RRH3529_Table 1

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
Balagopal et al. 2012 (ref. 10)	To test the effectiveness of a 6-month community-based DM prevention and management program in rural Gujarat, India	Whole-of-community	1638 rural Indians ≥18 years	CBPR approach	No	Yes	CBPR	No	NA	Yes Explicit	Yes Inferred	Yes Inferred
Ho et al. 2006 (ref. 11)	(1) To explore the needs and perceptions of community members surrounding health and DM (2) To assess the feasibility of adapting programs from Sandy Lake (3) To engage the community in the development of an integrated intervention program through participatory activities	Whole-of-community	72 participants from three communities	Participatory research and ethnography Qualitative and quantitative methods, including in-depth interviews, group activities, demonstrations, observations and discussions with participants	No	Yes	Participatory research	No	NA	NYI		
Zimmermann et al. 2012 (ref. 12)	This research describes the development and implementation of SSWICH, and examines the success of the initiative in reaching a population of rural women in southernmost Illinois.	Whole-of-community	Over 600 women in the community	Collaborative, ecological framework. SSWICH used a collaborative, multi-strategy approach to reduce cardiovascular disease risk in rural women through community-based health promotion, peer education and a mass media campaign. Evaluation data from each strategy were used to examine the success of SSWICH in reaching the women in southernmost Illinois.	No	Yes	CBPR	No	NA	Yes Inferred	Yes Inferred	Yes Inferred
Yeary et al. 2011 (ref. 13)	To assess the feasibility of delivering an adapted diabetes-prevention program intervention by lay health advisor leaders through rural churches	Community organisation	26 African Americans	CBPR approach	No	Yes	CBPR	Yes	Social cognitive theory	Yes Explicit	Yes Inferred	Yes Inferred
Bazzano et al. 2009 (ref. 14)	To increase knowledge, skills, and self-efficacy regarding health, nutrition, and fitness among adults with developmental disabilities	Whole-of-community	44 completed program (31 eligible) Community-dwelling adults 18–65 years, BMI≥25 plus another risk factor for DM	Single-group community-based demonstration project	No	Yes	CBPR	Yes	Social cognitive theory	Yes Inferred	Yes Inferred	Yes Explicit,
de Silva-Sanigorski et al. 2010 (ref. 15)	To determine the effectiveness of the Romp & Chomp intervention in reducing obesity and promoting healthy eating and active play in children aged 0–5 years	Whole-of-community	12 000 children aged 0–5 years	Initial study: community-wide, multi-setting, multi-strategy intervention This study was a repeat cross-sectional with a quasi-experimental design	Yes – comparison Comparison communities were exposed to subtle rather than directed health-promotion activities	Yes	Socioecologic framework	No	NA	Yes Explicit	Yes Explicit	Yes Explicit
Puder et al. 2011 (ref. 16) Niederer at al. 2009 (ref. 17)	To test the effect of a multidimensional lifestyle intervention on aerobic fitness and adiposity in predominantly migrant preschool children	Schools	652 children	One year cluster randomised controlled single blinded trial	Yes – control Lifestyle intervention (physical activity, sleep, nutrition, media use) vs no intervention	Yes	Social ecological model	No	NA	Yes Explicit	Yes Inferred	Yes Explicit
						Provided in ref. 17						

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
Prabhakaran et al. 2009 (ref. 18)	To outline the methods of developing a comprehensive CVD prevention and health promotion program, present the results of this program, and discuss their implications	Workplaces	6806 industrial site employees and their family members aged 10–69 years	Cross-sectional survey with a multi-level, multi-method and multi-component intervention	Yes – control Intervention vs no intervention	Yes	Socioecological theory	Yes	Social cognitive theory, social learning theory	No	Yes Inferred	Yes Inferred
Duffany et al. 2011 (ref. 19)	To present the results of a several-year planning process that includes a theoretical framework and study design that highlights the key elements of conducting complex community interventions in developing country settings	Whole-of-community	12 200 people from Community Interventions for Health sites in four countries (intervention and comparison)	3-year pilot study	Yes – control Intervention population and control population	Yes	Social ecological model	No	NA	Yes Explicit	Yes Explicit	Yes Inferred
