# REVISIÓN SISTEMÁTICA SOBRE EL IMPACTO DE UN PROGRAMA DE ACTIVIDAD FÍSICA EN LA CVRS DE TRABAJADORES ADULTOS.

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**RESUMEN**

El objetivo de èsta revisión sistemàtica es conceptualizar acerca de la definición de la actividad física, su prevalencia y relación directa con las estrategias desarrolladas desde la promoción de la salud. La revisión de literatura científica que contempla artículos de bases de datos especializados en salud. Donde se abordan como parámetros de búsqueda las variables actividad física y calidad de vida; de igual forma, se relacionan los aportes de expertos en las áreas en mención. La actividad física expone definiciones y juicios en torno al aumento del gasto energético por encima de la tasa basal, así como posturas referentes a la actividad física desde la salud, entrenamiento deportivo y educación. En cuanto a la prevalencia de actividad física se reportan que muy bajos porcentajes de la población que realizan actividad física, lo que se convierte en objetivo de obligatorio abordaje desde los entes nacionales e internacionales relacionados con la práctica de actividad física y la promoción de la salud para mejorar la calidad de vida. Esta revisión permite que el lector visualice los diversos enfoques y tópicos de la actividad física, así como su relación con los procesos de sensibilización, empoderamiento y autorregulación en torno a la calidad de vida del individuo y la comunidad, con el simple objeto de interiorizar la práctica de la actividad física como elemento complementario de su vida.

**PALABRAS CLAVES:** Actividad física, calidad de vida, adulto trabajador, obesidad y sobrepeso.

**ABSTRACT**

The objective of this systematic Revison is conceptualized on the definition of physical activity, its prevalence and relationship with the strategies developed from the health promotion. The review of scientific literature includes articles database specialized in health. Where are addressed as search parameters variables physical activity and quality of life; similarly, the contributions of experts in areas related references. Physical activity exposes definitions and judgments about the increase in energy expenditure above the basal rate and positions concerning physical activity from health, sports training and education. As for the prevalence of physical activity they reported very low percentages of the population who engage in physical activity, which becomes mandatory objective approach from national and international bodies related to physical activity and health promotion to improve the quality of life. This review allows the reader to visualize the different approaches and topics of physical activity and its relationship to the processes of awareness, empowerment and self-around quality of life of the individual and the community, with the simple aim of internalizing practice of physical activity as a complement to their lives.

**KEYWODS:**
Physical activity and quality life and adults worker and obesity and overweight.

# INTRODUCCIÓN

Este trabajo de investigación fundamenta su revisión sistemática en ensayos clínicos aleatorios, en donde la implementación de un programa de actividad física impacta en la calidad de vida relacionada con la salud, de trabajadores. Es un hecho notorio que la inactividad física se ha convertido en un problema de salud pública en Colombia y en el mundo. Por constituirse en un factor de riesgo de morbilidad en el cual los trabajadores están expuestos de contraer enfermedades laborales, según el Informe de Enfermedad Profesional en Colombia (2011). Cada año se presentan 160 millones de casos nuevos de enfermedad profesional en todo el mundo, por esta razón la actividad física se debería constituir como una estrategia, que permite prevenir dichas enfermedades que fomenten la calidad de vida relacionada con salud; para ello es necesario revisar lo que se ha desarrollado en el campo científico, identificando la calidad de los estudios publicados y su pertinencia para dar solución a la problemática.

Esta revisión puede convertirse en una base para identificar las estrategias y herramientas relacionadas con la actividad física que se han implementado en trabajadores, y que impactan la calidad de vida en salud, este estudio presentara en su primera instancia el planteamiento del problema donde mostrà la pregunta de investigación, las razones del porque se decidiò realizar èste estudio, en segunda instancia se presentan los objetivos general y específicos, seguido de un marco conceptual, el cual da al estudio un sistema estructurado y coherente de términos y proposiciones que permitan abordar el problema, seguido de un marco metodológico que pretende hacer revisiones de fuentes primarias en bases de datos, para seleccionar artículos a los que su contenido metodológico demuestren la veracidad, confiabilidad y validez del tema a tratar, motivando a la aplicación de formatos que filtren la información de manera directa, con el fin de describirlos en una matriz bibliomètrica y generar los resultados que respondan a la problemática planteada en èste estudio.

## PLANTEAMIENTO DEL PROBLEMA

En la actualidad la inactividad fìsica ocupa el cuarto lugar de los principales factores de riesgo de mortalidad a nivel mundial y se ha convertido en un problema de salud pública no solo en Colombia sino en el resto del mundo, “donde se estima que la inactividad física es la causa principal del 21–25% de los cánceres de mama y de colon, 27% de la diabetes, y aproximadamente un 30% de las cardiopatías isquémicas” (OMS, 2010), generando cada día más personas con un bajo porcentaje de practica de alguna actividad física, lo que contribuye al aumento del riesgo de presentar una enfermedad crónica no trasmisible, Dunn (2001), resalta “que más de 16 millones de muertes se atribuyen a esas enfermedades y se producen en personas menores de 70 años de edad: niños, jóvenes, adultos y ancianos son vulnerables a los factores de riesgo, como las dietas malsanas, la inactividad física, la exposición al humo de tabaco” y es la inactividad física uno de los factores que debe ser intervenido por medio de la promoción de la práctica de la actividad física como una clave para lograr beneficios en la salud, así como en la mejora de la calidad de vida de las personas, entendiendo ese término como la percepción que un individuo posee de su posición en la vida, teniendo como enfoque sus metas, expectativas y normas.

Por lo tanto la práctica de la actividad física “se asocia con una mejor percepción de la calidad de vida en relación con la salud, tanto en población general como en personas con diversas enfermedades y distintas discapacidades”. (Gillison, 2009), es así como la actividad física que se presentan en grupos poblacionales específicos, favorecer su estado de salud y la adquisición de un estilo de vida saludable, el cual a su vez contribuye en la calidad de vida de los sujetos, la cual involucra elementos desde una mirada objetiva y subjetiva de la percepción del ser humano.

Para Schumaker y Naugton (1996) “La calidad de vida relacionada con la salud (CVRS) es la percepción subjetiva, influenciada por el estado de salud actual, de la capacidad para realizar aquellas actividades importantes para el individuo”. Esto quiere dar a entender que la capacidad

de una persona de percibir como esta su estado emocional, físico, social y psicológico, influye en las actividades que a diario realiza, pero a su vez el entorno influye en dicha percepción subjetiva la cual se construye a partir de los intereses y el proyecto de vida de los sujetos.

Algunas investigaciones científicas asocian el efecto de la actividad física, con la CVRS de un determinado tipo de población, Es así como Imayama Ikuyo & Alfano Catherine (2011) desarrollo un estudio relacionado con la pérdida de peso mediante una dieta e intervenciones de ejercicios físicos sobre la calidad de vida de personas que presentan sobrepeso y mujeres posmenopáusicas, fue un estudio de 12 meses, que contó con la participación de mujeres entre los 50 y 70 años de edad, esta investigación revela que la combinación de la dieta para perder peso y el ejercicio físico tiene un efecto positivo sobre la CVRS y la salud psicológica, mejorando los factores psicosociales como la depresión, el estrés y el soporte social, permitiendo el aumento de la calidad de vida relacionada con la salud de las personas con sobrepeso y mujeres posmenopáusicas, que se benefician de un programa de ejercicio físico combinado con una dieta para la pérdida de peso.

En la siguiente investigación realizada por Gomes y Bastos (2014), el propósito de su estudio fue evaluar los efectos de la actividad física sobre la aptitud física y la calidad de vida de un grupo de 19 pacientes con esquizofrenia, con un programa de ejercicio físico durante 16 semanas, en el que pudieron concluir que la situación psicológica de los pacientes con un programa de actividad física la tomaròn como una manera de vida saludable, en la que pueden tener una a diario una vida normal, lo que conllevo a grandes avances conductuales en las personas con trastornos mentales, lo cual equivale a la mejorar de su calidad de vida.

