

Comparative Effectiveness Research Review Disposition of Comments Report

Research Review Title: *Childhood Obesity Prevention Programs: A Comparative Effectiveness Review and Meta-Analysis*

Draft review available for public comment from July 16, 2012 to August 20, 2012.

Research Review Citation: Wang Y, Wu Y, Wilson RF, Bleich S, Cheskin L, Weston C, Showell N, Fawole O, Lau B, Segal J. Childhood Obesity Prevention Programs: Comparative Effectiveness Review and Meta-Analysis. Comparative Effectiveness Review No. 115. (Prepared by the Johns Hopkins University Evidence-based Practice Center under Contract No. 290-2007-10061-I.) AHRQ Publication No. 13-EHC081-EF. Rockville, MD: Agency for Healthcare Research and Quality; June 2013. www.effectivehealthcare.ahrq.gov/reports/final.cfm.

Comments to Research Review

The Effective Health Care (EHC) Program encourages the public to participate in the development of its research projects. Each comparative effectiveness research review is posted to the EHC Program Web site in draft form for public comment for a 4-week period. Comments can be submitted via the EHC Program Web site, mail or email. At the conclusion of the public comment period, authors use the commentators' submissions and comments to revise the draft comparative effectiveness research review.

Comments on draft reviews and the authors' responses to the comments are posted for public viewing on the EHC Program Web site approximately 3 months after the final research review is published. Comments are not edited for spelling, grammar, or other content errors. Each comment is listed with the name and affiliation of the commentator, if this information is provided. Commentators are not required to provide their names or affiliations in order to submit suggestions or comments.

The tables below include the responses by the authors of the review to each comment that was submitted for this draft review. The responses to comments in this disposition report are those of the authors, who are responsible for its contents, and do not necessarily represent the views of the Agency for Healthcare Research and Quality.

	Commentator & Affiliation	Section	Comment	Response
1	Peer Reviewer 1	General Comments	Thank you for the opportunity to review this document. It is a very detailed and careful examination of the available literature and is a valuable piece of work, both for researchers in the field and for policy-makers and advocacy groups wanting to introduce obesity prevention measures.	Thank you for your comment
2	Peer Reviewer 1	General Comments	I have little to say about the quality of the work, which appears to be excellent, and the authors efforts are to be commended; especially as they have unearthed many more studies than were included in the recent Cochrane review.	Thank you for your comment
3	Peer Reviewer 1	General Comments	The issue that most concerns me is how this document will be read by non-scientists, primarily those that need evidence-based research for promoting policies either as advocacy organizations or as members of policy-making bodies. I recommend that some sort of Foreword for general readers is put into the first few pages, which would bring out the actual findings (as shown in the abstract) and also the contextual issues that help to interpret these findings. There are some valuable comments in the Discussion section, but this is over 100 pages into the main document, and is not well reflected in the Executive Summary. (The Executive Summary is itself over 20 pages long, and therefore may not be read carefully by general readers.)	We agree this is a very long and complex report developed following related AHRQ requirements. AHRQ has a specific process outside of the project to translate these evidence reports into very brief reports for other users such as patients and policy makers. The Conclusions section in the E.S. provides the results in an encapsulated format.
4	Peer Reviewer 1	General Comments	The report does not look at interventions which could affect childhood obesity but which do not target children directly, for example fetal nutritional status, maternal-gestational diabetes, maternal-gestational tobacco smoking, the initiation or maintenance of breastfeeding/bottlefeeding.	You are correct. We limited the scope of this review to diet, physical activity, and combined diet and physical activity interventions directly impacting children” Tables A and 1 detail the interventions of interest in this systematic review.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
5	Peer Reviewer 1	General Comments	In a more general sense, schools tend to be the setting for interventions because they are the easiest venues to organize RCTs, not necessarily because they are the most effective settings for preventing obesity. They create a settings bias in the literature which needs to be acknowledged. Schools are not necessarily the best places to intervene – they are unlikely to be the place where most obesity is being caused, and their ability to change family-led, or environment-led behavior may be limited.	<p>Yes – this statement may very well be true. Our report is organized by setting and we report the strength of evidence by setting; you are certainly correct that more research has been conducted in this setting than in others. We cannot comment on the appropriateness of that. Comparative studies may be needed that compare interventions conducted in schools with those conducted in homes.</p> <p>Under Interventions and controversy about the topic we have added “Schools are the most frequent setting for interventions as they are convenient for RCTs; it is uncertain, however, if schools are the most effective setting in which to intervene”</p> <p>In the Future Research Needs: “Studies might also be designed to compare outcomes of interventions delivered in school to comparable interventions delivered at home or in other settings.”</p>
6	Peer Reviewer 1	General Comments	The findings should be seen in the context of the research endeavor. Of the 100+ studies that fulfilled all the criteria to answer the KQs, fewer than half of them showed positive results, and the positive results were typically small and potentially transient. It is therefore unlikely the approaches being used in these studies, if replicated in the population at large, would successfully reverse the last two decades of rising child obesity. (In the Manios study mentioned above, which reported some of the largest effects in the present review, both intervention and control groups showed a very large rise in overweight prevalence during the period of the intervention, even though the intervention group’s increase was smaller than the controls’ increase.)	<p>Yes – we agree entirely with this comment and have addressed this in the Implications to Policy Makers section.</p> <p>“Based on these results and the results of previous reviews, school-based interventions are likely to remain a focal point for prevention interventions. The limited number of studies conducted outside school limits the evidence about the effectiveness of interventions in those settings.”</p>
7	Peer Reviewer 1	General Comments	There needs to be a short comment on the potential for reporting bias, with studies that fail to show a significant intervention effect not being properly reported. The Cochrane review (www.ncbi.nlm.nih.gov/pubmed/22161367) acknowledges the potential bias due to missing small studies with negative findings.	<p>This has been added to the report.” ... we considered blinding to be most essential at the point of group assignment to minimize selection bias, rather than requiring blinding to sustain throughout the intervention phase. This is a reasonable modification and more applicable to this review, but it does allow for reporting bias.”</p> <p>The reviewer may be referred to publication bias which we also acknowledge is a risk.</p>

	Commentator & Affiliation	Section	Comment	Response
8	Peer Reviewer 1	General Comments	There needs to be a short comment on potential negative effects of interventions. Although few trials reported negative effects, few actually looked for them. Negative effects can include a degree of lost self-esteem or a sense of failure, and given that the majority of studies did not find significant beneficial results of an intervention, it can be assumed that large numbers of children 'failed' to show the hoped-for effects.	We noted in the study about school based interventions (the largest section) "None of these studies reported on adverse events (harms)." In the ES. Additionally, we added this in our discussion, under "Implications" Very few intervention studies we identified have reported negative effects of interventions. Although no evidence on harms was found (insufficient evidence) in this review, those trying to implement a certain intervention program need to consider potential harms, which may include a degree of lost self-esteem or a sense of failure and the time taken away from the children and their families from their other activities.
9	Peer Reviewer 1	General Comments	In a more general sense, the focus on behavior change among individual children maximizes the risk that children will take onto themselves responsibility for their weight, and feel unhappy about weight gain, and these psychological responses are a generalized negative outcome of these types of interventions, even though they might not be noticeable in any single intervention study.	Thank you for your comment.
10	Peer Reviewer 1	General Comments	Lastly, policy making agencies, and funding agencies, often ask the question of value for money or cost-effectiveness. The present review should comment on the need for intervention reports to include some details on the resource requirements needed for the intervention to be replicated or scaled up for wider application.	We comment in the discussion about this; there are undoubtedly "opportunity costs if schools are required to divert attention and resources to these activities at the expense of other learning or enrichment activities." Systematically reviewing the value and cost-effectiveness is outside of the scope of this review.
11	Peer Reviewer 1	General Comments	In conclusion, I hope these comments are helpful. They do not diminish my respect for the effort that has been made to undertake the systematic review, but – precisely because this work is so impressive and likely to be widely cited – I feel it is important that general readers are helped to see what its strengths and its weaknesses are.	Thank you for your comments. We have made an effort to address all of your comments.
12	Peer Reviewer 2	General Comments	From my perspective as a public health professional, this report is somewhat interesting, but not very helpful. I think the authors have good done a good job identifying the key studies. But the analysis has several important gaps. These include: (see below)	Please see our response to #13. We have made many changes to improve the analysis.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
13	Peer Reviewer 2	General Comments	Suggestions: For those sections of the report where there is modest or high evidence of effect, add a new section on characteristics of the most effective interventions. These characteristics should include the (a) nature of the intervention (b) the resources needed to have the effect and (c) a meaningful discussion of the public-health impact. I think this new section can and should be accessible to an educated general reader. This discussion should be then brought into the executive summary as well.	<p>We have revised the sections in which we interpret the findings and have included a section called Implications for Clinical and Policy Decision making. We cannot comment on the resources necessary as this is outside of the scope of this review.</p> <p>We have added an overall summary of the key results in the discussion section: In general, for school-based intervention studies, we found those that had large sample size, longer follow up, with more vigorous and higher intensity intervention approaches were more likely to be effective. It seems those comprehensive interventions that included components promoting environmental changes (eg, modified food and beverage items offered in school cafeteria, or structural changes in school PE) and changes in individuals' psychosocial factors such as knowledge and attitude were more likely to be successful than those only target at either one. In addition, those educational interventions were less likely to be effective than those that promoted environmental changes. The number of studies for the other settings was relatively small to make such assessments.</p>
14	Peer Reviewer 2	General Comments	Clarity and Usability: See above comments.	Thank you for your comments we have attempted to address them and make changes in the document as was possible.
15	TEP 1	General Comments	General Comments: The aims, scope and questions are clearly stated.	Thank you
16	TEP 1	General Comments	Clarity and Usability: As expected in these types of documents, the text is dull and repetitive, but clear. I assume there are many mandatory sections and wordings required in these kind of reports?	Thank you for your comments,
17	TEP 1	General Comments	The organization of the report is not too user-friendly. At the beginning it is stated that the report will be organized by intervention setting. However, the content is organized by Key Questions. Perhaps a diagram or explanation of how the sorting by kq and settings relate to each other may help.	Each key question relates to the evidence for a setting. Figure A – the Analytic Framework describes the Key Questions.