Greening et al. 2011 (ref. 20)	To evaluate a healthy lifestyle school-based obesity intervention in a rural southern community, where the rate of obesity ranks as the highest	Schools	450 children 6–10 years, 204 attended the intervention school and 246 attended the control school	School-based intervention trial	Yes – an 8-month intervention program was completed at the intervention school The control school followed the state's standard health curriculum	No	NA	Yes	Social learning theory	Yes Inferred	Yes Explicit	Yes Explicit
Draper et al. 2010 (ref. 21)	Primary aims of HealthKick: promote healthful eating habits and increase regular participation in health enhancing physical activity to prevent overweight, and reduce risk of chronic diseases (particularly T2DM); and to promote the development of an environment within the school and community that facilitates the adoption of healthy lifestyles	Schools	16 schools (sample size not provided)	Three-phase design: intervention mapping and formative assessment, intervention development, and outcome and process evaluation	Yes – control Intervention 'co-implementation' schools and control 'self-implementation' schools	Yes	Intervention mapping	Yes	Social cognitive theory	Yes Explicit	Yes Inferred	Yes Explicit
Williamson et al. 2008 (ref. 22) Williamson et al. 2012 (ref. 23) Newton et al. 2011 (ref. 24)	Primary aim of the LA Health project is to test the efficacy of two school-based approaches for obesity prevention: primary prevention alone and a combination of primary and secondary prevention which will be compared to a no-intervention control group	Schools	2102 (in randomised controlled trial) 607 (in observation control group) Children in grades 4–6	Cluster randomised controlled trial	Yes – control Primary intervention (environmental approach) vs primary plus secondary intervention (classroom/internet approach) vs no intervention	No	NA	Yes	Social learning theory	Yes Explicit (ref. 24)	Yes Inferred (ref. 23)	Yes Explicit (ref. 22)
Carr et al. 2008 (ref. 25)	To determine whether the Active Living Every Day internet-delivered theory-based physical activity behaviour change program increases physical activity and improves cardiometabolic disease risk factors in sedentary overweight adults.	Whole-of-community	32 adults 21–65 years, BMI 18–40, sedentary lifestyle	Randomised controlled trial	Yes – control 16-week Active Living Every Day intervention vs delayed intent-to-treat control condition	No	NA	Yes	Social cognitive theory, transtheoretical model	Yes Explicit	Yes Inferred	Yes Explicit
Parra-Medina et al. 2010	To assess the effectiveness of a culturally appropriate, theory-based intervention to	Primary care	266 African American women ≥35 years	Randomised controlled trial	Yes – comparison Standard care	No	NA	Yes	Social cognitive theory,	Yes Explicit	Yes Inferred	Yes Inferred

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
(ref. 26)	reduce dietary fat and increase moderate-intensity physical activity in primary care settings among underserved African American women				intervention (provider counselling, nurse goal setting, and educational materials) vs comprehensive intervention (standard care intervention plus 12 months of telephone counselling and tailored print materials)				transtheoretical model			
Winett et al. 1999 (ref. 27)	To describe an intervention based on social cognitive theory that entails integrating self-regulatory procedures with social and environmental supports in rural churches serving people from lower socioeconomic groups	Community organisation	12 rural, low socioeconomic status churches	Cluster-controlled intervention study	Yes – comparison social cognitive theory intervention vs information-only program	No	NA	Yes	Social cognitive theory	No	Yes Inferred	Yes Inferred
Von Gruenigen et al. 2008 (ref. 28)	To assess feasibility of a lifestyle intervention program for promoting weight loss, change in eating behaviours, and increased physical activity in obese endometrial cancer survivors	Primary care	45 women, BMI>25, stage I or II endometrial cancer, received surgery, no evidence of disease at time of enrolment	Prospective two-group randomised controlled trial	Yes – control Lifestyle intervention vs usual care	No	NA	Yes	Social cognitive theory	No	Yes Inferred	Yes Inferred
Simmons et al. 2008 (ref. 29)	To assess the impact of personal lifestyle change supported by changes in the surrounding social and physical environment	Whole-of-community	5240 non-pregnant Maori family members without DM ≥28 years	Randomised cluster-controlled trial	Yes – control intervention (incl. personal support delivered by a Maori Community Health Worker) vs no intervention	No	NA	Yes	Social cognitive theory	No	Yes Inferred	Yes Inferred
Kilkkinen et al. 2006 (ref. 30)	To evaluate the adaptability of an effective intervention model to Australian primary healthcare settings	Primary care	237 adults 40–75 years, DM risk score ≥12, capillary plasma glucose ≤11 mmol/L	Longitudinal pre-test post-test study	No	Yes	Health action process approach	Yes	Social learning theory, self-regulation theory, transtheoretical model	No	Yes Inferred	Yes Inferred
