown:** declares that they have no conflict of interest.
- **Carolyn D Summerbell:** reports being affiliated with the WHO, and contributed to their work on 'Ending Childhood Obesity'.

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