	Commentator & Affiliation	Section	Comment	Response
18	TEP 1	General Comments	Since the report is organized by intervention setting, the definition of these is key to follow the report. On printed p. 1 a description of the different settings is presented. However, some settings include the word "intervention", others, like "child care setting" do not, although it is treated as an intervention setting. Conversely, "Consumer health informatics" is included in this list (same level and font size), although it is not treated as an intervention in the key questions or the table of contents, but rather as a tool for intervention.	We made related changes to be consistent in the report. The omission of "intervention" from the headings for Childcare Setting and Consumer Health Informatics was not intentional. Settings are the location of the intervention. We agree that consumer health informatics does not represent a setting. However we have chosen to include these as a unique group to be comprehensive in our review of interventions for childhood obesity. We have also revised the report to reflect Consumer Health Informatics as a unique group of interventions in the table of contents and in the body of the report.
19	Peer Reviewer 3	General Comments	This report provides is an exceptionally thorough review of the evidence to date on childhood obesity prevention, with a systematic approach to reviewing studies and pooling effects when possible.	Thank you.
20	Peer Reviewer 3	General Comments	My major concerns relate to how interventions approaches were compared to each other. First, it is not clear how the strength of the evidence was determined.	Additional information was added to the SOE sections of the report more clear how was came about the SOE determinations.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
21	Peer Reviewer 3	General Comments	First, more explanation is needed on “consistency” and “precision,” first introduced on page 8 of the report. For example, is there a minimum number of studies needed to apply the 70% rule for consistency or precision (see Appendix F)?	<p>We have further described the grading process in the ES and the methods</p> <p>We have added the following text to the Methods section in the ES and full report</p> <p>Added to last paragraph to the ES methods section: “We did not require a minimum number of studies to apply this rule, for example, a body of evidence with two positive and one negative study would be graded as inconsistent although we recognize that if the studies had been amenable to pooling, the precision might have increased with pooling.”</p> <p>And</p> <p>“We did not require a minimum number of studies to apply this rule, for example, a body of evidence with two precise and one imprecise study would be graded as imprecise.”</p> <p>This explanatory paragraph was added to the Methods section in the full report:</p> <p>“We considered the body of evidence consistent in direction if 70 percent or more of the studies had an effect in the same direction (i.e., showed desirable effect verse not). We did not require a minimum number of studies to apply this rule, for example, a body of evidence with two positive and one negative study would be graded as inconsistent. We identified all studies as providing direct evidence since all of the studied interventions would directly affect one of our primary outcomes. We considered a study precise if the results for the given outcome were significant at a p value less than 0.05, or had narrow confidence intervals that excluded the null. If 70 percent or more of the studies that reported statistical significance had significant results, we considered the body of evidence precise. We did not require a minimum number of studies to apply this rule, for example, a body of evidence with two precise and one imprecise study would be graded as imprecise although we recognize that if the studies had been amenable to pooling, the precision might have increased with pooling.”</p>
22	Peer Reviewer 3	General Comments	In determining consistency or precision, is the denominator the number of studies with the same outcome, e.g. BMI?	No, the denominator used in determining consistency and precision was the total N for studies in a particular setting investigating a particular intervention. If the N=1, consistency was rated as not applicable.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
23	Peer Reviewer 3	General Comments	And if a single study presents both BMI and BMI z-score, would the study be included in the denominator of consistency (and precision) for both BMI and BMI z-score outcomes? Or is one outcome selected, and if so, based on what hierarchy? This doesn't necessarily need to be fleshed out in the Exec Summary, but became a concern as I read through results. For example, in Appendix F, Diet-only interventions in the Primary Care are considered precise, presumably b/c BMI was significant, but there was no difference between groups in BMI z-score	No, there is a hierarchy of which outcomes we used to determine the SOE: it is located in the methods section "We assigned grades for all weight-related outcomes together with each study contributing only one weight-related measure to the grade by setting up a hierarchy of outcomes. The hierarchy was set as follows: BMI z-score, BMI, prevalence of obesity and overweight, percent body fat, waist circumference, skinfold thickness. If a study measured BMI z-score and body fat, we only graded BMI z-score. We chose to use this hierarchy because these outcomes are closely correlated within an individual--particularly BMI and BMI z-score."
24	Peer Reviewer 3	General Comments	Similarly, under PA studies in School/home setting, studies are listed as precise, yet only 2/3 studies were significant for outcome of BMI, while 2/2 were significant for BMI z-score.	We defined precision for a body of evidence as at least 70% of the outcomes in the same direction (whether statistically significant or not). This has been corrected throughout the report. Please see the text below explaining the Physical activity intervention data on BMI "Of the three studies reported above that measured change in BMI, all three showed a statistically significant reduction in the intervention group relative to the control group: -0.12 (p<.003); -0.26 at 2 years, -0.25 at 3 years, and -0.25 at 4 years, (p=0.01), and -0.45 (p=.002), respectively"
25	Peer Reviewer 3	General Comments	Even if consistency and precision are better explicated, it is not clear what process was used to determine the "strength" rating. E.g, on page 10 of the report, where diet and PA interventions in the School/home setting are first described, if only 10 of 23 studies showed a beneficial effect, and only 5 of 14 measuring BMI showed statistically significant effects, why was the strength of the evidence determined to be "high"? It would seem that this doesn't meet the standard of consistency or precision defined on page 8 and that further studies might change the estimate of the effect.	Strength of evidence has been better described so that readers can understand how each SOE rating was assessed. Additionally, summary strength of evidence tables appear at the end of each section describing each setting. These tables include details on outcomes as well as the domains as they were graded.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
26	Peer Reviewer 3	General Comments	Further, it appears that the pooled analyses of effect were not significant for either BMI or BMI z-score, yet the strength of evidence is “high.” It seems that the pooled effects should be a factor in the algorithm for determining strength in CER . And unclear why this is “high” when the strength for diet and PA in school setting (no home) was low, but had greater precision for BMI, with 12/15 studies showing significant effect and highly significant pooled effect.	<p>The SOE assessment includes all studies not just those included in the meta-analysis.</p> <p>The summary strength of evidence tables provide details about how we arrived at each grade.</p> <p>It is true that the pooled analyses were not significant for either BMI or BMI z-score. However, this was only for combined diet and PA interventions. The SOE for this category was moderate, not high. The reader may be getting mixed up with the fact that the SOE was high for PA-only studies. But there were only 3 of these studies and we did not conduct a pooled analysis for this group. So there is no case in which the pooled analyses in non-significant AND the SOE is ‘high’ for any of the school-home studies.</p>
27	Peer Reviewer 3	General Comments	It would be valuable to present a table early on that presents the results from the pooled effects.	We have included a summary table in the executive summary that presents the results and the strength of evidence.
28	Peer Reviewer 3	General Comments	<p>The report is clinically meaningful, and clearly represents an enormous undertaking. It has the potential to be widely used, and highly influential. The authors are to be commended for the scope of the project, attention to detail, and the generally good overall organization of the material.</p> <p>The fundamental conclusions are mostly (but not entirely) consistent with our own prior work in this area, and with most prior, recent systematic reviews/meta-analyses</p>	Thank you for your comment
29	Peer Reviewer 4	General Comments	The definitions of settings are clear and helpful	Thank you for your comment
30	Peer Reviewer 4	General Comments	The algorithmic grading of strength of evidence is a novel strength	Thank you for your comment
31	Peer Reviewer 4	General Comments	The statement that the views don’t represent those of AHRQ seems far-fetched; commissioned work by AHRQ, in the public domain- shouldn’t these be the views of AHRQ?	<p>This research was funded by AHRQ. Investigators worked with AHRQ staff to develop and refine the scope, analytic framework, and key questions. The AHRQ had no role in study selection, quality assessment, synthesis, or development of conclusions. AHRQ staff provided project oversight, reviewed the draft report, and distributed the draft for peer review. AHRQ reviewed the report for comprehensiveness and timeliness, and the analysis was of high quality. The investigators are solely responsible for the content.</p>

	Commentator & Affiliation	Section	Comment	Response
32	Peer Reviewer 4	General Comments	The authors state “We aimed to compare the effectiveness of childhood obesity intervention programs by reviewing all studies that compared diet, physical activity, or both in various settings (school, home, primary care, child care, consumer health informatics, combinations of them) conducted in high-income countries worldwide.” The statement ‘to compare...’ however should be followed by ‘to something.’ There is, in fact, no clear, actual comparison in this comparative effectiveness report; what is being compared to what?	<p>We are comparing the intervention to the control or usual care, as no head-to head comparison was available.</p> <p>Tables A and 1 state that the comparisons are: No intervention Usual care or other interventions by settings NOTE: We will compare the intervention group versus the control group (i.e., those who did not receive intervention or received usual care or other interventions) within each study and then across studies within the same setting (e.g., schools, child-care centers).</p>
33	Peer Reviewer 4	General Comments	Similarly, each of the key questions actually raises a question: comparative effectiveness relative to what? Is the intent to compare given intervention IN a setting to one another; or to compare comparable intervention across settings; or something else? Nowhere in this massive report is there a clear indication of what is being compared to what. Comparing intervention to ‘control’ as the authors state in their summary tables is not comparative effectiveness; it is merely the standard means of assessing efficacy.	<p>We are comparing the intervention to the control or usual care, as no head-to head comparison was available.</p> <p>We decided that we would compare like interventions within each setting only. This is due to the fact that intervention types (e.g., diet, physical activity, combinations) are very heterogeneous within settings and are even more diverse when compared across settings.</p> <p>Tables A and 1 state that the comparisons are: No intervention Usual care or other interventions by settings NOTE: We will compare the intervention group versus the control group (i.e., those who did not receive intervention or received usual care or other interventions) within each study and then across studies within the same setting (e.g., schools, child-care centers).</p> <p>Additionally for each key question we provide a summary table of the interventions which included a descriptor of the comparison group.</p>
34	TEP 2	General Comments	In general, the report is well written. The key questions are explicitly stated.	Thank you.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
35	TEP 2	General Comments	There does appear to be a need to better differentiate primary prevention studies, in which the goal is to decrease the incidence of overweight and obesity in those who are not overweight/obese at baseline, and secondary prevention studies which may target additional weight gain in those already overweight or obese. Many of these studies included normal weight, overweight, and obese children/adolescents in their populations.	<p>We explain in the background section: “We differentiate between prevention, often called “intervention” in the childhood obesity research field, and treatment, also called “weight management.”</p> <p>The main goal of most childhood obesity prevention programs is to prevent non-overweight children from becoming overweight or obese, while the primary objective of obesity treatment programs is for obese patients to achieve healthy body weight (e.g., losing weight, improving height-to-weight ratio). However obesity prevention programs may also help overweight or obese children to lose weight or stabilize their weight. This review focuses on prevention.</p> <p>We did not review targeted <i>treatment</i> of overweight or obese children; a recent AHRQ report already reviewed this. It is not known whether weight management programs, such as those that we reviewed, impact normal weight, overweight, or obese children differently. If the studies had reported results stratified by baseline weight, we may have been able to explore this in this review – this was not the case.</p>
36	TEP 2	General Comments	There are concerns that, in particular for school-based studies, the conclusions may go beyond the evidence. Some of the school-based studies that have been shown to be effective are in non-US populations, often with little racial/ethnic diversity or with small numbers in low SES groups, and may not be generalizable.	We identified non-US studies in the results section. This was an applicability issue and is discussed in the discussion.
37	TEP 2	General Comments	Also some of these studies were quite old—before the more recent large increase in obesity prevalence. Prevention strategies that worked in normal weight/mildly overweight children may not work well in current populations, in which a larger proportion of children may be very obese.	<p>The majority of studies we included are recent studies.</p> <p>To the discussion section, under “Applicability” we have added:</p> <p>“Also worth of noting, prevention strategies that worked being reported in old studies may not work well in current populations due to differences in the social and build environments.”</p>

	Commentator & Affiliation	Section	Comment	Response
38	TEP 2	General Comments	Small studies with short-term (e.g. 6 months) outcomes that found evidence of efficacy should be contrasted with large, well-designed RCTs such as the HEALTHY study, which looked at longer-term outcomes in a diverse population. In that study, despite a multicomponent intervention, the primary outcome (difference in combined prevalence of overweight/obesity) was NOT positive, although the secondary categorical outcome showed some efficacy only among those overweight/obese at baseline.	<p>We addressed this issue in several places in our discussion. We found considerable variations in the findings of small, short-term studies and the other well-designed RCTs. In general, we found that large and long-term studies were more likely to find significant effects than the other ones. However, the scope of our review limited us in conducting more rigorous systematic in depth analysis.</p> <p>For example, our discussion included such text:</p> <p>“In addition, these interventions had significantly effect on weight and other outcomes because many encouraged intense implementation; had long duration; targeted obesity...”</p> <p>“It is desirable to conduce in depth analysis to compare the findings from small, short-term (e.g., 6 months) studies with those form large, well-designed RCTs. However, we are limited by the scope of this review, the large heterogeneity across studies and small number of comparable studies.”</p>
39	Peer Reviewer 5	General Comments	A considerable effort has gone into this review of 96 intervention studies (in 113 reports). The authors refer to 20 other systematic review of childhood obesity prevention, but don't provide citations, or summarize the finding in a table.	<p>The aim of this SR is to systematically review the available literature on this topic. It was outside of the scope to systematically review the existing systematic reviews. We have included a high-level overview of the clinical and decisional uncertainties in the introduction. We have also discussed the results of this review in light of current literature (please see Discussion subsection “Findings in relationship to what is already known.”</p> <p>We have removed this statement from the final version of the report and described a select set of systematic reviews in the section “Findings in relationship to What is already Known”</p>
40	Peer Reviewer 5	General Comments	It would be useful to show key features that might explain lack of consistency, and show how this new review makes a unique contribution.	We have included a high-level discussion of limitations of the underlying evidence base and recommendations for future research.
41	Peer Reviewer 5	General Comments	The body of the report was clear, however, the nearly 500 pages of evidence tables were overwhelming and could have been more concisely presented by reporting characteristics of the study, participants, intervention, and measures in one table (over 2-3 pages) for each study. It was difficult locating information in many different tables on the same study.	We realize that the evidence tables are long. Our tables comprehensively report all abstracted data. For better navigation we have organized our tables by KQ and have clarified the table headings.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
42	Peer Reviewer 5	General Comments	The authors should add a table in the appendix (in alphabetical order by study) that provides: 1) effect sizes and measures of uncertainty for all weight-related outcomes in that study, 2) months at follow-up, and 3) p values for statistical tests of group difference.	The evidence tables do provide all of this information if it was provided in the original study.
43	Peer Reviewer 5	General Comments	The tables in the body of the report are helpful summaries, but depth of detail needed to answer some reader questions should be more readily accessible in the appendices.	Yes, and we modified our appendices for this. We have added new summary tables and improved those that already appear in the report. Most of the detailed information remains in the appendix.
44	TEP 3	General Comments	As we agreed, my comments are based primarily on the Executive Summary, although I did search the complete file for certain articles I thought should have been included.	Thank you
45	TEP 3	General Comments	In general I thought that the approach taken in the review was appropriate, and most aspects of methods were described sufficiently for readers to determine how things were done.	Thank you
46	TEP 3	General Comments	Some clarifications are needed. Some problems I noted made me worry about accuracy. These include omissions of articles I expected to see on the list and that I am pretty sure should have been picked up by the search but which were not on the list of either included or excluded articles. Some specific comments follow.	<p>The list of excluded articles only includes articles that were excluded at the full article review stage. There is a possibility that articles were excluded at earlier stages (title screening or abstract screening) and do not appear in the appendix.</p> <p>Thank you for the list of articles that may have been missing—we have included details on each of these—whether they were identified by the search, and at what stage they were excluded.</p>
47	Peer Reviewer 6	General Comments	In this well written comparative effectiveness review, the authors clearly define the key questions. The target population for the studies is explicitly defined and the audience while not explicitly defined can readily be inferred. The report is meaningful to those interested in obesity prevention for children.	Thank you for your comment