Daniel et al. 1999 (ref. 31)	To test the effect of a community-directed DM intervention program at the population level	Whole-of-community	925 adults ≥18 years, pregnant women excluded Intervention (475), comparison (212 and 238)	Quasi-experimental	Yes – comparison Single intervention community matched to two comparison communities	Yes	Precede–proceed model	Yes	Social learning theory, health belief model, theory of reasoned action, community change models, socio-behavioural theory	Yes Explicit	Yes Explicit	Yes Explicit
Hageman et al. 2011 (ref. 32)	To compare the effectiveness of an interactive website only, interactive website plus a peer-led online support group, and interactive website plus professional weight loss counselling via email in facilitating initial weight loss (baseline to 6 months), guided continuing	Whole-of-community	306 women 45–69 years, BMI 28–45, residents in one of ten rural counties in a Midwestern state in the US	Randomised controlled trial	Yes – control Interactive website vs interactive website plus peer-led online support group vs interactive website plus professional weight loss counselling	Yes	Health Promotion Model	Yes	Social cognitive theory	Yes Explicit	NYI	

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
	weight loss and maintenance (7–18 months) and self-directed weight maintenance (19–30 months)				via email							
Balagopal et al. 2008 (ref. 33)	This study evaluated a 7-month community-based non-pharmacological lifestyle intervention to prevent/reduce the risk of developing DM and its complications in a resource-poor village in Tamilnadu, India	Whole-of-community	703 village inhabitants (118 youth 10–17 years and 585 adults)	Collective population approach	No	Yes	Collective population approach	No	NA	Yes Inferred	Yes Inferred	Yes Explicit
Riddell et al. 2012 (ref. 34)	The protocol for a cluster randomised controlled trial of group-based peer support for people with T2DM in a community setting	Whole-of-community	120 participants per study arm. Participants and peer leaders, able to understand English, 25–75 years and diagnosed with T2DM for more than 12 months are eligible	A cluster randomised controlled evaluation of a group-based peer support program. This multi-faceted intervention comprises four interconnected components for delivering support to the participants	Yes – control. The intervention arm participate in the peer-support program for 12 months; the control arm will continue with their usual care.	Yes	Reach, Efficacy, Adoption, Implementation, and Maintenance framework	No	NA	NYI		
Rowley et al. 2000 (ref. 35)	To assess the sustainability and effectiveness of a community-directed program for primary and secondary prevention of obesity, DM and cardiovascular disease in an Aboriginal community in north-west Western Australia	Whole-of-community	*n*=49 high-risk individuals, and *n*=200 at baseline, 185 at 2-year and 132 at 4-year follow-ups	Evaluation of health outcomes in a cohort of high-risk individuals and cross-sectional community samples process (interventions and their implementation) and impact (diet and exercise behaviour)	Yes – but not considered by the authors to be a true control group, as the groups were self-selected. Persons participating in diet or physical activity interventions (the 'intervention group') were compared with persons not participating in diet or physical activity interventions (the 'non-intervention group')	No	NA	No	NA	Yes Explicit	Yes Explicit	Yes Explicit
Wapner et al. 2010 (ref. 36)	To address barriers to access to health services and medical education, the authors conducted TAKE ACTION, a small-scale pilot intervention to evaluate the effectiveness of a multidisciplinary, healthy lifestyle program for overweight youth and parents living in a rural community	Whole-of-community	14 youth and 12 parents participated in the program. Eligible youth were 6–17 years with BMI ≥85th percentile and a co-participating parent	Single-arm pilot study	No	No	NA	Yes	TTM	No	Yes Inferred	Yes Explicit
Debussche et al. 2012 (ref. 37)	To test the efficacy of a long-term (2 years) structured group self-management educational intervention in improving blood glucose in non-recent, insufficiently controlled DM.	Primary care	240 outpatients ≥18 years with T2DM treated for ≥1 year and initial HbA1c≥7.5% for ≥3 months	Randomised two-arm controlled trial	Yes – control Initial blinded structured education program, then unblinded group-based on-going structured self-management education support vs no on-going	No	NA	Yes	Socio-constructivism, social contextualisation, empowerment, action planning	NYI		