Por otro lado, Bowen y Fesinmeyer (2006) desarrollaron un ensayo clínico aleatorio, sobre el efecto del ejercicio físico en la calidad de vida de mujeres de mediana edad sedentarias. La muestra fue de 173 mujeres entre los 55 y 75 años, se enfoca en la intervención de ejercicios físicos estructurados y controlados en dos grupos de mujeres que determinaron que había una estrecha relación entre la calidad de vida y el ejercicio físico, demostraron que la práctica de un tipo de ejercicio moderado impacta positivamente la calidad de vida de las mujeres sedentarias, pero si se realiza un ejercicio físico de alta intensidad, efectos negativos influirán en aspectos concretos de la calidad de vida de estas personas.

Para culminar Randi (2009) realizó un estudio con el cual contó con la participación de 49 hombres obesos y buscó identificar si el ejercicio físico está relacionado con la calidad de vida de personas con obesidad y como la intervención de un ejercicio especifico, mejoraba la calidad de vida de los sujetos, y posteriormente poder realizar un programa de intervención de estilo de vida saludable.

Estos estudios demuestran que las investigaciones se han realizado en su mayoría con personas que presentan algún tipo de enfermedad y de qué manera un programa de ejercicio físico impacta positivamente en calidad de vida de los sujetos, sin embargo no se han hallado estudios específicamente en adultos trabajadores que se encuentran en un entorno diferente, expuestos a factores específicos propios del trabajo, que requieren de programas de actividad física que impacten la calidad de vida relacionada con la salud.

En cuanto a las enfermedades profesionales que padecen los trabajadores, cada año 160 millones de casos nuevos de enfermedad profesional surgen en todo mundo, incluidas las enfermedades respiratorias y cardiovasculares, cáncer, trastornos auditivos, osteomusculares y reproductivos, así como enfermedades mentales y neurológicas. Según el Sistema General de Riesgos Profesionales. (2011). Las principales enfermedades que aquejan a los trabajadores colombianos son de carácter osteomuscular (85%) y dentro de este grupo la de mayor incidencia es el síndrome de túnel carpiano, enfermedad que representa el 30% de este grupo. Es preocupante que el la cifra más alta de enfermedades que aquejan a los trabajadores sean de tipo osteomuscular como lo son lumbago no especificado, bursitis de hombro, síndrome del maguito rotatorio entre otras. Esto lleva a deducir que la actividad física como programa estructurado puede influir positivamente en la calidad de vida asociado a la salud de adultos trabajadores, que presentan o padecen de enefermedades laborales que las desarrollan en su lugar de trabajo.

Debido a la falta de estudios en la población trabajadora, la cual presente condiciones de salud asociada con la inactividad física y las jornadas de trabajo, es necesario desarrollar una investigación que permita resolver la siguiente pregunta:

¿Cuál es la evidencia científica existente, que estudie el impacto del ejercicio físico en la calidad de vida asociada a la salud de trabajadores adultos?

## JUSTIFICACION

Este estudio de revisión sistemática, surge de la necesidad de integrar de forma estructurada y objetiva, estudios de tipo: ensayos clínicos aleatorios donde se evidencien los efectos que un programa de actividad física, presenta en la calidad de vida relacionada con la salud (CVRS), de trabajadores adultos, con el fin de establecer la calidad de esos artículos, debido a que las evidencias de artículos científicos relacionados con el tema son escasos, puesto que el tipo de población a la que benefician no son los trabajadores, que actualmente están padeciendo de enfermedades crónicas no transmisibles así como osteomusculares, perjudicando su calidad de vida.

Es un hecho notorio que la inactividad física se ha convertido en un problema de salud pública en Colombia y el mundo, por constituirse en un factor de riesgo de morbilidad en el cual los trabajadores están expuestos a contraer enfermedades crónicas no transmisibles, que realizando actividad física podrían prevenirse o reducirse, fomentando la calidad de vida relacionada con su estado saludable, esta revisión sistemática servirá de referencia bibliográfica para que otros investigadores profundicen en la necesidad de realizar programas de actividad fisca que impacten en la calidad de vida relacionada con la salud de los trabajadores.

También es pertinente dado que la carrera de Cultura física, Deporte y Recreación, debe apropiarse del estudio de éstos temas que competen a su campo y área, en procura de contribuir a proporcionar alternativas de solución a los graves problemas de salud pública que aquejan a Colombia, buscando que la práctica de la actividad física se erija en una política pública de salud, que bien formulada e implementada apoyara decisivamente a mejorar la calidad de vida de todos los ciudadanos involucrados.

# OBJETIVOS

## GENERAL

- Establecer la calidad de los estudios clínicos aleatorios relacionados con el efecto de un programa de actividad física en la CVRS de trabajadores adultos.

## ESPECIFICOS

- Identificar los estudios relacionados con el tema de acuerdo a los criterios de búsqueda.
- Clasificar los estudios que cumplan con los criterios de calidad de la investigación de acuerdo a la declaración de consort.
- Inferir de los estudios clínicos controlados los sesgos sistemáticos, utilizando el formato Pedro.

## MARCO CONCEPTUAL

Este proyecto de investigación enmarca unos conceptos claves, en primera instancia se hablara sobre calidad de vida, la cual es una medida compuesta de bienestar físico, mental y social, tal como lo percibe cada individuo y cada grupo, esto según Levy y Anderson (1980), ese concepto se encuentra definido por varios autores, Chaturvedi menciona que la calidad de vida es la sensación subjetiva de bienstar del individuo, esto se puede interpretar como un estado de satisfacción que una persona presenta, en el que se reflejan aspectos subjetivos como: la intimidad, la expresión emocional, la productividad personal entre otras y aspectos objetivos como: bienestar material, relaciones armónicas con el ambiente y salud. La importancia de este concepto está en identificar la percepción de las personas sobre su estado de bienestar físico, mental y social, casi siempre dependerá de sus creencias, principios y valores que se enmarque en su contexto cultural. Algunas investigaciones muestran tres pilares para la evaluación de la CVRS, los cuales son la felicidad, los indicadores sociales y la salud, eso ítems han enmarcado unos parámetros para la investigación de la CVRS.

### *Perpectiva de la calidad de vida*

En cuanto al término de la calidad de vida relacionada con la salud, Patrick (2007) la define como la medida en que modifica el valor asignado a la duración de la vida en función de la percepción de limitaciones físicas, psicológicas, sociales y de disminución de oportunidades a causa de la enfermedad, sus secuelas, el tratamiento y/o las políticas de salud, por lo tanto en este proyecto de investigación se tendrá en cuenta el pilar salud, entorno a la percepción de la CVRS de adultos trabajadores que hagan parte de un programa de actividad fisca, entendiéndola como cualquier movimiento corporal producido por los músculos esqueléticos, con el consiguiente consumo de energía según la definición de la OMS (2010), otra definición resalta la actividad

física como un movimiento corporal que es producido por los músculos del cuerpo, requiriendo de un gasto energético para moverlos.

Por otro lado; "la ruptura de la supuesta identidad entre nivel de vida y calidad de vida hace que se ponga en duda que los indicadores objetivos de carácter cuantitativo sean los únicos que nos sirvan para marcar el grado de bienestar de las personas o de los grupos sociales". La diversidad de elementos constituyentes de este concepto le hace difícil de ser definido. Generelo (1998), citando textualmente a Setién (1993) define calidad de vida como "el grado en que se satisfacen las necesidades humanas. En los ámbitos geográficos y en las áreas concretas donde las necesidades queden más satisfechas, la calidad de vida será mejor; tal sociedad o tales áreas estarán más desarrolladas. En el caso contrario, la sociedad o el aspecto concreto estará menos desarrollado y la calidad de vida será peor". Dependiendo de el concepto que cada perona y cada empresa quiera tomar de estos conceptos dara parte paarq ue sea bueno o malo.

Se puede señalar y cabe rescatar que" los estilos de vida están constituidos por la adquisición de diversos hábitos que, por otro lado, pueden ser saludables o no saludables. Los hábitos de salud y los hábitos de vida están íntimamente unidos, de manera que sería más apropiado hablar de hábitos saludables de vida". Coreil y cols. (1992), asocian los conceptos de hábitos saludables de vida, con el concepto de calidad de vida. Dawson (1994), considera que se debe dar un paso más allá del modelo salud-enfermedad y utilizar indicadores de un concepto de salud integral bio-psico-social. Será dentro de un entorno educativo donde podremos intervenir en la generación de hábitos y conductas dirigidas a la creación de estilos de vida saludables. Con un programa de actividad física que motive a las personas trabajadoras a que se somentan a ello y lo puedan llevare n sus vidas diarias y contrubuyan a su mejora de calidad de vida.