	Commentator & Affiliation	Section	Comment	Response
48	Peer Reviewer 3	General comments	Report should also discuss the tradeoffs/context of the settings, and how this affects the feasibility/sustainability of various approaches, in light of the strength of the evidence.	<p>We agree. We discuss in the future research needs the need for investigations of other approaches that may be more sustainable: “Thus, the effective and sustainable prevention of obesity in children may have to target many factors, which calls for a systems approach in study design, implementation, and evaluation, that take into account multiple risk factors and the complex interactions and feedback loops among them.² To fill in the gaps, researchers first need to understand the contexts and challenges associated with implementing prevention programs in different settings. For example, to conduct a childhood obesity prevention program in a community setting, researchers often need to work with the local community and its key stakeholders, which requires considerable effort and resources. Such demand may help explain the small number of intervention studies conducted in non-school settings. Researchers should report these contextual factors to help decisionmakers get a better idea of the applicability of a specific intervention program to their own community.”</p> <p>Additionally, we added in the Discussion:</p> <p>The feasibility and sustainability of these approaches vary across settings. For example, it is known that school-based interventions are less costly than interventions implemented at home or in primary care. For this reason, school based interventions are more likely to be sustainable if proven effective. Policy change is very difficult to effect; nevertheless, in recent years, there is strong interest in the U.S. and some other industrialized countries to push community and policy based interventions. Likely with the growing government and public support, such interventions could become more feasible and sustainable in the future.</p>
49	Peer Reviewer 5	General Comment	Also note that the font in Appendix C was mostly unreadable.	We apologize; we unfortunately use large data abstraction forms that are web-based and do not fit into traditional page sizes when created. These forms, when transferred to a printable format (currently constrained to an 8.5x11 inch page) do not translate as well as we would like.
50	TEP 3	General Comment	Finally, a minor point, on page 209, line 27, a Fitzgibbon trial in adults is listed as excluded in a different category.	Thank you—often there are multiple reasons for exclusion and we do not require that all of the exclusion criteria be identified.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
51	Peer Reviewer 4	Clarity and Usability	Lack of clarity about what comparative effectiveness means, and how it informed this effort	<p>Comparative effectiveness for the EHC program is defined as a comparison <u>of two or more alternatives</u>. This can include usual care or an active comparison.</p> <p>We have inserted statements in the E.S. and in the introduction which define comparative effectiveness. “We focus in this report on the comparative effectiveness of interventions; thus, outcomes need to be compared between two groups each of which received an intervention or two groups where one group received usual care or no intervention.”</p> <p>We limited our definition and application of comparative effectiveness reviews in this report for a number of reasons such as the fact that interventions across settings may not be comparable considering the differences in study design as well as the scope of the study.</p>
52	Peer Reviewer 4	Clarity and Usability	Lack of prominent indications for WHY results were what they were, ie, the need to distinguish issues related to quantity of evidence from issues related to the quality of evidence	<p>As we describe in the Methods section, the grading of evidence follows the recommendation in the AHRQ Methods guide which is based on the GRADE system – this system allows us to consider both the quantity of literature and the quality of the literature when we assign an evidence grade.</p> <p>We have considered both the quantity of evidence and the quality of evidence when we assess the level of evidence.</p> <p>We have added details (where applicable) to the interpretation sections of the report. Here, we identified whether or not there were specific attributes that specific studies shared that may have lead to their success.</p>
53	Peer Reviewer 4	Clarity and Usability	Consider that this report, if used literally, would argue AGAINST addressing both physical activity and diet and school, and FOR addressing diet only. That is counter-intuitive at best, and at worst, actually misleading.	<p>We have made extensive changes throughout the text to reinforce that the strength of evidence is not a reflection of the magnitude of effect. Indeed, the strength of evidence is higher for diet only interventions, but this is largely because this intervention has been studied more and has higher quality studies; there is also evidence supporting physical activity and diet together, but the strength of evidence has not yet achieved that for diet-only interventions.</p> <p>We are careful not to argue for or against any interventions – we are describing the strength of the evidence so that users of the report can make decisions based on evidence.</p>

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
53	Peer Reviewer 4	Clarity and Usability	Consider that this report, if used literally, would argue AGAINST addressing both physical activity and diet and school, and FOR addressing diet only. That is counter-intuitive at best, and at worst, actually misleading.	<p>We expanded the interpretations of the data throughout the report and our conclusions are supported by the evidence. We are not making recommendations about what should be implemented – we are describing the present strength of the evidence that is available to support interventions. An intervention may be highly effective but if there are few available studies, the evidence supporting its effectiveness might still be low.</p> <p>We addressed the issue, eg, see the paragraph under " Implications for Clinical and Policy Decisionmaking</p> <p>To date, it has been unclear whether physical activity and/or diet should be the primary focus of population-based obesity intervention programs..."</p>
54	Peer Reviewer 5	Clarity and Usability	A table showing all weight-results by study (see above recommendation) would be helpful.	All results are available in the appendices. Due to the volume of data, we are not able to put this information in the main report.
55	Peer Reviewer 5	Clarity and Usability	Interpreting the results in terms of actual impact (i.e. effect sizes) would aid decision-making.	<p>Interpretations have been added throughout. Please also see our response to Peer Reviewer 2 about public health impact:</p> <p>"We have added results in the tables and text that describe the magnitudes of effect of the interventions so the reader can more clearly see the potential public health and clinical benefit of the interventions."</p>
56	Peer Reviewer 6	Clarity and Usability	The report is well-structured and organized. The main points are clearly presented. The conclusions are more likely to be used to inform policy than practice but may be useful in both arenas.	Thank you for your comment
57	Peer Reviewer 3	Abstract	Page vi, Abstract: consider changing "Data Sources" heading to "Study Selection" and add study inclusion criteria, at a minimum note that only experimental studies (RCT, quasi- and natural) were included, and only those lasting 1 year (or 6 months in school setting).	<p>The headings are consistent with current AHRQ guidance in structuring the abstract.</p> <p>We added the following text to the end of the "Review methods" of the abstract: "Only experimental studies were included with followup of at least 1 year (6 months for studies in school-settings)."</p>

	Commentator & Affiliation	Section	Comment	Response
58	Peer Reviewer 3	Abstract	Add analytic approach: E.g., what comparisons were made? Not clear here if you compared across settings or just within settings, and what you compared. State # of studies for which pooled analyses were possible.	<p>We added the following text to the end of the “Review methods” of the abstract: “We abstracted data on comparisons of usual care to the intervention.”</p> <p>The following text was added to the results: “Results of four studies were pooled for BMI, and three for BMI z-score in the school-only setting; results of five school-home studies were pooled for BMI.”</p> <p>We have made some crude comparisons across settings, eg, we stated that more studies were conducted in schools than in other settings, and more school-based studies were effective than those in other settings. We think the studies in different settings are too different and the numbers of non-school based studies are too limited to make more in-depth across-setting analysis, which is also beyond the scope of the study</p>
59	Peer Reviewer 3	Abstract	In Results, would be easier to read if numbers were used exclusively, rather than spelling out the number (e.g. “six studies in seven articles”)	Thank you for your suggestion. The use of numbers spelled out is consistent with AHRQ’s Publication Guide.
60	Peer Reviewer 3	Executive Summary	Page 2, Community-based and Env-level: Would this include an intervention taking place at the YMCA? Did you not consider interventions in the community setting unless they dealt with “policy, legislative, built environment, etc.”? Clarify and provide examples.	Yes, these would be included. We have included examples as suggested. In the Executive Summary we say, “Additionally, these interventions involve interaction with the community (a group of individuals who exist prior to the intervention and who share one or more common characteristics such as the YMCA, Church groups).”
61	Peer Reviewer 3	Executive Summary	Page 2, Scope of the Review: Make clear what the comparisons were. Was the intent to compare targeted behaviors and modalities within settings? Clarify here. Also, be sure to use the same terminology throughout. “Target behaviors” and “Modalities” seem clear – would introduce early and use consistently.	<p>We have added “We reviewed all studies of children that tested interventions targeting diet, physical activity, or any combination of these in any setting or combinations of settings (e.g., school, home, primary care, child care, CHI) over at least 1 year, with the exception of school-based studies or studies in other settings with a school component (which only required 6 months).</p> <p>We compared the effects of the interventions on weight or body composition related outcomes (e.g., BMI, weight, BMI-z score, waist circumference, percent body fat, skinfold thickness, prevalence of obesity or overweight), clinical outcomes related to obesity (e.g., blood pressure, blood lipids), energy balance-related behavioral outcomes (e.g., dietary intake, physical activity, sedentary behaviors), and adverse effects of interventions”</p>

	Commentator & Affiliation	Section	Comment	Response
62	Peer Reviewer 3	Executive Summary	Page 2, Scope of the Review: On further reading, it seems important to address why modalities were not compared. Would be helpful to know which modalities are most effective. Likely not possible with existing evidence, but this should be stated.	<p>Modalities (diet, physical activity, combination interventions) were not compared as there were few examples where the study evaluated an intervention (or modality) in comparison to another intervention. Most studies (all but 1) reported on the intervention versus a control or usual care.</p> <p>We have added a clarifying sentence in the “Limitations of the evidence base” section in the discussion: “Throughout the report we only compare interventions to usual care (or control).”</p> <p>We have conducted a search in order to address leadership’s comment regarding whether other reviews have grouped their outcomes by modality (diet, PA, and combo). We were unable to find a review that was comparable to this one.</p>
	Peer Reviewer 3	Executive Summary	Page 3, Key Questions: it seems that when asking “What is the comparative effectiveness of X,” the comparator should be built into the question. Need to clarify what comparisons were planned/done within settings.	To improve the clarity of the question, the comparator was not included. However consistent with other AHRQ systematic reviews, greater detail is specified in the corresponding PICOTS.
63	Peer Reviewer 3	Executive Summary	Page 4, Table 1, Intervention section: Clarify what is meant by “Includes” under each Key Question. Is this a list of all the interventions conducted within each setting? Are these “modalities” or “target behaviors” that were compared? In either case, what happened to “physical activity” in the school setting? Seems like this list should be exhaustive and you should explain how you defined each category (e.g., what types of interventions fell under “parenting styles/education” in the school setting?). Could certainly refer to another section of the full document if no space here.	<p>They are the main interventions in each setting.</p> <p>The table gives examples of the types of interventions that were included but was not intended to be a comprehensive list as this could not be known definitively before we conducted the search. We did not exclude interventions if they were not on the list.</p> <p>We revised this table (1 and Table A) to read (in the intervention row “Examples of interventions...”</p>