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
					support							
Huang et al. 2011 (ref. 38)	To evaluate the effects of a community intervention program, which focused on improving the hypertension knowledge, diets and lifestyles in a rural Chinese area	Whole-of-community	1509 (≥35 years, not suffering from CAD, DM or chronic kidney disease)	Community intervention trial	Yes – control Intervention (hypertensioneducation and dietary and lifestyle guidance) vs no intervention	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Janicke et al. 2011 (ref. 39)	To evaluate the effects of a behavioural 'family-based' intervention and a behavioural 'parent-based' intervention relative to an education control condition, delivered via group contacts to overweight and obese children and/or their parents in rural counties, on children's standardised BMI	Primary care	240 parent-child dyads (240 children 8–12 years with a BMI≥85th percentile for age and gender plus parent/legal guardian(s) (if ≤75 years))	Three-arm randomised controlled trial	Yes – control (a) A family-based behavioural group intervention (b) A parent-only behavioural group intervention (c) An education control condition	No	NA	No	NA	NYI		
Johnson et al. 2010 (ref. 40)	To determine the effectiveness of a 6-week beauty salon-based health intervention in improving diet, physical activity, and water consumption behaviours in African American women using a quasi-experimental design	Community organisation	20 African American women aged 18–70 years who were beauty salon clients	Quasi-experimental design (pilot study)	Yes – comparison Intervention (motivational sessions, information packet and starter kit) vs no intervention	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Adams et al. 2011 (ref. 41) Adams et al. 2009 (ref. 42)	Tooty Fruity Vegie aimed to reduce the incidence of overweight and obesity childhood by increasing the proportion of children who eat a nutritionally adequate diet, improving 12 fundamental movement skills and increasing the proportion of children with adequate physical activity levels	Schools	18 preschools (matched with 13 control preschools) (3–5 years)	One-year intervention with a quasi-experimental design study	Yes – control	Yes	Health Promoting Schools framework	Yes	Health belief model, competence motivational theory	Yes Explicit	Yes Explicit	Yes Inferred
Naylor et al. 2010 (ref. 43)	To explore the feasibility and implementation of Action Schools! BC in three remote Aboriginal communities in northern British Columbia	Schools	3 rural remote Aboriginal schools	Case study design	No	Yes	Action Schools! BC	No	NA	Yes Explicit	Yes Inferred	Yes Inferred
Nguyen et al. 2012 (ref. 44)	Evaluate the impact of healthy lifestyle promotion campaigns on CVD risk factors in the general population in the context of a community-based program on hypertension management	Whole-of-community	4650 adults >25 years	Quasi-experimental study	Yes – control intervention commune (hypertensive-targeted management program integrated with a community-targeted health promotion) vs no new program	No	NA	No	NA	No	Yes Explicit	Yes Inferred
Parker et al. 2010 (ref. 45)	The LIFE Project is a 10-week intervention designed to reduce obesity in rural African American women	Community organisation	28 African American or Black non-pregnant women 25–64 years	Church-based 10-week weight-loss educational intervention program	Yes – comparison Spiritually based vs non-spiritually based interventions	No	NA	No	NA	No	Yes Inferred	Yes Inferred

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
Qiao et al. 2010 (ref. 46)	(1) To raise the public awareness of DM and DM risk factors, and promote healthy diet and physical activity (2) To reduce the number of high-risk people developing DM through lifestyle counselling (3) Early diagnosis of DM (4) To evaluate the effectiveness, cost-effectiveness, feasibility, acceptability and sustainability of the programs	Primary care	1313 individuals with impaired fasting glucose/impaired glucose tolerance	Randomised controlled trial	Yes – control Intervention (lifestyle counselling) vs no intervention	No	NA	No	NA	No	Yes Inferred	Yes Explicit
Reinhardt et al. 2012 (ref. 47)	To investigate whether phone-based lifestyle education using motivational interviewing resulted in positive lifestyle change post gestational DM for women in a large rural area	Primary care	38 women following gestational DM diagnosis	Pilot randomised controlled trial	Yes – control Intervention (6-month phone-based motivational interviewing) vs no intervention	No	NA	No	NA	Yes Inferred	Yes Inferred	Yes Inferred