***Perspectiva de la actividad física***

Cuando se habla de una actividad planeada, estructurada y organizada el término ejercicio físico es resaltado, la practica regular y constante de una actividad específica beneficia ciertos factores del ser humano, pero si una persona evita la práctica de la actividad física y su estilo de vida se vuelve sedentario se puede hablar de la inactividad física y lo que ésta abarca, "A nivel mundial, uno de cada tres adultos no tiene un nivel de actividad física y las recomendaciones mundiales sobre actividad física para la salud de la OMS, siguieren que los adultos entre los 18 y 64 años,

deben acumular 150 minutos semanales de actividad física aeróbica moderada o 75 minutos semanales de actividad aeróbica vigorosa, al igual que deberían realizar ejercicios de fortalecimiento muscular de dos o más días a la semana". (OMS, 2010). Por tal motivo es fundamental que en un grupo de adultos que trabajan dejen de lado la inactividad física, para mejorar la calidad de vida que está relacionada a la salud de cada uno de ellos, mediante programas estructurados de ejercicio físico.

La actividad física regular disminuye el riesgo de obesidad, sin embargo, casi el 30% de los estadounidenses se clasifican como sedentarios. De hecho, en comparación con otros programas preventivo y opciones terapéuticas, aumentos modestos en actividad física regular puede producir un amplio espectro de salud beneficios con poco riesgo, incluyendo la mejora en el control de peso la actividad física puede ayudar a prevenir y gestionar enfermedades del corazón y se asocia con reducciones en la prevalencia de la hipertensión, hiperlipidemia y cáncer de mama. En cuanto a la la actividad física realizada por las personas de edad avanzada lo asocian con la reducción de los síntomas de dolencias como insomnia y artritis. La actividad física entre los jóvenes se ha asociado con un menor riesgo de problemas sociales importantes como embarazos adolescentes y uso de drogas ilícitas En todos los grupos de edad la actividad fisica se asocia con un menor riesgo de depresión y desordenes mentales y con la mejora general de la calidad devida, la mayoría de los beneficios de la actividad física regular devengan sólo gradualmente con el tiempo. Sin embargo, de inmediato mejoras en el funcionamiento diario como mayor estado de alerta y el rendimiento cognitivo y disminución de la ansiedad se ha demostrado que se producen después de un programa de 10 a 15 minutos de caminata. Kovar PA. (2000).

La Asociación de Medicina Deportiva de Colombia (AMEDCO). (2002). "conceptualiza la actividad física como cualquier movimiento corporal voluntario de contracción muscular, con gasto energético mayor al de reposo; además, esta actividad es entendida como un comportamiento humano complejo, voluntario y autónomo, con componentes y determinantes de orden biológico y psico-sociocultural, que produce un conjunto de beneficios de la salud, ejemplificada por deportes, ejercicios físicos, bailes y determinadas actividades de recreación y actividades cotidianas, las cuales se consideran como un derecho fundamental , conceptualización que evidencia la integración de elementos contextuales que en la actualidad se

consideran de gran importancia durante el abordaje de la actividad física" para logara esto la persona debe tener la disposición y el tiempo para no decaer en la decion que toma de estra bien y sentirse bien.

***Población en estudio***

En cuanto a la población de éste estudio, un factor influyente en la realización de actividad física es el entorno donde laboran, Quintiliani (2010), define que "el lugar de trabajo es un entorno ideal para la promoción de hábitos alimentarios saludables ya que los empleados pasan muchas de sus horas de vigilia allí" esto refiere a que el lugar de trabajo de una persona muchas veces puede ser un impedimento para realizar una actividad diferente al trabajo. Algunas investigaciones en los sitios de trabajo se centran en técnicas de cambio del comportamiento, tales como la enseñanza de una adecuada nutrición con el fin de mejorar los hábitos alimentarios de los empleados. "Estos conductual enfoques de cambio, incluyendo grupo y asesoramiento nutricional individuo, tours de compras supervisadas y correos electrónicos semanales han mostrado una moderada efecto positivo en el consumo de frutas y verduras." (Maes et al, 2011; Ni Mhurchu et al., 2010; Michie et al., 2013). Estas herramientas son ideales para promover la buena alimentación pero también cabe resaltar que una nutrición balanceada combinado con ejercicio físico puede mejorar la calidad de vida relacionada a la salud.

***Perspectiva de la salud***

En 2003, un grupo Nacional de empresas de Salud estableció el Instituto sobre los costos y Efectos sobre la salud de la obesidad, teniendo como finalidad "el proponer soluciones innovadoras que los grandes empleadores pueden implementar para controlar los costos relacionados con las conductas relacionadas con el estilo de vida "(National Business Group on Salud, 2008). Estas medidas están siendo implementadas en diferentes países y lugares de trabajo teniendo como fundamento una idónea calidad de vida que se relacione con la salud de trabajadores y se eviten gastos en la producción, cuando un trabajador enferma.

Si se analiza la forma de entender la salud en el presente siglo XI, aparecen dos etapas bien diferenciadas, (Devís y Peiró, 1992).dicen que la primera estaba ligada a problemas de higiene y condiciones de salubridad, y se ubica a principios del siglo XX, donde la sociedad empezaba a sufrir las consecuencias de la revolución industrial. En ella el ejercicio físico adquiere un papel terapéutico. La segunda, se origina con las mejoras del entorno social y cultural, sobre todo a partir de mediados de siglo. Las condiciones de vida van cambiando y el concepto de salud adquiere connotaciones de promoción de ambientes y estilos de vida saludables, lo que se traduce en el ámbito de la Educación Física en desarrollar una actitud positiva hacia la práctica de actividad física, con el fin de prevenir la aparición de las enfermedades modernas enfermedades crónicas no transmisibles. "En la actualidad, los programas de actividad física están orientados bajo una perspectiva de promoción de la salud que integra diversas dimensiones de la formación humana. Se busca el diseño de programas de ejercicio más individualizado, seguro y motivante, que genere en todo momento una fijación hacia la práctica" (Meredith, 1988; Hutchinson y cols., 1990; Quenneville y Sidney, 1992; Fox, 1993; Mahoney, 1993; Morrow y Gill, 1995; Gill, 1996).

***Perpectiva del sitio de trabajo***

"El lugar de trabajo ofrece un entorno único para implementar la salud programas de promoción y proporcione una oportunidad ideal para participar grande número de individuos en una manera muy eficiente y rentable" Hennrikus y Jeffery (1996). Esto quiere decir que los sitios de trabajo se puede realizar campañas de promoción de la actividad física parar prevenir enfermedades, mejorando la calidad de vida de los trabajadores, este tipo de población esta expuesto a diversas enfermedades según las encuestas inglesa (1998) y finlandesa (2000) sobre autorreporte de enfermedades relacionadas con el trabajo llevaron a la conclusión de que el 7.3 y 8.3%, respectivamente de los trabajadores reportan anualmente una o más enfermedades de origen laboral que causan ausencia del trabajo.

La obesidad es un importante problema de salud pública en los Estados Unidos debido a su alta prevalencia (Flegal et al., 2002), la relación de causalidad con enfermedades médicas graves (Allison et al., 1999; Hu et al, 2001; Hubert et al., 1983; Manson et al., 1990), el impacto

económico, y negativa efectos sobre el rendimiento en el trabajo (Pronk et al., 2004). Esto quiere decir que si los trabajores están enfermos no rinden de la misma menera que lo harian si gozaran de buena salud, esto los lleva a ser menos proactivos en lo que realizar diariamente, para ello es importante implementar programas en los sitios de trabajo para que las personas tengan mas opciones de desempeño.