	Commentator & Affiliation	Section	Comment	Response
64	Peer Reviewer 3	Executive Summary	For Key Question 5, will need to define (or rephrase) "community level." As per comment above, would this include an after-school program based at a YMCA? If so, that would be a "in the community." "Community level" would imply an intervention targeting a community, not a group of participants in a community-based program (i.e. a community setting). I note that it is called different things in different pages (e.g. Page 3 and Page 5) and would be good to standardize.	Under child-care, we added this sentence to the ES and full report: "We classify child care interventions delivered in other settings as child care-based interventions." Added "...such as the YMCA, Church groups" to clarify community-based settings
65	Peer Reviewer 3	Executive Summary	Page 4, Table 1, Comparisons section: Is it possible to compare the impact of interventions across settings, e.g. home vs. school? Seems like a relevant question in helping decide where to focus efforts.	Our protocol stated that the report would be organized by setting because users of this report will likely be most interested in implementation of results in a specific setting. (Individuals who can effect change in schools probably cannot effect change in physician offices). It would have been prohibitively challenging to <i>also</i> report the results organized by interventions, across settings, but we certainly acknowledge that the information could have been organized in this way.
66	Peer Reviewer 3	Executive Summary	Page 4, Table 1, Timing section: What was the rationale for limiting non-school studies to 1 year, when school-based studies by necessity have shorter follow-up periods? While we generally assume that longer duration of intervention means greater effect, it may be more difficult to sustain changes over longer periods of time; thus, the greater effect of school based interventions may reflect the shorter time period. How many more studies in other settings would be available if studies with follow-up of 6 months were included? Would this change results? At a minimum, within school setting could compare studies of 6 months duration to those of 1 year or more.	Under Methods/Study selection we state: "Studies were eligible for inclusion if they followed children for at least 1 year after the intervention, or for at least 6 months for school-based intervention studies (given the length of a typical school year in the U.S.), to include relevant studies." We initially believed that ALL studies should have at least 1-year followup considering the time needed to show effect, but took into account that many school-based interventions would not last more than one school year which is typically 9 months. 626 abstracts were excluded for less than 1-year followup and 60 articles were excluded for less than 1 year followup It is likely that many of these were excluded for other reasons as well so we cannot say definitively how many more would have been included had we only required 6 months of followup.
67	Peer Reviewer 3	Executive Summary	Page 5, Figure – make font larger	Figures A, B, 1 and 2: font size is within standards. Figures 3-5 have all been revised and have larger font.
68	Peer Reviewer 3	Executive Summary	Page 6, line 43: not clear why this sentence refers to Table 1.	This is removed in the revised version

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
69	Peer Reviewer 3	Executive Summary	Page 9, line 7: referring to Figure 2 here seems odd as the 96 intervention studies aren't depicted in the Figure. Also, rather than giving the 97 of 113, would rather know the number of the 96 unique intervention studies reporting on the school setting (82?).	Figure 2 (also Figure B) has been revised to include the number of articles and studies, and the breakdown by KQ (articles and studies) was added to these figures.
70	Peer Reviewer 3	Executive Summary	Page 9 and throughout report: replace "which" with "that" when referring to specific types of interventions (e.g. "interventions, without home involvement, THAT target...").	We corrected this where appropriate.
71	Peer Reviewer 3	Executive Summary	Page 9 and throughout when reporting pooled effects (e.g. p. 43): be consistent in the order in which results and pooled effects are presented. Seems logical to use the order described in hierarchy on p. 37, i.e. BMI z-score first.	This only applies to figures 3 and 4 in the revised report. Figure 3 reflect data for BMI-Z score and figure 4 reflects data on BMI as detailed by the hierarchy in the report.
	Peer Reviewer 3	Executive Summary	Page 9, lines 50-53. Was pooling of studies not feasible? If not, state this, and is it possible to present the mean effect size for studies that used same outcome measure (without a pooled CI, obviously, and with caveat that it's just a mean, not a pooled estimate) just so the reader can get a sense for the effect size?	In many instances we were not able to conduct a quantitative synthesis. We have included more complete information in the main report. We did not report mean effect sizes if we could not report a pooled CI; this is not a standard method and is not a method that is recommended in the AHRQ Methods guide.
72	Peer Reviewer 3	Executive Summary	Page 10, line 5: here you refer to the difference between groups as negative but for dietary interventions you use positive.	We have modified this statement.
73	Peer Reviewer 3	Executive Summary	Page 10, line 12: might be helpful to give brief description of the range of dose of home interventions – would imagine the range is broad and that some of the "home" components were a VERY light touch	Thank you for the suggestion. We describe this in the body of the report but the page constraints of the E.S. prevent us from including more detail.
74	Peer Reviewer 3	Executive Summary	Page 10, line 31: would expect to see the PA-only interventions described here, before the combined interventions. Where are the PA-only interventions – they are noted in opening paragraph for this section to be of "high" strength.	We have included this information as suggested.
75	Peer Reviewer 3	Executive Summary	Page 10, lines 42-end: wouldn't give so much detail on a single study	We agree. We have included a less detailed description.
76	Peer Reviewer 3	Executive Summary	Page 12, Table 2: seems like it would be of real interest to add the effect size from pooled analyses where possible, for both BMI and BMI z-score.	We have included this for studies that were pooled (Table 2)

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
77	Peer Reviewer 3	Executive Summary	Page 13, line 19: eligibility criteria included 1-year duration but length of follow-up is as low as 34 weeks?	For school-based studies the eligibility criteria was 6 months of follow up after the intervention. This study has been reclassified as a school based study.
78	Peer Reviewer 3	Executive Summary	Page 13, line 36: How did you differentiate between a Home-based intervention with a school component, and a school-based intervention with a home component? This info doesn't necessarily belong here, but should be introduced at some point to give context for this	The differentiation was made based on the primary location of the intervention. For example, if most of the intervention took place in the school (classes, gym, change in school lunches) with guidance to change diet and exercise at home, we classified it as school-home.
79	Peer Reviewer 3	Executive Summary	Page 14, line 40-45: level of detail in describing individual studies varies from section to section (e.g., calling a study just dietary, vs. adding in the modalities used). Would be good to keep it consistent, with briefer being more appropriate in the Exec Summary.	Thanks we have done this.
80	Peer Reviewer 3	Executive Summary	Page 15, Community-based: As in previous comments, would be helpful to clarify what is meant by "community-based"	We have added: "a group of individuals who exist prior to the intervention and who share one or more common characteristics such as the YMCA, Church groups" to the description of this setting in both the ES and the full report.
80	Peer Reviewer 3	Executive Summary	Page 16, line 44: Would suggest saying "96 interventional studies" instead of "113" and could add "as described in XX manuscripts."	We revised the text to improve clarity. In the E.S.: "We included 122 interventional studies described in 131 articles (some multiple articles described the same studies)"
82	Peer Reviewer 3	Executive Summary	Page 16, Key Findings: Seems appropriate to reference the effect sizes from the pooled analyses and directly comment on differences in effect sizes for different target behaviors.	Done.
83	Stephen Cook- public comment	Executive Summary	The Hip Hop to Health Jr studies from Chicago are really childcare interventions and not really school based interventions.	Thanks. We have moved this study to the Childcare-based intervention section.
84	TEP 3	Executive Summary	Page vi, line 45 (and elsewhere), the point that the school based interventions seemed to work only if they included a home component could be clearer. This seems to be an important finding, but the language used in the report— derived from the format of the key questions— makes it hard to always know what distinctions are being made in the summary statements.	We modified it to make this clearer. "The strength of evidence is high that school-based interventions that target diet and physical activity, or physical activity alone, and particularly those that have a home component, prevent obesity or overweight."

	Commentator & Affiliation	Section	Comment	Response
85	TEP 3	Executive Summary	Page vi, lines 46-48, the terminology was confusing. Is the use of 'weight control' intended to be synonymous with obesity prevention? Given other comments in the report, weight control sounds more like it relates to treatment and would not be a topic in this review.	We changed the terminology to 'obesity prevention'.
86	TEP 3	Executive Summary	Page vi, Conclusions—please review this again. Some of it seems to contradict your findings about which school based interventions work (e.g., using community resources). Perhaps it is just terminology, but I found it confusing.	We have modified our conclusions section.
87	Peer Reviewer 2	Introduction	Introduction: This is fine.	Thank you.
88	TEP 1	Introduction	When the adverse consequences of childhood obesity are mentioned (e.g., at the beginning of the EXECUTIVE SUMMARY), an important one is worth adding: premature death. See Franks et al, NEJM 2010.	Yes, in the introduction we say that childhood obesity impacts mortality.
89	Peer Reviewer 3	Introduction	Introduction: I am placing all of my detailed comments in this box, as the structure of the report doesn't lend itself to the typical headings.	Thank you for the clarification
90	Peer Reviewer 3	Introduction	Page 29, Scope of Review and Key Questions: as per comments about Exec Summary, should clarify the comparisons made.	Thanks, we have clarified this.
91	Peer Reviewer 4	Introduction	The statement that the views don't represent those of AHRQ seems far-fetched; commissioned work by AHRQ, in the public domain- shouldn't these be the views of AHRQ?	This research was funded by AHRQ. Investigators worked with AHRQ staff to develop and refine the scope, analytic framework, and key questions. The AHRQ had no role in study selection, quality assessment, synthesis, or development of conclusions. AHRQ staff provided project oversight, reviewed the draft report, and distributed the draft for peer review. AHRQ reviewed the report for comprehensiveness and timeliness, and the analysis was of high quality. The investigators are solely responsible for the content.
92	Peer Reviewer 4	Introduction	More discussion of what 'comparative effectiveness' means, and how it informs this report, is warranted. It was unclear to this reviewer how this report is actually about 'comparative effectiveness,' since at no time is there an explicit comparison of anything to anything else. A comparison of 'intervention to control' is not comparative effectiveness; it is the time-honored approach to measuring efficacy.	We have included a statement in the introduction that better explains comparative effectiveness research. "We focus in this report on the comparative effectiveness of interventions; thus, outcomes need to be compared between two groups each of which received an intervention or two groups where one group received usual care or no intervention."

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
93	Stephen Cook-public comment	Introduction	you really should look at the Hip Hop to Health Jr interventions and actually put their evidence into early childcare. These studies do describe themselves as pre-school and in head start centers, but their target population is 3-5 yr olds. The settings maybe called pre-school but they are really in the early childcare & education field.	We agree. This was moved to the Childcare-based intervention section
94	TEP 2	Introduction	P1: Line 16—eating disorders and other mental health issues such as depression are listed as consequences of childhood obesity, but the relationship is bidirectional. Suggest you say “correlates”	Thank you for this suggestion. We have modified the text as suggested.
95	TEP 2	Introduction	P1 lines 36-45. You note that interventions for overweight/obese children are “weight loss” interventions aimed at helping them to lose weight; however, especially in young children, the intervention goal in overweight/obese children may be to slow the rate of weight gain, allowing the child, who is gaining in height, to reduce the level of obesity or to “grow into” a healthy body weight. Suggest that you change wording here to “weight management” rather than “weight loss” interventions, and not that in growing children the goal may be reducing rate of weight gain.	We changed it to “weight management” from “weight loss” interventions as suggested.
96	TEP 2	Introduction	P1 lines 36-45. Also-you may want to differentiate here between primary prevention in the non-overweight and secondary prevention in those who are already overweight/obese. Prevention studies often include both populations.	Done.
97	Peer Reviewer 5	Introduction	A brief background of causes, complexities, and consequences of childhood obesity is provided. The issue of measurement of overweight/obesity populations experiencing varying rates of growth and development between early childhood and later adolescence would have been useful in the context of determining intervention effectiveness.	Thank you for your comment