Sarrafzadegan et al. 2009 (ref. 48)	To assess the effects of a comprehensive, integrated community-based lifestyle intervention on diet, physical activity and smoking in two Iranian communities	Whole-of-community	12 600 adults from urban and rural populations	Community-based lifestyle intervention program	Yes – control Two intervention counties (Isfahan and Najaf-Abad) and a control area (Arak)	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Vadheim et al. 2010 (ref. 49)	To evaluate the feasibility of translating the DPP lifestyle intervention into practice in a rural community	Whole-of-community	101 adults ≥18 years, BMI≥25 plus one other diabetic/CVD risk factors	Risk reduction intervention study	No	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Vadheim et al. 2010 (ref. 50)	To assess the feasibility of delivering an adapted group-based version of the DPP's lifestyle intervention through telehealth video conferencing	Primary care	27 adults ≥18, BMI≥25 plus one other DM/CVD risk factors	Controlled DPP intervention	Yes – comparison DPP lifestyle intervention through telehealth vs on-site	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Ackermann et al. 2008 (ref. 51)	To evaluate the delivery of a group-based DPP lifestyle intervention in partnership with the YMCA	Community organisation	92 adults, ADA risk score ≥10 and CCBG of 110–199 mg/dL	Pilot cluster-randomised trial	Yes – comparison Compare group-based DPP lifestyle intervention delivery by the YMCA to brief counselling alone	No	NA	No	NA	Yes Inferred	Yes Inferred	Yes Inferred
Stock et al. 2007 (ref. 52)	To pilot Healthy Buddies in one elementary school and evaluate the effect of the program on students' health knowledge and behaviours, self-competence, body satisfaction, disordered eating behaviours and fitness, as well as physical characteristics of height, weight, BMI, blood pressure, and heart rate	Schools	383 children (kindergarten to year 7)	Controlled prospective pilot study	Yes – control Intervention (Healthy Buddies program) vs no intervention	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Dalton et al. 2011 (ref. 53)	(1) To establish a primary-care based and parent-mediated childhood overweight intervention program in the primary care setting	Primary care	80 children 5–11 years, BMI≥85th percentile plus one parent/guardian who	Cluster-randomised controlled trial	Yes – control 10-week intervention with parents of obese/overweight	No	NA	No	NA	NYI		

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
	(2) To explore the efficacy of this intervention in promoting healthier behaviours of children (3) To examine the acceptability and feasibility of the approach among parents and primary care providers		agrees to participate in the study		children vs no intervention							
Janicke et al. 2013 (ref. 54)	To assess the effectiveness of a behavioural family weight management intervention in an important and at-risk population, overweight young children, 3–6 years, and their parents from underserved rural counties	Whole-of-community	96 parent–child dyads Children 3–6 years, BMI≥85th percentile, plus participating parent/guardian(s) ≤75years	Two-arm pilot randomised controlled trial	Yes – control Behavioural family-based intervention vs a waitlist control	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Janicke et al. 2008 (ref. 55)	Primary aim of Project STORY is to evaluate the effects of a behavioural 'family-based' intervention and a behavioural 'parent-based' intervention, delivered via group contacts to overweight children and/or their parents in rural counties, on children's standardised body mass index	Whole-of-community	90 parent-child dyads Children 8–13 years with BMI≥85th percentile plus participating parent/guardian(s) living in same house	Three-arm randomised planning and feasibility study	Yes – control (a) A family-based behavioural group intervention (b) A parent-only behavioural group intervention (c) A waitlist control condition	No	NA	No	NA	NYI		
Pettman et al. 2009 (ref. 56)	To evaluate the health benefits of a minimally prescriptive group-based lifestyle intervention in participants with the metabolic syndrome	Whole-of-community	153 obese adults with metabolic syndrome	Randomised controlled parallel group design	Yes – control Intervention (education, practical strategies and group-based support) vs no intervention	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Samuel-Hodge et al. 2012 (ref. 57)	To present the rationale, study design, and baseline characteristics of a type 2 translational study that evaluates both the processes and outcomes of a weight loss intervention for low-income women given at 6 county health departments in North Carolina	Primary care	189 women 40–64 years, BMI 27.5–45	Randomised controlled trial	Yes – control Weight Wise intervention vs wait-listed control	Yes	Reach, Efficacy, Adoption, Implementation, and Maintenance framework	No	NA	Yes Explicit	Yes Inferred	Yes Explicit