Para poder relacionar la motabilidad de las enfermedades de los trabajadores debemos observar las tasas de mortalidad y morbilidad de las enfermedades nombradas en cuestión, desde allí se puede inferir que a comienzos del siglo XXI se registraron 520 casos de enfermedades profesionales lo que equivalía a una tasa de enfermedad profesional por cada 100.000 habitantes de 24,9, para el 2010 está cifra aumentó a 9.411 casos con una tasa de 136,4 por 100.000. Sin embargo, el diagnostico sigue siendo una preocupación, las cifras muestran que más del 85% son enfermedades asociadas problemas osteomusculares, mientras que en las enfermedades de larga latencia y crónicas, como las respiratorias, el cáncer y las asociadas a exposición a químicos aún se desconoce su magnitud. (Informe de Enfermedad Profesional en Colombia) (2002)

Según El Sistema General de Riesgos Profesionales (2011). Se estima también este mismo organismo que de las enfermedades profesionales que ocurren anualmente en el mundo, aproximadamente entre el 30% y el 40% se tornan crónicas, el 10% generan una incapacidad permanente y entre 0,55 y el 1% son mortales; Ahora bien, al analizar las cifras de enfermedad por sector económico se encuentra que aproximadamente el 66% de las enfermedades profesionales diagnosticadas se concentran en 4 sectores económicos: industria (28,3%), inmobiliario y temporal (17,8%), agricultura 12,5% y administración pública (7,4%). No obstante, si se revisa la tasa de morbilidad profesional por actividad económica, es decir, el número de enfermedades profesionales diagnosticadas por cada 100.000 trabajadores a9liados en cada sector económico, encontramos que, en promedio, las tasas más altas se encuentran en los sectores de minería (415,2), agricultura (338,3), construcción (246) y educación (243,9). Se puder dar cuenta que las tasas de nefermedades en trabajadores son demasiado altas y en el campo se puede trabajar con esta población fácilmente y ayudar a mejorar su calidad de vida y logrra que estas tasas bajen un poco.

## METODOLOGIA

El presente estudio es una investigación cuanlitativa, con diseño denominado revisión sistemática, el cual pretende describir la evidencia científica existente relacionada con el impacto de los programas de actividad física en población trabajadora.

Los criterios de inclusión:

- Artículos de ensayos clínicos aleatorizados que contenían un impacto de un programa de actividad física en la CVRS de trabajadores adultos.
- Artículos de acceso libre.
- Estudios realizados entre el 2000 y 2014.
- Bases de datos de ciencias de la salud y de la vida tales como: Science Direct y Pubmed
- Ecuaciones de Busqueda: physical activity and quality life and adults and obesity and over weight. Definidos a partir de la busqueda de términos MESH.
- Artículos en Inglés.

Para el desarrollo de esta investigación se contará con las siguientes fases:

1. Realizar la búsqueda de los artículos en las bases seleccionadas.
2. Se realiza la clasificación de los artículos por título y abstract teniendo en cuenta la pregunta de investigación y los criterios de inclusión.
3. Se aplica CONSORT para verificar la calidad de los ensayos clínicos aleatorizados.
4. Se aplica PEDRO para determinar el nivel de sesgo de los artículos.

Sistematización de los resultados de los artículos finalmente seleccionados en la matriz bibliometrica, donde se realiza la descripción del tipo de población, el resumen, relación calidad de vida y actividad física, teniendo como finalidad la redacción de los resultados y conclusiones.

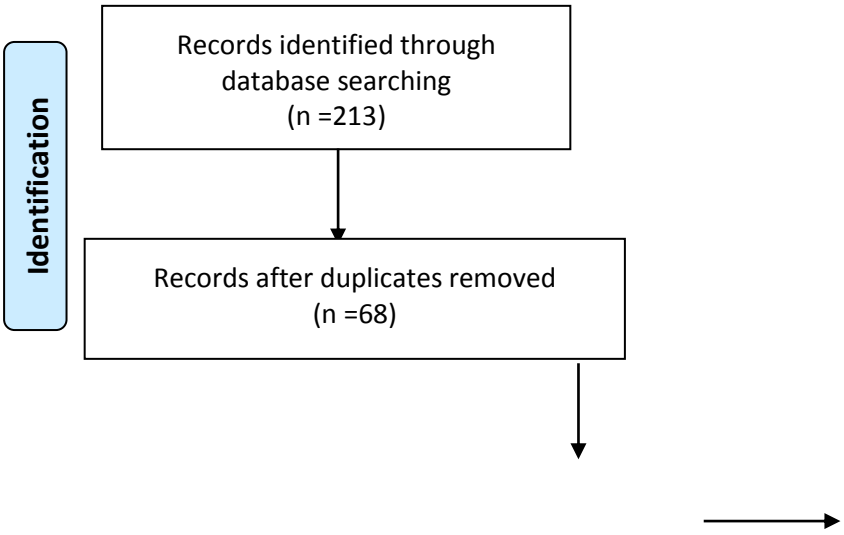
## RESULTADOS

### Sistematización

A partir de la búsqueda se encontraron 213 artículos de los cuales 122 fueron rechazados por título y abstract, quedando 91 artículos, de los cuales 68 estaban duplicados en las bases de datos 23 artículos ECA fueron seleccionados a los cuales se aplicó el formato CONSORT de los cuales 5 presentaban confusión en términos metodológicos, y por lo tanto fueron rechazados. A los 18 articulos se le aplicò el formato Pedro.

El diagrama de flujo de èsta revisión sistematica se puede observar en (figura 1), la cual muestra la estructura mendionada anteriormente.