	Commentator & Affiliation	Section	Comment	Response
98	Peer Reviewer 5	Introduction	There is a clear statement of the research questions. The authors provide a road map to the organization of the report. The analytic framework is explicit and reasonable	Thank you
99	TEP 3	Introduction	Page 2—as I read through your definitions of settings and the use of these terms in the report, I wondered if there is a distinction to be made in interventions that worked one on one with individual children (e.g., primary care or homes or perhaps some child care settings) vs. those that were group programs (e.g., in schools). Is setting confounded with the unit of intervention?	This is an important comment. We addressed this issue in our discussion--limitations: To group the interventions, we considered the differences in interventions that aimed to work one on one with individual children (e.g., primary care) vs. group programs (e.g., in schools). However, we recognized that both types of interventions (individual verse group targeted ones) could be conducted in the same setting depending on the specific intervention. For example, those group programs in schools might still involve some one on one intervention activities. In primary care setting, some interventions can be health professionals working with individual children one on one, but it is also possible the intervention target the children as group (e.g., provides education materials and other education programs in the waiting room). Thus, we used setting, but not the one on one versus group focus to group the interventions.
100	TEP 3	Introduction	Page 4—PICOTS framework—why is cost included as an adverse effect? What aspect of cost are you considering here?	We consider some intervention may add cost to the family when they change their food consumption and increase physical activity and there are certainly costs to schools to implement programming. None of the studies reported on costs.
101	Peer Reviewer 6	Introduction	The introduction is well written and provides a good overview of the problem.	Thank you for your comment
102	Peer Reviewer 6	Introduction	I believe in line 37 of page 27 the authors essentially describe the socioecological model for considering the causes of obesity. However, they do not mention this model or provide a reference for it, which I think is warranted.	Thank you. We have referenced this.
103	Peer Reviewer 6	Introduction	Page 28 line 51: additional references that support the cost of obesity in childhood include Hampl S et al 2009 (indicating the increased cost of outpatient care for obese vs. non obese children) and Woolford SJ et al 2007 (indicating the increased cost of inpatient care for obese vs. non obese children).	Thank you for this input. We have included the Hampl paper as a reference in our background section.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
104	Peer Reviewer 2	Methods	The classification of the interventions may be fine as a starting point, but the approach begs the question of what actually works in the intervention.	<p>Added to methods section: “Studies were grouped by the predominant setting of the intervention as we anticipated that this would best meet the needs of the users of this report.”</p> <p>It would have been a different report had we chosen to study the effectiveness of diet on obesity prevention, for example.</p> <p>We synthesized the evidence at the level of the intervention – the interventions were all so different that otherwise there would not have been any synthesis – just description of interventions in the 100 studies. We expect that it is useful to the reader to see that “Physical activity” works or that “both diet and PA” work – this may suggest that the user of the report has flexibility in implementing an intervention.</p> <p>We provide details of the components of the interventions in the tables</p>
105	TEP 1	Methods	Not clear how was the sample size considered in the selection of studies. There are some studies that, although well designed, have too small sample sizes. There is a study presented on [printed]page 14 that has an n=26. Should such a study be considered? And if so, a justification should be presented. Perhaps One could define a lowest cutoff for sample size, or a stratification scheme.	We revised the strength of evidence (SOE) throughout. SOE can be low if there is one large, high quality study. This is consistent with the methods described in this report guidance.
106	TEP 1	Methods	Since many school-based studies are randomized by school or classroom, how was the issue of intraclass correlation considered? There are many studies that do not address this important issue, and incorrectly compare individuals across classrooms or schools.	We have described as a limitation of this report. “We also note that studies had variable analytic approaches and that not all accounted for correlations between individual students within classrooms. We did not differentiate those studies that did and did not address this clustering.”
107	TEP 1	Methods	Measurement of PHYSICAL ACTIVITY: It should be emphasized that there are no clear standards on how to measure PA, particularly spontaneous activity throughout the day. This makes difficult to compare PA levels (or to pool results) across studies.	Yes – we have included this in the discussion. “The measurement of some outcomes, such as physical activity is controversial. There are no consistent standards on how to measure physical activity, especially spontaneous activity, which makes it different to compare physical activity levels across studies when studies use different types of measurements.”
108	Peer Reviewer 3	Methods	Page 36, Data Synthesis, line 54-5: provide examples of education-only interventions, modification to environment, and self-management.	We added examples. “The elements that we abstracted about the interventions included the targeted behavior (e.g., diet or/and physical activity), and the mode of delivery for the intervention (e.g., education, a modification of the environment, instruction in self-management techniques).”

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
109	Peer Reviewer 3	Methods	Page 37, lines 13-15: Cite the DerSimonion & Laird paper. Similar to overall comment made, was there an attempt to do “Indirect Comparisons” as described in the AHRQ Method Guide on CER (e.g., Bucher’s simple method)? It seems that the utility of CER lies in its ability to rigorously compare treatment strategies. Clarify analytic approach and rationale.	Reference added We did not do any indirect comparisons. The majority of this report used qualitative, rather than quantitative synthesis, There are not established methods for indirect qualitative synthesis.
110	Peer Reviewer 3	Methods	Page 37, lines 27-30: Unclear what is meant by “report conclusions.” Does this mean your statement of conclusion addresses the areas listed? Or that you only report results for the areas listed? You do report effect sizes for BMI and BMI z-score, so unclear.	This was changed to “we describe the evidence about...”
111	Peer Reviewer 3	Methods	Page 38, line 30-32: unclear how you would combine BMI and BMI z-score. E.g., if a single study presented both, would you select BMI z-score as the indicator for that study, or would both “count” toward the outcome of “prevention of obesity.”	The reviewer understands correctly – if a study presented both BMI z score and BMI, we would use BMI z-score as the indicator for that study.
112	Peer Reviewer 4	Methods	It is unclear how the analytical framework, and in particular the intermediate variables in it, were used	The analytic framework portrays relevant clinical concepts and the clinical logic underlying beliefs about the mechanism by which interventions may improve health outcomes. In particular, the analytic framework illustrates and clarifies the relationship between surrogate or intermediate outcome measures (such as cholesterol levels) and health outcomes (such as myocardial infarctions or strokes). When properly constructed, it can provide an understanding of the context in which clinical decisions are made and illuminate disagreements about the clinical logic that underlie clinical controversies. More information about analytic frameworks in AHRQ systematic reviews can be found in the AHRQ EPC Program methods guide chapter “Principles in Developing and Applying Guidance” http://www.effectivehealthcare.ahrq.gov/ehc/products/119/325/2009_0805_principles.pdf

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
113	113	Peer Reviewer 4	Excluding interventions focused on the already-overweight will bias results toward the null, since observable results would be most likely there; this should be noted in limitations. Related is the fact that what works for intervention at the population level is likely to work for prevention as well.	We did not exclude studies of overweight children unless they exclusively enrolled overweight or obese children. We believe studies in this population would not be applicable to the non-overweight population.
114	Peer Reviewer 4	Methods	When intermediate variables are considered, relevant studies appear to have been missed, perhaps because the authors searched for the outcome (effects on weight) rather than the intervention (promoting PA, improving nutrition)	<p>That is correct - we only evaluated intermediate outcomes if one of the primary weight outcomes was present. We recognize that this incompletely captures the universe of studies on the intermediate outcomes.</p> <p>Under Methods/Study Selection we state: For inclusion in this review, we required that the study reported on the attained differences between the intervention and control groups in the prevalence of obesity or/and overweight, BMI or BMI distribution in the groups, or other weight and adiposity measures such as waist circumference, percentage of body fat, or skinfold thickness.</p> <p>It was a requirement of inclusion that a weight outcome be present.</p>
115	Peer Reviewer 4	Methods	It is not entirely clear, given the overall paucity of evidence, why studies focusing on the intermediate outcomes in the analytical framework were excluded. If these are, indeed, intermediate, then evidence of interventions influencing them should inform studies to change the outcomes further downstream	<p>The Key Questions were: "Do interventions based in X prevent obesity or overweight?" We did not have separate key questions for intermediate outcome and clinical outcomes. Intermediate outcomes would be indirect for the clinical questions that people really want to know, and thus would still be unlikely to provide high confidence in effectiveness.</p> <p>We should clarify we did not exclude studies focusing on the intermediate outcomes, and only exclude them if they did not provide results regarding weight related outcomes, which is our primary outcome.</p>

	Commentator & Affiliation	Section	Comment	Response
116	Peer Reviewer 4	Methods	The authors conclude that more comprehensive programming, across settings, will likely be required to prevent childhood obesity. Those of us who have long since reached this conclusion may not presume to identify BMI as a primary outcome measure when testing a more limited intervention- rather, we may choose to target one of the intermediate variables in the authors' analytical framework. In doing so, such studies are, apparently, excluded from this review- but they could, in fact, represent MORE effective means of producing change in these intermediate variables- and thus they might be the very components that are best suited to be bundled into the 'comprehensive' whole the authors recommend. That the analysis is apparently blind to such studies is an important limitation, warranting discussion. (Two such studies as examples: Katz DL, Katz CS, Treu JA, Reynolds J, Njike V, Walker J, Smith E, Michael J. Teaching healthful food choices to elementary school students and their parents: the Nutrition Detectives™ program. J Sch Health. 2011 Jan;81(1):21-8; Katz DL, Cushman D, Reynolds J, Njike V, Treu JA, Walker J, Smith E, Katz C. Putting physical activity where it fits in the school day: preliminary results of the ABC (Activity Bursts in the Classroom) for fitness program. Prev Chronic Dis. 2010 Jul;7(4):A82)	<p>We only evaluated intermediate outcomes if one of the primary weight outcomes was present. You are correct in saying that we did not include all articles relevant to the intermediate outcomes given this strategy.</p> <p>The link between intermediate and clinical outcomes is a dashed line. Consistent with the convention for Analytic Frameworks in AHRQ Systematic Reviews, this indicates an association but does not imply a causal link.</p> <p>The association between intermediate and clinical outcomes was not systematically reviewed for this report so authors are not able to comment on this.</p>
117	Stephen Cook- public comment	Methods	N/A	No comment to reply to
118	TEP 2	Methods	Comments on methods are detailed in results section, below	Thank you.
119	Peer Reviewer 5	Methods	The search strategy appeared comprehensive. Inclusion/exclusion criteria were clearly stated, as was the process for considering and assessment of risk of bias.	Thank you

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
120	Peer Reviewer 5	Methods	While it appeared the entire Downs & Black ROB instrument was completed for each study, only seven (of 27) items were used to characterize bias. In the Methods and also in the Executive Summary this should be stated, and if and of the other items were used this should be clarified. Otherwise, the decision rules the authors used, including how they strength of the body of evidence was determined, were clearly spelled out.	You are correct and we have described this in the methods section: "To be considered to be a study at low risk of bias, the study must have done all of the following: stated the objective clearly, described the main outcomes, described the characteristics of the enrolled subjects, described the intervention clearly, described the main findings, randomized the subjects to the intervention group, and concealed the intervention assignment until recruitment was complete. Additionally, the study had to have at least partially described the distributions of (potential) principal confounders in each treatment group".
121	TEP 3	Methods	Page 6, how did you justify included uncontrolled (pre-post studies). Given that children are growing, the only way you can tell if their weight status is improving is if BMI Z scores are reported (so that the BMI reference curves serve as an implicit control). I was not clear if this was the way you viewed it. BMI changes with age in growing children and weight gain is expected; so some type of control is essential.	Yes – the pre-post studies that we envisioned would be analyses at a population level – such as the prevalence of obesity in a school before and after an intervention (not the same children longitudinally over time)
122	TEP 3	Methods	Following are some articles that I expected to see. Please check on why they were not picked up in your search. All three are two-year childhood obesity prevention trials. Outcomes and design papers are included in the citations below. The Fitzgibbon Hip Hop paper is included with respect to the Latino children, but the Latino children were only half of the study. The 2 year paper also includes results for the other 12 sites, which reached African American children. The study had 24 sites in all. Results differed for the AA vs Latino children.	This paper was included in the search results and is included in the report