Robinson-Whelen et al. 2006 (ref. 58)	To examine the efficacy of a health promotion program for women aging with physical disabilities	Whole-of-community	137 women ≥45 years with a physical limitation ≥1 year duration that interferes with ADL	Randomised controlled trial	Yes – control 8-week health promotion program vs waitlist control group	No	NA	Yes	Social learning theory	No	Yes Inferred	Yes Inferred
Vogt et al. 2008 (ref. 59)	To illustrate how survey and key informant data can enhance knowledge of local study populations and guide interventions to improve asthma control and treatment	Whole-of-community	4925 adults in the Behavioural Risk Factor Surveillance Survey system in Salinas	Large community based intervention	No	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Taylor et al. 2006 (ref. 60)	To determine whether increasing levels of extracurricular activity could reduce weight gain in children	Whole-of-community	384 children 5–12 years	Controlled intervention study	Yes – control Lifestyle intervention vs no intervention	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Gracey et al. 2006 (ref. 61)	To attempt to prevent T2DM and other nutrition-related lifestyle diseases through	Whole-of-community	4 discrete, remote Aboriginal communities	Community-based lifestyle modification intervention study	No	No	NA	No	NA	No	Yes Inferred	Yes Inferred

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
	community-based lifestyle modification		(population sizes 200, 400, 350 and 400)									
Amundson et al. 2009 (ref. 62)	To evaluate the feasibility of translating the DPP lifestyle intervention into practice in the general community	Primary care	293 adults ≥18 years, BMI≥25, plus one or more diabetic/CVD risk factors	Lifestyle modification intervention program	No	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Williams et al. 2004 (ref. 63)	To test a worksite intervention designed to reduce CVD risk factors in low-income African American women	Workplaces	294 (160 rural and 134 urban low-income African American women employees)	Risk factor reduction intervention	No (but comparisons made to the AHA national sample)	Yes	Health promotion model	No	NA	No	Yes Inferred	Yes Inferred
Ronda et al. 2004 (ref. 64)	To realise an effective combination of population strategy, (aiming at all inhabitants), and high risk strategy, (focusing on individuals with a high risk for CVD) so that CVD can be reduced	Whole-of-community	4 low socioeconomic status areas in Maastricht, (Mariaberg 5100, Malberg 6300, Wittevrouwenveld 6000, Heugemerveld 3000)	Community project – community-wide health intervention High-risk project – randomised controlled intervention study	Yes – control	Yes	Precede–proceed model	Yes	Health belief model, theory of planned behaviour, transtheoretical model	Yes Explicit	Yes Explicit	Yes Inferred
Aoun and Rosenberg 2004 (ref. 65)	To increase the quality of life of participants through the provision of knowledge and skills about cardiac events and their management, as well as participation in physical activity programs; to increase compliance with diet, exercise and non-smoking regimens and prescribed medications	Primary care	203 hospital clients with a history of hospital admission for a cardiac event related to ischaemic heart disease and those identified to be at high risk of CAD	Cardiac rehabilitation program	No	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Lupton et al. 2003 (ref. 66)	To change cardiovascular risk factors through community-based intervention in a fishing community in the Norwegian Arctic	Whole-of-community	4 communities (intervention community Båtsfjord (2500) and three control communities (total ~5000) from the same coastal area)	Quasi-experimental design	Yes – control Intervention (based on empowerment and cooperation) vs no intervention	Yes	Community empowerment	No	NA	No	Yes Inferred	Yes Inferred
Mayer-Davis et al. 2004 (ref. 67)	To evaluate the effectiveness of a state-of-the-art lifestyle intervention for weight management and metabolic control of DM	Whole-of-community	187 adults ≥45 years, BMI≥25, clinical diagnosis of DM	Randomised controlled trial	Yes – control 'Intensive-lifestyle' vs 'reimbursable-lifestyle' interventions vs usual care (control)	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Rowley et al. 2000 (ref. 68)	To assess the sustainability and effectiveness of a community-directed program for primary and secondary prevention of obesity, DM and cardiovascular disease in an Aboriginal community in north-west Western Australia	Whole-of-community	49 (high-risk overweight and diabetic people)	Controlled intervention study	Yes – control Intervention vs no intervention (self-selected) (in high-risk intervention) No comparison for the wider community intervention	No	NA	No	NA	Yes Explicit	Yes Explicit	Yes Explicit