PRISMA 2009 Flow Diagram



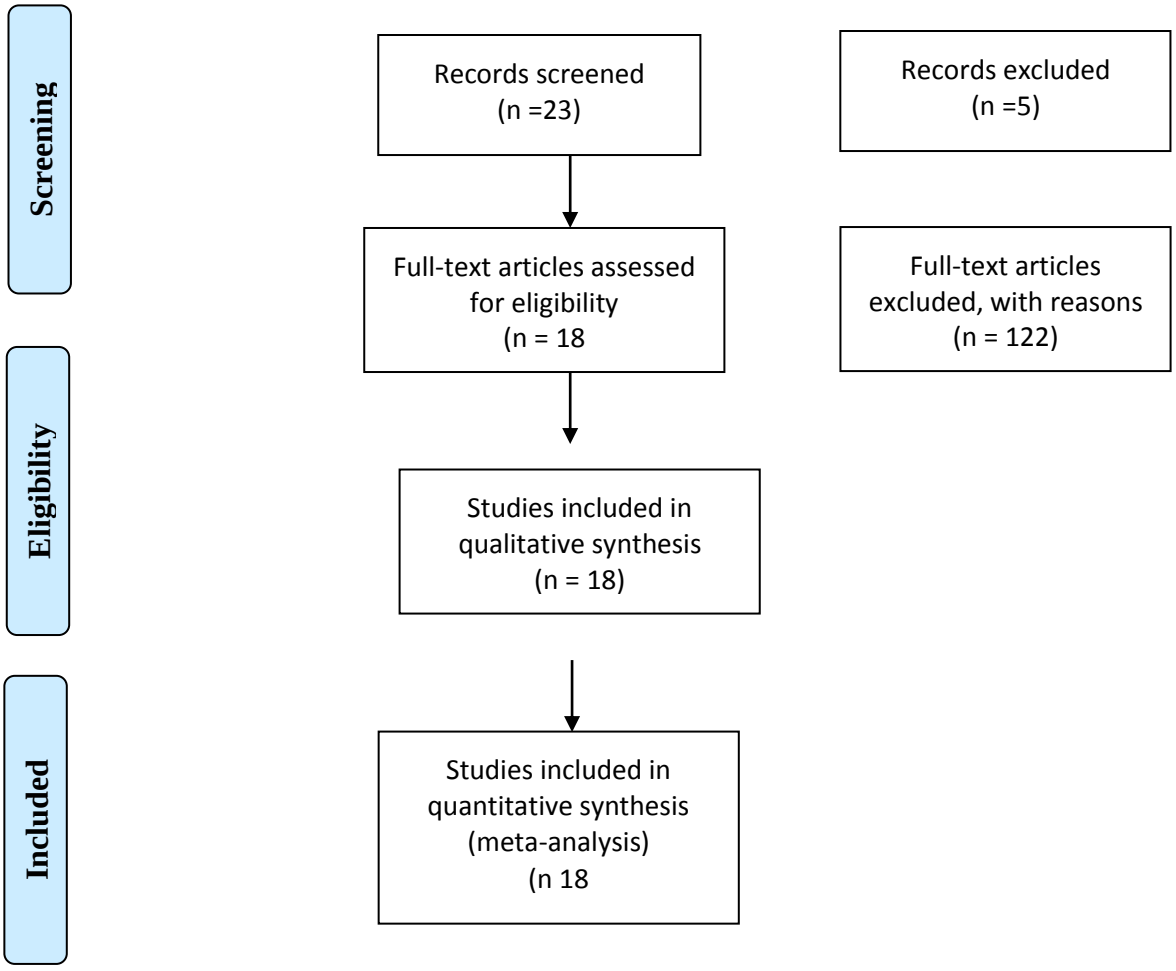



**Figura 1.** Diagrama de flujo del proceso de selección de los ECA

## El formato Consort

Se le aplico a los 23 artículos inicialmente escogidos para poder evaluar la metodología de un ECA a partir de su publicación, es preciso que se describan detalladamente, con exactitud y con transparencia, su diseño, ejecución, análisis y resultados. Sin embargo, la información facilitada en las publicaciones es muchas veces insuficiente o inexacta. "Estas carencias motivaron el desarrollo de la declaración CONSORT (acronimo de consolidated Standards Of Reporting Trials) (1965) el cual se compone de 25 ítems, en él se registró la información de 23 artículos seleccionados, pero 5 artículos fueron rechazados por que en su contenido carecían de discusión y resultados que se requieren para el presente estudio. Ver en Anexos

## Escala Pedro

Después de la fase de selección de artículos se contaron finalmente con 18 artículos a los cuales se le aplicó la escala Pedro que se utiliza para determinar el sesgo sistemático de la revisión bibliográfica, èste formato se compone de 10 items, Cada criterio es calificado como presente o ausente en la evaluación del estudio.

Se encontraròn 18 articulos cuya puntuación era superior de 5, esto quiere decir que contaron una alta calidad metodológica y con un bajo riesgo de sesgo. De los cuales 15 tuvieron un puntaje superior de 5 y 3 articulos estuvieron sobre 5. Ver anexos

**Matriz Bibliometrica**

Para continuar con18 artículos, a partir de la sistematización de la información de la matriz se logró identificar el tipo de estudio, la base de datos, el autor, el país, la población, la página web, el concepto de actividad física y el concepto de calidad de vida. (Tabla 3)

**a. Población**

La población de los (18) artículos ECA, fueron aproximadamente 10000 hombres, 5000 mujeres y 500 jóvenes en edades entre los 21-65 años, se encontraron 3 artículos en el que la población estaba entre los 45 años, 3 artículos se encontraron entre 20-49 años; 3 artículos entre los 18-64 años, 4 artículos entre los 37-57 años y finalmente 5 artículos entre los 40-64 años.

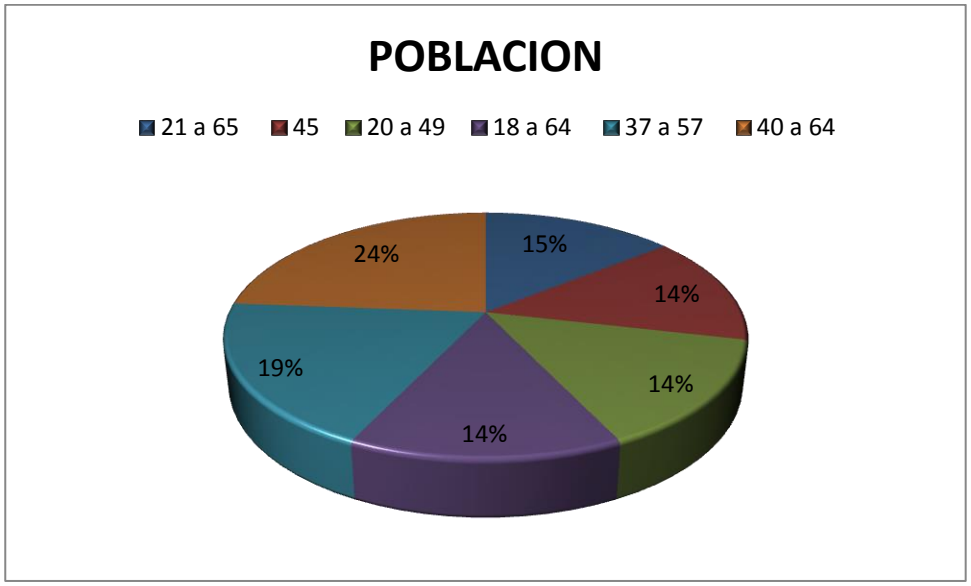



***Tabla 4.*** *Poblaciòn de los artículos ECA.*

**b. Perspectivas de las enfermedades**

Las enfermedades crónicas no transmisibles (ECNT) fueron las que más se evidenciaron en los 18 estudios ECA. Donde se observaron que las enfermedades más comunes son el sobrepeso con un (47 %) con 8 artìculos, hipertensión arterial con un (21%) con 4 artìculos, problemas coronarios un (26%) con 5 artìculos y con síndrome metabólico un (4%), con 1 artìculo.

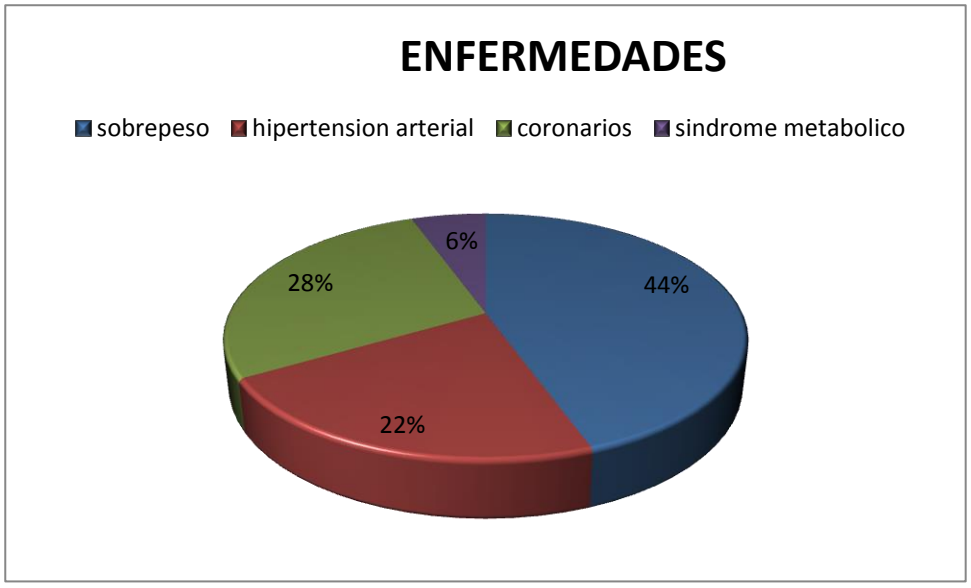



***Tabla 5****. Tipo de enfermedades.*

**c. Tiempo para la aplicación de los programas de actividad fisica**

Se observaron en los 18 artículos, programas de actividad física donde adoptaron los siguientes tiempos para su aplicación, 9 artículos lo adoptaron por 12 meses, 4 artículos por 12 semanas, y 1 artículo por 14 semanas, 1 artículos por 24 meses, 2 artículo por 6 meses y 1 artículos de 2 meses.

Finalmente se pudo determinar que el tiempo que más utilizaron los estudios ECA, fueron de 12 semanas, en la que ellos fijan para desarrollar un adecuado programa de actividad física a trabajadores adultos.