	Commentator & Affiliation	Section	Comment	Response
123	TEP 3	Methods	1: Klesges RC, Obarzanek E, Kumanyika S, Murray DM, Klesges LM, Relyea GE, Stockton MB, Lanctot JQ, Beech BM, McClanahan BS, Sherrill-Mittleman D, Slawson DL. The Memphis Girls' health Enrichment Multi-site Studies (GEMS): an evaluation of the efficacy of a 2-year obesity prevention program in African American girls. Arch Pediatr Adolesc Med. 2010 Nov;164(11):1007-14. PubMed PMID: 21041593; PubMed Central PMCID: PMC3052791.	This study was excluded at title review based on the input of two screeners. Upon further review, this article should have been included in the report and has been added to the KQ5 community-based interventions section.
124	TEP 3	Methods	2: Robinson TN, Matheson DM, Kraemer HC, Wilson DM, Obarzanek E, Thompson NS, Alhassan S, Spencer TR, Haydel KF, Fujimoto M, Varady A, Killen JD. A randomized controlled trial of culturally tailored dance and reducing screen time to prevent weight gain in low-income African American girls: Stanford GEMS. Arch Pediatr Adolesc Med. 2010 Nov;164(11):995-1004. PubMed PMID: 21041592.	This paper was captured by the search and is included in the report under school based interventions with a home component
125	TEP 3	Methods	3: Robinson TN, Kraemer HC, Matheson DM, Obarzanek E, Wilson DM, Haskell WL, Pruitt LA, Thompson NS, Haydel KF, Fujimoto M, Varady A, McCarthy S, Watanabe C, Killen JD. Stanford GEMS phase 2 obesity prevention trial for low-income African-American girls: design and sample baseline characteristics. Contemp Clin Trials. 2008 Jan;29(1):56-69. Epub 2007 May 25. PubMed PMID: 17600772; PubMed Central PMCID: PMC2259274.	This study included only baseline data.
126	TEP 3	Methods	4: Klesges RC, Obarzanek E, Klesges LM, Stockton MB, Beech BM, Murray DM, Lanctot JQ, Sherrill- Mittleman DA. Memphis Girls health Enrichment Multi-site Studies (GEMS): Phase 2: design and baseline. Contemp Clin Trials. 2008 Jan;29(1):42-55. Epub 2007 May 21. PubMed PMID: 17588824.	This study was excluded for lack of follow-up period

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
127	TEP 3	Methods	5: Fitzgibbon ML, Stolley MR, Schiffer LA, Braunschweig CL, Gomez SL, Van Horn L, Dyer AR. Hip-Hop to Health Jr. Obesity Prevention Effectiveness Trial:postintervention results. Obesity (Silver Spring). 2011 May;19(5):994-1003. Epub 2010 Dec 30. PubMed PMID: 21193852.	This paper was included in the search results and is included in the report under home-based studies
128	TEP 3	Methods	6: Fitzgibbon ML, Stolley MR, Schiffer L, Van Horn L, KauferChristoffel K, Dyer A. Two-year follow-up results for Hip-Hop to Health Jr.: a randomized controlled trial for overweight prevention in preschool minority children. J Pediatr. 2005 May;146(5):618-25. PubMed PMID: 15870664.	This study was excluded for lack of sufficient followup description
129	TEP 3	Methods	Page 6, line 39, --you say that follow up had to be at least 1 year (or, for schools) six months after the intervention. Do you mean after the intervention started? Was completed? There is a big difference. If total follow up from randomization or baseline was one year, then you might want to clarify that you included studies with at least 1 year of intervention/follow up post randomization.	It was one year after the start of the intervention. We have clarified. "Studies were eligible for inclusion if they followed children for at least 1 year after the initiation of the intervention"
130	Peer Reviewer 6	Methods	The methods appear rigorous and are well described. The search strategies are explicitly stated and logical. The definitions for the outcome measures are appropriate, as are the statistical methods used.	Thank you for your comment
131	Peer Reviewer 6	Methods	However, the choice to use only 6 month follow-up for the school-based interventions I believe is questionable. This appears to be an inadequate time period and seems to give school based interventions an advantage in the analysis when comparing them to interventions that are assessed over a 12 month period. I believe this choice was not adequately defended and may have incorporated a bias into the analysis.	We added this in methods: "Studies were eligible for inclusion if they followed children for at least 1 year after the initiation of the intervention, or at least 6 months if it was a school-based intervention given the expectation that most studies would not observe children past the 9-month school-year."
132	Peer Reviewer 2	Results	Results: See general comments. The absence of analysis of resource intensity is striking.	We would have extracted cost data if available – no studies reported on costs. In the analytic framework, cost is listed as an adverse effect.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
133	TEP 1	Results	One issue that may merit additional discussion is incident cases of obesity during the follow-up period. This is a risky estimation, since incidence in relatively short periods (e.g., 6 months for school-based studies) may be difficult to interpret/generalize. Caveat Emptor!	We agree – this was very rarely reported.
134	Peer Reviewer 3	Results	Page 40, Description of type of studies: consider a figure for this? (would explode the final box in Figure 2)	We added a more descriptive paragraph to the results of the literature search section to make this more clear “One hundred and four ... under the above KQs. Eighty-three studies ... and four addressed KQ 5.”
135	Peer Reviewer 3	Results	Page 43, Key Points: why not include effect sizes?	Effect sizes are included in some cases. Most typically the studies did not report measures of variance so we could not calculate effect sizes.
136	Peer Reviewer 3	Results	Page 43, lines 27-29: similar to prior comment, unclear why strength is low if strength for diet & PA in school w/home is high. Perhaps there was qualitative interpretation of “quality” based on number of outcomes measured? Concern that quality should be determined objectively and based only on BMI/BMI z-score outcomes.	SOE has been greatly expanded to explain how the score was derived. We have also added additional figures to further explain this.
137	Peer Reviewer 3	Results	Page 43, lines 32-36: detail provided on studies is inconsistent in these Key Points	We have modified this section for consistency.
138	Peer Reviewer 3	Results	Page 46, Table 3: Grade appears in 2 columns and values don't always match (same for Table 5, 7, etc)	Tables have been revised.
139	Peer Reviewer 3	Results	Page 51, Table 4: Presumably these link to definitions on page 36 in Data Synthesis – however, language is inconsistent – what is Physical/Environmental? Maybe clarify in text on page 36 and add ref to Table 4?	The table headings do not link to the definitions. The definitions (described in the Methods section) are descriptions of the intervention setting. The headings: physical/environmental, and educational (which has been changed to psychosocial) are a description of how the interventions of diet, physical activity, and combination diet and physical activity are applied. Physical/environmental=actual change to the environment or policy. Psychosocial = educational or behavior change.
140	Peer Reviewer 3	Results	Table 4: some of the studies, e.g. Stock 2007 and Vandongen 1995, have multiple arms that cannot be differentiated in this table. Could add detail in appropriate box to clarify?	This has been revised

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
141	Peer Reviewer 3	Results	Page 55 (and throughout rest of sections), “Interpretation” paragraph: given concerns about how the strength of the evidence has been determined, this paragraph would be a very appropriate place to give rationale for ranking of the strength of the evidence for each particular targeted behavior. Would be helpful to use the same structure for this “Interpretation” paragraph in concluding each section. For example: number of studies, consistency and precision, pooled effects (where available), and assigned strength of evidence.	Yes – the interpretation sections have been expanded and made consistent.
142	Peer Reviewer 3	Results	Page 55, line 46: add something to the effect of “but there was a lack of precision around statistical significance” to end of sentence.	We have revised all strength of evidence descriptions to make them clearer. Results were presented as in the original study publication.
143	Peer Reviewer 3	Results	Page 56, line 7: would adding another decimal place clarify the -0.0 effect?	We could only write the numbers as precisely as presented in the original articles.
144	Peer Reviewer 3	Results	Page 57, BMI z-score: no pooled analysis?	No pooled analysis was done. There were not enough applicable studies with appropriate data (see Methods section of the full report for details) for this outcome.
145	Peer Reviewer 3	Results	Table 6 (and subsequent similar tables): why is the Arm column blank for so many studies? Not consistent with Table 4.	We have clarified on the table whether the arm represents the intervention arm or control arm.
146	Peer Reviewer 3	Results	Page 75, line 50: Not clear why there’s a “Synthesis” paragraph – seems like it belongs to the “Interpretation” paragraph (next page) as in all other sections.	We have removed the data synthesis paragraph and added interpretation where it belongs.
147	Peer Reviewer 3	Results	Figures 7 & 8, Title: What does the “only” imply in “combined diet and PA only interventions”	This has been removed throughout
148	Peer Reviewer 3	Results	Page 83, Interventions (and p 88 and p 102 and p 112): provide example of the “community-based” piece of the intervention	We have clarified that “Community-based and environment-level interventions include those interventions that result from policy, legislative, built environment, and economic/pricing/food subsidy interventions. We classified school-based policies with the school-based interventions. Additionally, these interventions involve interaction with the community (a group of individuals who exist prior to the intervention and who share one or more common characteristics such as the YMCA, Church groups).”
149	Peer Reviewer 3	Results	Page 88, BMI Change: check prose – “for this outcome” vs. what other outcome?	This has been revised for clarity

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
150	Peer Reviewer 3	Results	Page 108, Strength of the Evidence: with only 1 study in the Diet & PA combined, how can the strength of the evidence be considered low? Is this because it was a null (or negative) result? I would have expected the strength to be insufficient on both counts.	We revised the strength of evidence (SOE) throughout. SOE can be low if there is one large, high quality study. This is consistent with the methods described in this report.
151	Peer Reviewer 3	Results	Page 114, PA Interventions: Number of studies? No BMI outcomes?	There were no Physical Activity interventions in this setting (key question 3). We have made this clearer in the text.
152	Peer Reviewer 3	Results	Page 125, Key Findings, line 9 & 13: shouldn't this be 96 "intervention" studies, not 97?	We have revised the number of studies throughout the report.
153	Peer Reviewer 3	Results	Page 125, lines 20-24: as noted above, this seems at odds with the abstract, which states that PA and PA/diet interventions had strongest evidence.	This has been modified so that there is consistency.
154	Peer Reviewer 3	Results	Page 125, final paragraph: It is possible (even likely) that the dose of the home component of most school-based interventions would be very low, rendering it very similar to plain school-based interventions.	We have added this point to the Discussion "In addition, worth noting it is possible and even likely that the dose of the home component of many school-based interventions with a home component would be very low, rendering them similar to those school-only based interventions. "
155	Peer Reviewer 4	Results	The authors report 'moderate' evidence for school-based interventions that address alone; and 'low' evidence for diet plus physical activity. This, of course, is counter-intuitive- and a clear case of 'absence of evidence' rather than 'evidence of absence.' Our own findings on this topic actually showed the combination to be superior (Katz DL, O'Connell M, Njike VY, Yeh MC, Nawaz H. Strategies for the prevention and control of obesity in the school setting: systematic review and meta-analysis. Int J Obes (Lond). 2008 Dec;32(12):1780-9), so the conclusion is something of a surprise. Be that as it may, it would help readers to be told clearly WHY evidence is moderate or low, ie, the authors should clearly differentiate between findings that demonstrate weak effects, and lack of data.	Strength of evidence for the school-only based section of the report has been expanded, including with a summary table, to explain in detail how SOE was derived.

	Commentator & Affiliation	Section	Comment	Response
156	Peer Reviewer 4	Results	A section comparing the conclusions of this report directly to other related systematic reviews/meta-analyses, and a rationale for any differences in findings/conclusions, would be very helpful	We added this information in the “Findings in Relationship to What is Already Known” section of the Discussion.
157	Stephen Cook-public comment	Results	N/A	No comment to reply to
158	TEP 2	Results	The conclusion that there is moderate evidence that school-based studies targeting diet only were effective while multi-component interventions that included diet AND physical activity had only low strength of evidence for efficacy lacks face validity. Since your review found moderate evidence diet interventions had at least short-term efficacy and low strength of evidence that PA interventions had efficacy, it would seem counterintuitive that there would be only low evidence that a combined intervention have efficacy for weight gain prevention. Thus, this finding is likely to be more related to study design and degree of intensity of the intervention than due to the fact that a combined intervention was less effective than diet alone.	Please note that the Strength Of Evidence (SOE) was revised for the School only section. The SOE that diet or physical activity impact obesity prevention positively is moderate. The Evidence is insufficient for combination interventions. A clarifying statement has been added to the report noting that the studies were too inconsistent (positive or negative benefits) to lead to a conclusion. We agree that the reasons for the insufficiency are likely design and intensity. A more elaborate interpretation section appears in this report and gives some insights as to why some studies were more effective than others
159	TEP 2	Results	Similarly, on page 80, it is noted that there is insufficient evidence that school/home based interventions which target diet prevent overweight or obesity, while there is high evidence that physical activity or combined diet/physical activity prevent obesity. There was only one diet intervention, which was of very low intensity (e.g. educational approach), so it is not surprising that there was insufficient evidence to support this approach.	Thank you for your comment. In the new version of the report, the SOE was changed to ‘high’ for PA studies, and ‘moderate’ for Diet and PA combined studies. The SOE remained ‘insufficient’ for the one diet study.