Weinehall et al. 1999 (ref.	To examine the impact of a systematic risk factor screening and counselling carried	Whole-of-community	1893 people aged 30, 40, 50 and 60 years in	Quasi-experimental design	Yes – reference Intervention area	No	NA	No	NA	No	Yes Inferred	Yes Inferred

Study (reference)	Aim	Setting	No. of participants (+ important criteria)	Design/methods	Comparison/ control groups	Planning, implementation and evaluation framework used		Appropriate theoretical constructs explicitly integrated		Results (evaluation)		
						Yes/ No	Specify	Yes/ No	Specify	Process	Impact	Outcome
Adams et al. 2012 (ref. 9)	To test whether a mentored, home-based healthy lifestyle intervention targeting both American Indian primary caregivers and their 2–5-year-old children will reduce 'American Indian' child overweight	Whole-of-community	150 child–carer dyads 2–5-year-old American Indian children and their primary caregivers	Randomised controlled trial with a CBPR approach	Yes – intervention (home mentoring and tool kit lessons) and control (tool kit lessons and mailings only)	Yes	CBPR	Yes	Social cognitive and family systems theories	NYI		
69)	out by family physicians and family nurses within the larger framework of a community intervention programme for the prevention of cardiovascular disease		community		(Northern Sweden municipality (5500 inhabitants)) vs reference area (Northern Sweden region (510 000 inhabitants))							
Gibbins et al. 1993 (ref. 70)	To assess the effectiveness of a program for reducing cardiovascular risk in men in terms of clinical measurements and perceptions of patients	Primary care	526 men 28–60 years, attending well persons clinic	Collection of paired data on men attending well person clinics over 3–5 years. Questionnaire to determine changes in risk related habits	No	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Lakerveld et al. 2008 (ref. 71)	To investigate the effects of a CBP, compared with providing written information and brochures only on the risk of developing T2DM and/or CVD in high-risk individuals	Primary care	600 adults 30–50 years, abdominal obesity (male waist ≥102 cm, female waist ≥88 cm), plus high risk of developing T2DM and/or CVD	Randomised controlled trial	Yes – control Intervention (CBP plus motivational interviewing and problem-solving treatment) vs control (written information about their risk and brochures)	Yes	Cognitive behavioural program	Yes	Theory of planned behaviour, theory of self-regulation	Yes Explicit	NYI	
Chow et al. 2009 (ref. 72)	To investigate the effects of algorithm-based care on individuals at very high risk of a cardiovascular event who were identified and managed according to basic guidelines	Whole-of-community	44 villages ≥30 years at high risk of CVD	Factorial, cluster-randomised trial design	Yes – control Algorithm-based care approach vs health-promotion campaign (villages will be exposed to one, both or neither)	No	NA	No	NA	NYI		
Harrell et al. 2005 (ref. 73)	To evaluate the effectiveness of a school-based pilot intervention program aimed at increasing knowledge of CVD risk factors among fifth grade students in a rural Mississippi community	Schools	205 fifth-grade students	Controlled school-based intervention	Yes – control 16-week school-based intervention vs control school within same community	No	NA	No	NA	No	Yes Inferred	Yes Inferred
Perri et al. 2008 (ref. 74)	To compare the effectiveness of extended-care programs designed to promote successful long-term weight management, using Cooperative Extension Service offices in rural communities as venues for the trial	Primary care	234 obese women 50–75 years with BMI>30 from rural communities who completed an initial 6-month weight-loss program at Cooperative Extension Service	Randomised controlled trial	Yes – control Extended care (problem-solving counselling delivered in 26 biweekly sessions via telephone or face to face) vs an education control group (received 26 biweekly newsletters containing weight-control advice)	No	NA	Yes	Self-regulation theory	No	Yes Inferred	Yes Inferred

ADA, American Diabetes Association; ADL, activities of daily living; CAD, coronary artery disease; CBP, cognitive behavioural program; CBPR, community-based participatory research; CCBG, casual capillary blood glucose; CVD, cardiovascular disease; DM, diabetes mellitus; DPP, Diabetes Prevention Program; HbA1c, haemoglobin A1c; NA, not applicable; NYI, not yet implemented; SSWICH, Southern Seven Women's Initiative for Cardiovascular Health; T2DM, type 2 diabetes mellitus