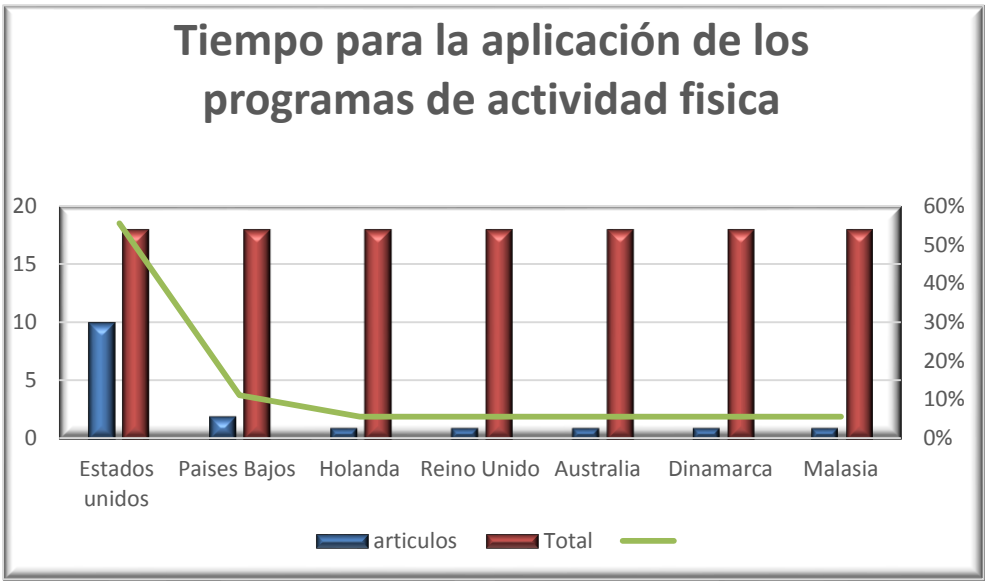



***Tabla 6.*** *Tiempo para la aplicación de los programas de actividad física.*

**d. Países**

En el país que más estudios se encontraron sobre el tema de CVRS fue en Estados Unidos con 5 artículos y sus estados de Filadelphia, los Ángeles, Missouri cada uno con 1 artículo y Canada con 2 artículos; seguido de los Países bajos con 2 artículos, los demás países como Holanda, Reino Unido, Australia, Dinamarca, Malasia e Irlanda, también con 1 artículo por país, esos países fueron en los que se hallaron menor cantidad de articulos.

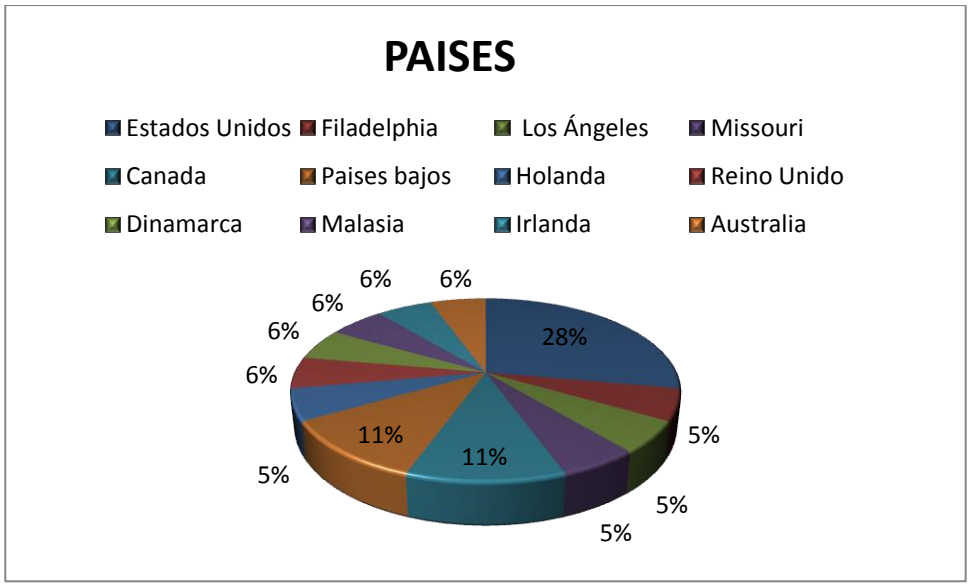



***Tabla 7.*** *Paises de los artoculos ECA.*

**e. Metodología**

La metodología utilizada en los 18 artìculos, revisados fue determinar si un programa de actividad física estructurado y controlado en poblaciones de trabajadores, influye en su calidad de vida relaiconada con la salud a través de un ensayo clínico aleatorizado, utilizando factores como: modificar su ambiente laboral, relaizando intervenciones con los programas de actividad física en horas espeficìficas, cambios alimenticios entre otros.

**f. Perspectiva de la actividad física.**

La perspectiva de la actividad física que más se trataron en los 18 artículos fue directamente relacionada con la buena salud, estilo de vida y la realización de programas de actividad física a los trabajadores, podían lograr cambios significativos en la calidad de vida. La definición que mas se utilizo en 10 artìculos fue “La actividad física es un estilo de vida saludable, que perdura en el tiempo, generando que el estrés se deje a un lado, permitiendo relajar el cuerpo”. En 4 artìculos se observo esta defincion “La actividad física es la rutina diaria que se debe seguir para disminuir los riesgos de enfermedades coronarias y lograr una bienestar saludable”, otros 2 artìculos definieron “La actividad física es la rutina diaria y supervisada para mantener el peso ideal y reducir el riesgo de enfermedades cardiovasculares” y finalmente 2 artìclos definieron “La actividad física es un forma para mantenerse saludables”. Permitiendo recofirmar que un programa de actividad física impacta positivamente en la calidad de vida relacionada con la salud de los adultos trabajadores.

**Perspectiva de la calidad de vida relacionada con la salud.**

Se logro identificar que los 18 artículos ECA resaltaban el impacto que un programa de actividad física daba a la calidad de vida relacionada con la salud de trabajadores, tomándo como una herramienta para relajar su cuerpo y mente, adquirir hábitos alimenticios saludables, para liberar el estrés que se maneja en el trabajo laborar y prevenir la enfermedades laborales que pueden afectar a un trabajador, fomentando que ellos cambien de mentalidad, mejorando su caldiad de vida.