	Commentator & Affiliation	Section	Comment	Response
160	TEP 2	Results	In the discussion and conclusions more emphasis should be placed on the many ways in which these various studies differed, and that it may well be factors such as intensity of approach or the population in whom the studies are being done, rather than the approach itself, which drives the results.	<p>Yes – we have described in the limitations section the variation across studies and its impact on the report.</p> <p>We have added the following text to the report: “Within each study setting, we grouped interventions by their targeted behavioral changes (e.g., diet, physical activity, or both) although the studies might have applied very different intervention approaches. It is possible that the inconsistent findings across studies are a result of heterogeneity within study populations (e.g., in U.S. vs. other countries, high vs. low socio-economic status), or due to the different intensity of interventions (e.g. 3-month vs. 2-week interventions) rather than study settings. However, due to the limited number of studies by categories, we could not conduct further stratifications and analyses to explore the comparative effectiveness of the specific intervention approaches (e.g., education intervention vs. environmental change), or specific intermediate outcomes (e.g., fruits and vegetable intake vs. total energy intake).”</p> <p>To make the results more transparent, we have added statements to the interpretation sections throughout the report about potential reasons “why” a specific intervention works. We looked for patterns across effective interventions to see if there was a common facet and added this information to the results.</p>
170	TEP 2	Results	The Robinson study (ref 21) did not target increased Physical Activity, but rather sedentary behavior (screen time). This is a critical distinction, because there is evidence that PA and sedentary behavior represent separate constructs, and may contribute differentially to health risk and/or obesity prevention. I would add “sedentary behavior” to the title of sections where sedentary behavior was a separate target.	We agree and re-assessed our results and modified the report as suggested.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
171	TEP 2	Results	Also—in determining efficacy, the results state that “some components” were positive. It leaves me wondering how many of these were secondary analyses or post hoc testing that was not prespecified. It is an unfortunate truth that investigators often work quite hard to “eke out” a positive result when their primary outcome does not show the expected result. Do these studies note up front which analyses were primary? Were multiple comparisons appropriately controlled for? Some critical review of this issue, both in determining the conclusions and in the discussion of interpretation would be useful for the reader.	Yes – we have added this as a possible limitation of this body of literature in the limitations section. “It was frequently unclear whether the results reported were from prespecified or post-hoc analyses. However, the process of assigning strength of evidence grades puts more weight on studies of high quality lessening the impact of small or poor quality studies.”
172	TEP 2	Results	Did I miss inclusion of the HEALTHY study, published in 2010 in the NEJM. A school-based intervention for diabetes risk reduction. Although couched as a diabetes prevention study, it was really an obesity prevention study, with the primary outcome being combined prevalence of overweight and obesity between intervention and control schools. This was a very large and well-designed school based study in a diverse US population, and its omission would be a mistake. HEALTHY Study Group, Foster GD, Linder B, Baranowski T, Cooper DM, Goldberg L, Harrell JS, Kaufman F, Marcus MD, Treviño RP, Hirst K.N Engl J Med. 2010 Jul 29;363(5):443-53. Epub 2010 Jun 27. PMID:20581420[PubMed - indexed for MEDLINE]	Thank you. We added the study to KQ1 school only setting—outcomes added were BMI z=score, BMI>_95 th percentile, prevalence of overweight/obesity and waist circumference.
173	Peer Reviewer 5	Results	In trying to critically review the results of the study it was difficult to seek detail in the appendices when information was sought that was not presented in the tables of the body of the report. This can be corrected as suggested above (i.e. a single detailed evidence table for each study, rather than many) and a weight-related outcomes table with effect size and variance, follow-up period(s), and p value for significance testing).	We realize that the evidence tables are long. Our tables comprehensively report all abstracted data. For better navigation we have organized our tables by KQ and have clarified the table headings.

	Commentator & Affiliation	Section	Comment	Response
174		Results	The authors did not discuss the distinction between the impact of the intervention (e.g. a meaningful effect size) and the p value (test of a difference between groups). This would help when describing the findings.	In the methods section we have included the following: “Rather our conclusions indicate whether the intervention suggests benefit, no benefit, or unknown benefit. We could not explicitly state whether the reported effects met a clinically relevant threshold as this is not well established in the obesity research community.” Additionally, p-values are incorporated into the SOE under precision. “We considered a study precise if the results for the given outcome were significant at a p value less than 0.05, or had narrow confidence intervals that excluded the null.”
175	Peer Reviewer 5	Results	It was somewhat difficult interpreting the results as the effects were presented in different metrics, but it was useful to have the author’s prioritized list of outcomes for inclusion where multiple weight-related outcomes were reported.	Thank you.
176	Peer Reviewer 5	Results	It was notable that few studies could be included in meta-analysis among interventions (e.g. school combination diet/PA) where >20 studies were found. The reasons might be discussed in more depth.	We describe in the methods section our rationale for including studies in the meta-analyses. The qualitative heterogeneity across studies and the absence of measures of variation precluded inclusion of many of the studies in the quantitative pooling.
177	TEP 3	Results	Page 13—On line 19 you indicate that total follow up ranged from 34 to 104 weeks. These are not school based interventions, so how can you have studies with less than 52 weeks of total follow up.	There are studies that include a school component, and thus meet the criteria for being followed up to 26 weeks. They are now included in the school-based studies section.
178	TEP 3	Results	Page 13, line 19—noting that you looked at 2 year follow up, I wonder if you should look at one year follow up for all studies and then look separately at 2 year follow up to see if the duration of follow up makes a difference.	Our prespecified methods were that we would look at the time of last follow-up. We agree that your suggestion would have been a valid addition to the report.
179	TEP 3	Results	Page 14, lines 50 and following—I could not tell how to interpret the changes in prevalence? What do they mean with respect to the intervention? Was this an uncontrolled study?	This was a pre post study design with no control group. We clarified the statement.
180	TEP 3	Results	Page 16, Table—You have 5 studies, but only give citations for two of them in the narrative. Please indicate which were the other studies in this category.	This has been fixed.

	Commentator & Affiliation	Section	Comment	Response
181	Peer Reviewer 6	Results	The results are presented in a great deal of detail which might initially be deemed too extensive. However, the authors help greatly by providing an easy to follow breakdown of the results for each outcome which makes it possible to quickly find the outcome of interest.	Thank you, we appreciate this comment.
182	Peer Reviewer 6	Results	In addition, the figures (e.g. figures 3 to 10) provide very helpful representations of the data. The tables are somewhat busy but provide important information. Some columns could be consolidated (for example age range and mean age could be combined) thus making space for information such as percent drop out.	We have made some revisions to the tables for clarity.
183	Peer Reviewer 1	Discussion	I suffered some confusion about the actual number of trials on which the results are based. In the Abstract we are told that 113 studies were included in the final analysis. In the Summary we have tables (summary tables 2 – 6) which show how these are allocated under different Key Questions, and the total shown in these tables is 104 studies. This appears to be discrepant. Looking more closely at KQ 1, the Summary narrative text describes 45 studies 'based primarily in schools' but the accompanying table (summary table 2) shows only 40 in the category 'school only' although there are 45 in the main text table of 'school only' studies (table 3 in the main text). In the Discussion of the results of each KQ it says there were 41 studies in the school-only category.	We have carefully reviewed our study counts. We have also included new studies based on our search for more recently published studies.

	Commentator & Affiliation	Section	Comment	Response
184	Peer Reviewer 1	Discussion	Also, in the same Discussion section, it says "Only 11 (41 percent) out of the 27 school-based intervention studies which also included a home intervention component reported significant beneficial effects of the intervention on weight related outcomes. The single diet intervention reported a beneficial effect; all three studies that focused exclusively on physical activity reported beneficial effects; and 10 of the 23 studies that tested diet and physical activity interventions reported beneficial effects" I make that 14 studies reporting beneficial effects, not 11 as stated.	We have carefully reviewed our study counts. We have also included new studies based on our search for more recently published studies.
185	Peer Reviewer 1	Discussion	Again, looking more closely at KQ 5 in the Summary, table 6 shows five studies, but in the main text where KQ5 is described in more detail six studies are listed (tables 23 – 32). I haven't checked for other possible discrepancies.	We have reviewed and updated the numbers of studies throughout the report.
186	Peer Reviewer 1	Discussion	A very minor point – please re-number tables and figures so that duplicate numbers are avoided in the report (e.g. there is a table 2 in the Summary and another table 2 in the main text).	Figures and table have been renumbered.
187	Peer Reviewer 1	Discussion	The text needs some more explanation on why school-based interventions which lasted as little as six months were included, but all other interventions had to be over one year in duration to be included.	We have provided an explanation in the methods. Most school-based interventions last only through the school year which is typically 9 months in most industrialized countries; few school based studies crossed school years or extended into the vacation months. Therefore, in order to capture the rich school-based literature, we chose to include these shorter studies.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
188	Peer Reviewer 1	Discussion	The meta-analysis shown in Figure 6 main text (and presumably the narrative results also) show several studies by Manios et al which are in fact one longitudinal study with repeated sampling, and at each stage it excludes any drop-outs. There is a danger this over-emphasizes the one cohorts' results in the meta-analysis. Is it not the case that a single study which is repeatedly sampled should only count once – presumably over the longest duration, if a choice should be made? If the Manios trial had been reported every few months instead of every few years it would completely overwhelm the other studies, and create a very false view of what can be achieved in school-based interventions.	We analyzed the last reported time point for studies that were eligible for the meta analyses. We understand your concerns, and after re-review of the Manios studies we determined, based on the criteria described in the Methods, that these studies were not actually eligible for inclusion in the MAs. The meta-analyses were re-run.
189	Peer Reviewer 1	Discussion	The issue of drop-outs raises a further question: it is quite plausible that children in an intervention arm of a trial are aware that they are supposed to be losing weight, and if they fail to lose weight they may well prefer not to be re-examined and reported. In the case of the Manios et al study, the initial recruits consisted of 602 intervention children and 444 controls, but the final study reports results for only 284 intervention children and 257 controls (www.nature.com/ejcn/journal/v59/n9/pdf/1602216a.pdf). Surely some account should be made for this when undertaking a meta-analysis and coming to a conclusion in the systematic review?	Dropouts are taken into account when risk of bias is assessed for individual studies. Studies with many dropouts are considered to have a high risk of bias and contribute proportionately less to the evidence base. We acknowledge that this is not taken into account in the quantitative pooling. As above, the Manios study is not included in the pooling.
190	Peer Reviewer 2	Discussion	Provide focus in the executive summary on several interventions that really did well in the analysis. Maybe this could be done as a box text.	We have revised the Executive Summary and have highlighted the effective interventions including physical activity and diet with physical activity in schools – preferably with a home component.
191	Stephen Cook-public comment	Discussion	N/A	No comment to reply to
192	TEP 3	Discussion	Page 17—line 9 and following—are the results regarding fruits and vegetables mentioned in the prior narrative? If not, they should be. They seem more like results than points to make only in the discussion.	They were included under the results, in the intermediate outcomes section.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
193	TEP 3	Discussion	Page 18—line 44 and following – I disagree that it is appropriate to include studies that targeted diet but not weight. Once can target CVD through qualitative changes in diet (e.g., fat, salt, etc), without regard to whether caloric consumption is appropriate. Including studies that did not really target caloric consumption sets up a false negative scenario and incorrectly adds to the sense that prevention of obesity does not work.	We discussed this issue during the early stages of the study. It was decided early on that we would include all studies that abstracted change of weight related outcomes in response to an intervention. Our rationale is that a diet, physical activity, or combination intervention designed to impact a clinical outcome in children will most commonly be aiming to alter calories taken in or calories expended.
194	TEP 3	Discussion	Page 19, future research needs; I could not tell if these needs emerged from this particular review or were more general statements garnered from other sources. Also, regarding the need for research on environmental and policy changes, the authors of this review should be aware of the comprehensive classification and review of such studies by RWJF through Transtria and Wash U, St. Louis. See: Brennan L, Castro S, Brownson RC, Claus J, Orleans CT. Accelerating evidence reviews and broadening evidence standards to identify effective, promising, and emerging policy and environmental strategies for prevention of childhood obesity. <i>Annu Rev Public Health</i> . 2011;32:199-223.	The needs emerged from the evidence gaps identified in this review. We appreciate this review and have now cited it in this section.
195	TEP 1	Discussion/ Future Research	Point v. Cost information. I would be more specific here. It is not just stating the cost, it is cost-benefit and opportunity cost that we need. For example, how does the cost of diverting teacher's time to a prevention activity impacts on overall cost of obesity to the institution and the community.	We agree. In the Implications for Policy Makers Section we state “In addition, the environmental factors that affect food consumption in schools might be easier and less costly to modify than those affecting physical activity, although there are undoubtedly opportunity costs if schools are required to divert attention and resources to these activities at the expense of other learning or enrichment activities.”