## Tabla 1. Matriz Bibliometrica

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Factors associated with non-participation in a physical activity promotion trial (Los factores asociados con la no participación en un ensayo de promoción de la actividad física). | ECA | Pubmed | Chinn DJ, White M, Howel D, Harland J, Drinkwater CK. | Public Health. 2006 Apr;120(4):309-19. Epub 2006 Feb 13. | Reino Unido | 842 pacientes | Los pacientes de 40 a 64 años fueron reclutados de forma aleatoria durante la cirugía visitas en una práctica general del centro urbano en Newcastle Upon Tyne, Reino Unido. Las actitudes hacia la actividad física, los puntos de vistas de sus beneficios para la salud, y los obstáculos a la participación eran evaluados en las entrevistas con los participantes, y por cuestionario postal de los no participantes. Los datos en poder de los médicos generales se utilizaron para comparar la antropometría y estilo de vida entre los grupos. La contratación de 'difícil participar' individuos requiere una cuidadosa redacción del mensaje a centrarse en sus metas personales y para hacer frente a las algunas en su conocimiento sobre la actividad física y las principales barreras que perciben.<br>Asociado diferencias en todos los subgrupos de población podría conducir a una ampliación de las desigualdades en salud. | Mejorar el estilo de vida para la gerencia en salud. | si no hay compromiso no hay cambios en la calidad de vida | Caminatas, pedalear en bicicleta, gimnasio | El estudio presenta que algunas personas no practican actividad física debido al tiempo de sabr solos de sus lugares de habitación y así se presentan barreras para ejecutar el ejercio físico. | http://www.publichealthjrnl.com/article/S0033-3506(05)00298-X/abstract | La incidencia de consumbres como el hábito de fumar y las barreras internas frente a la practica de la actividad física no permite que se mejoren estilos de vida saludables. |
| 2 | Baseline reach and adoption characteristics in a randomised controlled trial of two weight loss interventions translated into primary care: A structured report of real-world applicability (Alcance y adopción de las características basales de un ensayo controlado aleatorio de dos intervenciones de pérdida de peso en la atención primaria. Un informe estructurado de aplicación en el mundo real). | ECA | Pubmed | Veronica Yank, Randal S. Stafford, Lisa Goldman Rosas, Jun Ma | Contemp Clin Trials. 2013 Jan;34(1):126-35. doi: 10.1016/j.cct.2012.10.007. Epub 2012 Oct 31. | California-Estados | 2391 pacientes | Los adultos con sobrepeso / obesos con mayor riesgo cardiometabólico matriculados de una clínica de atención primaria. Usando el modelo RE-AIM (Reach, Eficacia, adopción, implementación, mantenimiento) con intervenciones de estilo de vida de E-LITE-lenan junto a un buen potencial de alcance de atención primaria y la adopción. Nuestras pruebas de ensayos e informes resultados pueden informar a la aplicación en el mundo real de los ensayos de traslación por las redes de salud, médicos y pagadores. | La actividad física es la manera de poder mantener los resultados luego de procedimientos quirurgicos. | si hay mecanismos distintos de actividad física no hay calidad de vida. | Cimasio y actividad cardio vascular y respiratorio. | El sobrepeso incide en la precepción de las personas y por ello provoca estados de agresión,. | http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3643977/ | En la vida real, el sobrepeso y refermedades como la diabetes no permite que las personas adopten estrategias saludables sino que al contrarirse espera que con soluciones quirurgicas se logre un mejor estado de salud. |
| 3 | Associations between physical activity and metabolic syndrome among Malay adults in a developing country, Malaysia (Asociación entre la actividad física y el síndrome metabólico entre los adultos trabajadores malayos en un país en desarrollo: Malasia) | ECA | Pubmed | Aime H.Y. Chua, F.M. Moya | J Sci Med Sport. 2014 Mar;17(2):195-200. doi: 10.1016/j.jsams.2013.04.00 3. Epub 2013 May 9. | Malasia | 686 personas con presión arterial sistólica / diastólica, glucosa en ayunas, los niveles de colesterol de lipoproteínas en ayunas de triglicéridos y de una densidad | Los niveles moderados y altos de actividad se asocian con cada uno de los componentes del síndrome metabólico independiente del género. Aunque una prevalencia ligeramente inferior de síndrome metabólico fue asociada con alta actividad física en una actividad moderada, se observaron beneficios adicionales para la salud cuando se realizó una actividad moderada. | La actividad física es la manera de adquirir una vida saludable. | los niveles moderados y de a | Actividad cardio vascular y respiratoria | El sedentarismo ha hacebo que se gene problemas de salud en las personas mayores de Malasia, lo que equivale a la falta de interación social. | http://dx.doi.org/10.1016/j.jsams.2013.04.003 | Los riesgos metabólicos estan influenciados por la falta de actividad física. |
| 4 | A translational worksite diabetes prevention trial improves psychosocial status, dietary intake, and step counts among employees with prediabetes: A randomized controlled trial (Un ensayo de prevención de la diabetes en el lugar de trabajo traslacional mejora el estado psicosocial, la ingesta dietética y los pasos entre los empleados con prediabetes: un ensayo controlado aleatorio) | ECA | Science direct | Carla K. Miller a, Kellie R. Westfall , David G. Mannino, Halkadi N. Nagaraja, Brian C. Focht | Preventive Medicine Reports 2 (2015) 158–126 | Estados unidos | 2 grupos, uno de 25 otro de 33 empleados de una universidad con prediabetes | El impacto de una intervención de estilo de vida en el lugar de trabajo en resultados psicosociales, la calidad de la ingesta de alimentos, y el recuento de pasos para la actividad física. Una diferencia significativa se produjo entre los grupos después de la intervención para la auto-eficacia asociada con la alimentación y actividad física, compromiso objetivo y dificultad, satisfacción con la pérdida de peso y la condición física; mirar apoyo social para la alimentación saludable; generación de alternativas para la resolución de problemas; y la ingesta de frutas, carne, pescado, aves, frutos secos, y semillas. | La actividad física permite tener el estilo de vida saludable sea perdurable en el tiempo, a pesar de la intervención social. | la calidad de vida depende de la enfermedad que padezca | Actividad física, cardio vascualr y respiratoria, gimnasio | La sociedad, amigos y familiares influyen en la adopción de estilos saludables de vida, la ingesta de alimentos se ve influenciada por ello. | http://www.sciencedirect.com/science/article/pii/S2211335515000133 | Es posible que junto a un control d ingesta de la alimención de la actividad física y salud emocional se pueda tener un estilo de vida saludable. |
| 5 | Choice of commuting mode among employees: Do home neighborhood environment, worksite neighborhood environment, and worksite policy and supports matter? (Elección del modo de conmutación entre los empleados: ¿el entorno familiar, barrio, lugar de trabajo y la política de apoyo son importantes?) | | Science direct | Lin Yang, J. Aaron Hipp, Deepti Adlakha, Christine M. Marx, J. Rachel Tabak, Ross C. Brownson | Journal of Transport & Health 2015 Jun 1;2(2):212-218 | Missouri-Estados unidos | 1338 personas entrevistadas | La promoción del uso del transporte público y el transporte activo (a pie y en bicicleta) en lugar de coche conducción es una estrategia atractiva para aumentar la actividad física en general. Tanto el medio ambiente, las características y los soportes lugar de trabajo y las políticas están asociados con la elección de modo de conmutación. Los estudios futuros deben utilizar diseños longitudinales y evaluar los efectos causales de los cambios en los alrededores de trayecto a través de los esfuerzos de los lugares de trabajo que soporten los desplazamientos sostenibles. Intervenciones, así como el potencial de las mejoras controladas entorno. | La actividad física se asocia con el menor riesgo de enfermedades crónicas. | la calidad de vida cambia con las intervenciones realizadas en las personas influenciando en su vida | Caminatas, montar en bicicleta | Las distancias entre el lugar de trabajo y la casa son medianamente cortas y pueden aprovechrse para hacer caminatas y montar en bicicleta y así hacer actividad física, sin embargo, el bajo costo en el transporte público y las distancias que recomienden incide en la no elección de hacer actividad física. | http://www.sciencedirect.com/science/article/pii/S2214140515000067 | El uso de transporte público mejora las condiciones de seguridad pero evita la implementación de actividad física. |