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
196	Peer Reviewer 4	Discussion/Conclusion	The authors report 'moderate' evidence for school-based interventions that address alone; and 'low' evidence for diet plus physical activity. This, of course, is counter-intuitive- and a clear case of 'absence of evidence' rather than 'evidence of absence.' Our own findings on this topic actually showed the combination to be superior (Katz DL, O'Connell M, Njike VY, Yeh MC, Nawaz H. Strategies for the prevention and control of obesity in the school setting: systematic review and meta-analysis. Int J Obes (Lond). 2008 Dec;32(12):1780-9), so the conclusion is something of a surprise. Be that as it may, it would help readers to be told clearly WHY evidence is moderate or low, ie, the authors should clearly differentiate between findings that demonstrate weak effects, and lack of data.	<p>We have added detailed descriptions about how we determined the Strength Of Evidence (SOE) in appendix F and the Methods section of the report.</p> <p>Additionally, we re-evaluated the SOE and have changed the GRADE of many setting/interventions to "insufficient" when a conclusion could not be drawn based on the evidence. We reiterate that the strength of the evidence reflects more than the magnitude of effect in a single study.</p> <p>We have added one sentence to the methods section in the Executive Summary and in the main report: "We caution that a "high" strength of evidence grade is not necessarily an indicator of effectiveness – there can be strong evidence that an intervention is ineffective or even strong evidence of no effect"</p>
197	Peer Reviewer 4	Discussion/Conclusion	A section comparing the conclusions of this report directly to other related systematic reviews/meta-analyses, and a rationale for any differences in findings/conclusions, would be very helpful	We agree that this is helpful to our readers. We have a section "Findings in relationship to what is already known" in the Discussion.
198	TEP 2	Discussion/Conclusion	More attention should be paid to the need for more large and well-designed studies to answer these questions. As noted above, some of the evidence differences found may be more related to populations studied (US or foreign; high or low SES; racial/ethnic makeup; proportion of children already overweight or obese) or to intensity of intervention, rather than to the modality or setting. Explicitly stating this would be more useful and give the reader a better understanding of the many limitations of this literature. Otherwise, using these data to determine that, for example, a school based PA study is likely to lead to clinically meaningful reductions in overweight/obesity prevalence is likely to be met with disappointing results.	We agree and have expanded our Future Research Needs section.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
199	Peer Reviewer 5	Discussion/Conclusion	Again, discussion of statistical significance (p value) versus meaningful change (i.e. effect size) should distinguish between the two.	<p>We added this in our Discussion:</p> <p>What is a meaningful difference (i.e., effect size) versus statistically significant difference when measuring the intervention effect? It is optimal to consider both statistical significance (p value<0.05) and biologically or clinically meaningful change (i.e., effect size) when interpreting the effect of intervention programs. However, to our knowledge, there is no consensus in the pediatric obesity field regarding what effect size might be considered a meaningful change. This is partially due to the complexity of adiposity measures in children. For example, many different measures have been used to measure adiposity and childhood obesity although BMI is the most widely used measure. These measures have different units and distributions, and vary by age and sex, and by populations.</p>
200	Peer Reviewer 5	Discussion/Conclusion	Interpretation of results in terms of how much change in weight-related outcomes these interventions achieved, and how meaningful this change is clinically and practically could be discussed in more depth.	<p>See comment #199.</p> <p>We added details in our Discussion and Methods sections. To our knowledge there is no consensus in the field regarding the cut point for a meaningful effect size. Throughout the document, we have provided additional information about the magnitudes of effect in the trials that will help the reader to see the potential impact if implemented.</p> <p>Our reply to comment 199 details our additions to the discussion section</p>
201	Peer Reviewer 5	Discussion/Conclusion	Although it may not be possible to precisely quantify the magnitude of effect in the group of studies where sufficient evidence was found (i.e. school combined interventions and school-home combined interventions) it would be useful to discuss and summarize what actual change might be expected if the users of this review were to invest in these intervention strategies, and would this change likely lead to change in obesity-related clinical outcomes.	<p>Because of the diversity of outcome measures, we could only determine whether or not there was benefit. We could not provide a summary estimate across studies.</p> <p>We did, however add effect sizes for individual articles where the impact was significant.</p>
202	Peer Reviewer 5	Discussion/Conclusion	Furthermore, it would be helpful to discuss issues such as publication bias (considering the overall impacts found) might have implications on how one interprets these results.	<p>We addressed this issue in our discussion.</p> <p>“Publication bias is inevitable in this review, as journals are less likely to publish those intervention studies failing to achieve a desirable effect. We partially addressed this bias, as we searched and included some “gray literature” (e.g. unpublished working papers) in our review. However, none of the grey literature studies met our inclusion criteria in this search. “</p>
203	Peer Reviewer 6	Discussion/Conclusion	The major findings and implications are stated clearly and the limitations are addressed adequately. The gaps in the literature and the future research section provide insightful information to guide new research.	Thank you for your comment

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
204	Peer Reviewer 6	Discussion/Conclusion	The conclusions in general appear appropriate, with the exception of the conclusion regarding Key Question 5 (page 126 line 37). With only 3 out of 7 studies showing significant positive effects, it seems that there would not be moderate evidence to suggest that this type of intervention can prevent obesity.	We have revised the text for KQ 5. There were 9 studies. All settings except Community-school (3) and community-school home (2) included one study and were insufficient. We have revised the Key points and the ES to make this clear
205	Peer Reviewer 2	Discussion/Conclusion	<p>The authors write</p> <p>"It is also clear that most effective intervention research programs have not disseminated nor are sustainable. More attention and resources should be devoted to disseminate the successful intervention programs and conduct related evaluations, especially long-term ones, to reverse the childhood obesity epidemic in the United States and in other countries that are affected by the epidemic."</p> <p>Without the changes I am suggesting, however, I do not think this report will move the ball very far down the field in this regard. I am in a position to move resources to effective programs. I need to understand what makes programs effective, whether these programs can be implemented at reasonable cost, and most importantly, what impact the programs will have. This report is not at the moment geared to any of these questions. With some modest changes, I believe this report could be much more helpful.</p>	<p>Thank you. These are very good points. We made many changes to improve the report ,</p> <p>For example, please see what we reported under, "Implications for Clinical and Policy Decision making," and we have added new discussion.</p> <p>In addition, we'd like to point out the following: Although the evidence is insufficient to support most interventions in most settings, there is sufficient evidence about interventions in schools. We have described in the abstract, executive summary, as well as throughout the report, where the evidence is strongest.</p> <p>The Strength Of Evidence (SOE) is high that targeting physical activity in a school setting with a home component prevents obesity; the SOE is moderate, in this setting, for interventions targeting both diet and physical activity (i.e., combination interventions). The SOE is also high that combination interventions in a school setting that has both home and community components prevent obesity. The SOE is moderate that combination interventions in a school setting with a community component prevent obesity.</p> <p>However, some of the questions the reviewer raised cannot be answered, for example, few studies have reported costs. Even if they did, it is hard to tell the actual cost to implement the intervention as the cost may include the cost for program design/development.</p> <p>Regarding the "impact the programs will have", the study reported effect would shed light into this.</p>
206	TEP 1	Discussion/Conclusion	[printed]p. 17: "Our approach was thoughtful" "Our review was rigorous". These are inherently biased, self-serving statements, and not really useful to the reader, who should be allowed to decide by her/himself if your approach was thoughtful.	We agree and have changed these statements.

	Commentator & Affiliation	Section	Comment	Response
207	Peer Reviewer 3	Conclusion	Finally, the conclusion needs to be more thoughtful, particularly given the absence of quantitative comparisons between approaches. For example, the abstract suggests that physical activity interventions and PA/diet interventions are most promising, yet under “Key Findings” in the Discussion (p. 125), it says that diet interventions are more promising. How did the authors think about comparing studies across settings? Across targeted behaviors within settings?	Please see our revised conclusion. We have carefully reviewed the conclusion section to eliminate inconsistencies with the evidence presented in the results section. Given that the report is organized by setting, it would have been prohibitively challenging to also report the results organized by interventions, across settings, but we certainly acknowledge that the information could have been organized in this way.
208	Peer Reviewer 2	Analysis	Categories that speak to where the intervention takes place, but not what the intervention is. It is like saying “hospital based interventions work for heart attacks,” but not providing analysis at the level of the actual treatment.	We categorized the report by setting. However, within each setting, we described the outcomes by the interventions delivered in that setting. We did not compare the interventions across settings due to the heterogeneity of the interventions.
209	Peer Reviewer 2	Analysis	Focus on statistical significance but not public health relevance. You have to dig deep into the report to see the nature of the effect. And the data is provided in a manner that is quite inaccessible. It would take me a while to understand what impact was really had.	We have added results in the tables and text that describe the magnitudes of effect of the interventions so the reader can more clearly see the potential public health and clinical benefit of the interventions.
210	Peer Reviewer 2	Analysis	No discussion of resource intensity. It is impossible to distinguish easily those interventions that cost a fortune and had a modest impact from those that are truly replicable (in the resource constrained world we live in) and worthwhile.	Cost was not reported as an outcome in any of the studies we included in this review. We have described the lack of reporting on this outcome under Future Research Needs in the Executive Summary and the full report discussion
211	Peer Reviewer 3	Appendices	Appendix F: What does NR mean? Under School, Home interventions, Diet, replace “Insufficient” with “NA” under Consistency (to be consistent). This seems like a logical table in which to insert the pooled effects (when available), listing: outcome(s), number of studies included, effect size & CI.	We have revised this throughout so that we have consistent and defined use of the term NR (not reported).
212	Peer Reviewer 2	Appendix	The appendices are totally unwieldy. I have never seen tables so long.	We understand that the appendices contain a large amount of information. We felt it was important to include all of the information collected during data abstraction in the evidence tables. Not all of the data is presented in the report.
213	Peer Reviewer 2	Appendix	Develop an online database of all the studies, which will be much more useful than the unwieldy appendices.	The appendices do ultimately appear on-line. We intend on submitting our data to the Systematic Review Data Repository (SRDR) when the report is completed.

Source: <http://effectivehealthcare.ahrq.gov/search-for-guides-reviews-and-reports/?pageaction=displayproduct&productID=1524>

Published Online: June 10, 2013

	Commentator & Affiliation	Section	Comment	Response
214	Stephen Cook-public comment	Figures	N/A	No comment required
215	Stephen Cook-public comment	References	Hip-Hop to Health Jr. Obesity Prevention Effectiveness Trial: postintervention results. Fitzgibbon ML, Stolley MR, Schiffer LA, Braunschweig CL, Gomez SL, Van Horn L, Dyer AR. Obesity (Silver Spring). 2011 May;19(5):994-1003. Epub 2010 Dec 30. PMID: 21193852 [PubMed - indexed for MEDLINE] Hip-Hop to Health Jr. for Latino preschool children. Fitzgibbon ML, Stolley MR, Schiffer L, Van Horn L, KauferChristoffel K, Dyer A. Obesity (Silver Spring). 2006 Sep;14(9):1616-25. PMID: 17030973 [PubMed - indexed for MEDLINE]	Thanks for the specific reference.
216	Stephen Cook-public comment	Tables	N/A	No comment required
217	Peer Reviewer 1		Quality of the Report: Superior	
218	Peer reviewer 6		Quality of the Report: Superior	
219	Peer Reviewer 2		Quality of the Report: Fair	
220	TEP 1		Quality of the Report: Good	
221	Peer Reviewer 5		Quality of Report: Good	
222	Peer Reviewer 3		Quality of the Report: Fair	
223	Stephen Cook-public comment		Quality of the Report: not reported	
224	TEP 2		Quality of the Report: Good	
225	Peer Reviewer 4		Quality of the Report: Good	
226	TEP 3		Quality of the Report: not reported	