| 6 | Design and implementation of a randomized controlled social and mobile weight loss trial for young adults (project SMART) (Diseño e implementación de un ensayo controlado aleatorio social y móvil de la pérdida de peso en los jóvenes adultos (proyecto SMART) | ECA | Pubmed | K. Patrick , S.J. Marshall, E.P. Davila, J.K. Kolodziejczyk, J.H. Fowler, K.J. Calfas, J.S. Huang, a.a.C. Rock, L. Raab, W.G. Griswold, A. Gupta, C. Merchant, C.J. Norman, F. Raab, M.C. Donohue, B.J. Fogg, T.N. Robinson | Contemp Clin Trials. 2014 Jan;37(1):10-8. doi: 10.1016/j.cct.2013.11.001. Epub 2013 Nov 9. | California-Estados Unidos | 404 estudiantes con sobrepeso | La intervención se basa en la teoría del comportamiento e integra elementos de intervención a través de múltiples puntos de contacto, incluyendo Facebook, mensajes de texto, aplicaciones de teléfonos inteligentes, los blogs, y correo electrónico. Se anima a los participantes a buscar el apoyo social entre sus amigos, la auto-monitorear normalmente los pesa, publicar sus comportamientos de salud en Facebook, y correo electrónico, con el objetivo de perder 2 libras por semana durante un período de 6 meses de salud. La intervención es adaptativo porque impulsa una teoría nueva y elementos de intervención adaptados iterativamente son desarrollados y puestos en libertad en el transcurso de la intervención. Las estrategias basadas en la evidencia para la actividad física, el comportamiento sedentario, y la ingesta dietética se puede incrustar en una intervención utilizando tecnologías sociales y móviles para promover comportamientos saludables relacionados con el peso en adultos jóvenes. | La actividad física es el estilo de vida que ayuda a bajar de peso junto una ingesta controlada de alimentos. | la influencia de los factores intrapersonales sobre el aprendizaje y el cambio de comportamiento de la calidad de vida | Actividad cardio vascular y respiratoria | La influencia de las redes sociales y comunicación influye en la adapatación de medidas para perder peso, el compartir con otras personas que tambien tiene sobrepeso, en ocasiones desanima. | http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3925080/ | Los estudiantes universitarias debido al desorden de horario y demás tienen tendencia hacia el sobrepeso. |
| 7 | Effect of fresh fruit availability at workstores on the fruit and vegetable consumption of low-wage employees (Efecto de la disponibilidad de fruta fresca en los lugares de trabajo en el consumo de frutas y verduras de los empleados con salarios bajos). | ECA | Science direct | Blackman D, Gonzaga G, Sugerman S, Francis D, Cook S. | J Nutr Educ Behav. 2011 Jul-Aug;43(4 Suppl 2):S113-21. doi: 10.1016/j.jneb.2011.04.003. | Los angeles, Estados unidos | 391 empleados de bajos salarios | La ingesta de frutas y verduras permite la prevención de enfermedades crónicas, se basa en la teoría del comportamiento e integra elementos; el impacto de la disponibilidad de fruta fresca en el lugar de trabajo en el consumo de frutas y verduras y relacionadas con los determinantes psicosociales de los trabajadores de bajos salarios. Los participantes en los lugares de trabajo de intervención mostraron un aumento significativo en frutas, verduras, y frutas y el consumo de verduras, compras de la fruta, la compra de la familia de vegetales, y autoeficacia hacia comer 2 porciones de fruta al día en comparación con los sitios de trabajo de control. | La actividad física es un estilo de vida saludable. | si no hay horarios flexibles en el trabajo no se puede gozar de una buela calidad de vida. | Ingesta de frutas y verduras, junto a la actividad diaria. | Los bajos salarios hacen que las personas no compren frutas y verduras por tener dinero para una buena alimentación. | http://www.sciencedirect.com/science/article/pii/S1499404611002867 | La ingesta de frutas y verduras permite adquirir hábitos de buena salud. |
| 8 | Efficacy of a workplace-based weight loss program for overweight male shift workers: The Workplace POWER (Preventing Obesity Without Eating like a Rabbit) randomized controlled trial (Eficacia de un programa de pérdida de peso basado en el lugar de trabajo para los trabajadores de turno hombres con sobrepeso: El poder del lugar de trabajo (prevención de la obesidad sin comer como un conejo) ensayo controlado aleatorio) | ECA | Science direct | Philip J. Morgan, Clare E. Collins, Ronald C. Plotnikoff, Alycia T. Cook, Bronwyn Berthon, Simon Mitchell, Robin Callister | Preventive Medicine 52 (2011) 317–325 | Australia | 110 trabajadores nocturnos obesos | El estudio pretendió evaluar la viabilidad y la eficacia de un programa de pérdida de peso basado en el lugar de trabajo, los hombres fueron evaluados al inicio y al final de 14 semanas de seguimiento, el programa fue factible y eficaz y resultó en la pérdida de peso significativa y mejora de los resultados relacionados con la salud y los comportamientos de los trabajadores por turnos sobrepeso masculino. | La actividad física es un estilo de vida difícil de seguir por sus hábitos. | la calidad de vida no depende solo de bajar de peso sino estar bien consigo mismo | Actividad cardiovascular, respiratoria, hábitos alimenticios, caminata. | Las condiciones económicas actuales refuerzan | http://www.sciencedirect.com/science/article/pii/S0091743511000594 | Adoptar un estilo de vida de trabajo, no debe ser excusa para la aplicación de hábitos saludables. |
| 9 | Efficacy of Tailored Physical Activity on reducing sickness absence among health care workers: a 3-months randomised controlled trial (Eficacia de 'Actividad Física Adaptada' en la reducción de las bajas por enfermedad entre los trabajadores de la salud: un ensayo controlado aleatorio de tres meses) | ECA | Science direct | Lotte Nygaard Andersen, Birgit Juul-Kristensen, Kirsten Kaya Roessler, Lene Gram Herborg, Thomas Lund Sørensen, Karen Søgaard | Man Ther. 2015 May 2. pii: S1356-689X(15)00108-3. doi: 10.1016/j.math.2015.04.017. [Epub ahead of print] | Dinamarca | 64 trabajadores de la salud. | Una intervención TPA no fue significativamente más eficaz que la REF en la reducción de las bajas por enfermedad causada por problemas musculoesqueléticos. Sin embargo, hubo mejoras significativas para los participantes en comparación con TPA-REF en la reducción de la intensidad del dolor de 47,0 m a 21,8 mm ($ P <0.01), lo que aumenta la capacidad de trabajo de 7,3 a 8,1 (p = 0,04) y disminuyendo kinesiofobia 26,7-23,5 (p <0,01). Una tendencia hacia una mejora significativa se observó para aeróbica capacidad, mientras que ningún efecto de la intervención se encontró en la productividad, el IMC o la fuerza de agarre. | La actividad física es un forma para mantenerse | sin actividad física no hay calidad de vida. | Actividad acardiovascular y respiratorio, gimasio, bicicleta, remo, | Debido a las ocupaciones, la práctica de la actividad física y de hábitos saludables. | http://www.sciencedirect.com/science/article/pii/S1356689615001083 | Los trabajadores de la salud tienen tendencia a la obesidad y sedentarismo. |
| 10 | Evaluation of a community-based weight control worked program (Evaluación de un programa de control de peso basado en la comunidad trabajadora) | ECA | Pubmed | E. Nicole Culos-Reed, Patricia K. Doyle-Baker, David Paskevich, Julie A. Dennisth, Raylene A. Reimer | Physiology & Behavior 92 (2007) 855–860 | Canada | 31 adultos obesos | El presente estudio informa sobre la eficacia de un programa de control de peso basado en la comunidad en 31 adultos con sobrepeso y obesidad. TrymGymIII es un comportamiento y/o estilo de vida multi-dimensional, un programa de cambio para la mejora de la dieta y la actividad física (AF) el comportamiento vacunado con la educación y el entrenamiento cognitivo conductual. El programa se evaluó usando nutricional, fisiológica, y medidas psicológicas tomadas con la actividad física antes y después del programa de 12 semanas. | La actividad física es un estilo saludable para reducir peso. | la calidad de vida se mide no solo por la actividad física sino por sus hábitos alimenticios y estado de animo | Caminatas, gimnasio. | No hay referencia. | http://www.sciencedirect.com/science/article/pii/S0031938407002594 | La obesidad se combate a traves de cambios reales en los hábitos, en la práctica de actividad física y dieta. |
| 11 | Measuring self-management of patients' and employees' health: Further validation of the Patient Activation Measure (PAM) based on its relation to employee characteristics (Medición de la autogestión de los pacientes y de los empleados de la salud: Además de validación de la medida de activación del paciente (PAM) en función de su relación con las características de los empleados) | ECA | Science direct | Jonet Briggs Fowles, Paul Terry, Min Xi, Judith Hibbard, Christine Taddy Bloom, Lisa Harvey | Patient Education and Counseling 77 (2009) 116–122 | Estados unidos | 825 empleados | La activación del paciente (PAM) en relación a las características personales en poblaciones ocupadas a través de un enfoque ahuecando, controlando prueba de dos programas de promoción de la salud diferentes. Población de estudio incluidos 825 empleados (de cuello predominantemente blanco) a partir de dos empresas en el norte del Medio Oeste de Estados Unidos. Un sistema de salud grande, integrada y una línea aérea nacional para ver el proceso de autogestión de enfermedades crónicas. | La actividad física se puede dar cuando hay tiempo para hacerse, y esta es una herramienta más para tener condiciones saludables. | si se tiene autogestion se puede mejorar la calidad de vida mas eficientemente | Actividad cardiovascular y respiratoria. | Las condiciones de los trabajadores de salud y la areolinea aunque similares no presentan similitud en el desarrollo de la actividad física. | http://www.sciencedirect.com/science/article/pii/S0738399109000949 | A pesar de no de tner hábitos malignos, la obesidad puede atacar y es necesario adquirir rutinas de actividad física. |
| 12 | Modest effects of a controlled worksite environmental intervention on cardiovascular risk in office workers (Efectos modestos de una intervención ambiental en el lugar de trabajo controlada y el riesgo cardiovascular en trabajadores de oficina) | ECA | Science direct | Luuk H. Engbers, Mireille N.M. van Poppel, Willem van Mechelen | Preventive Medicine 44 (2007) 356–362 | Países bajos | 540 trabajadores de oficina | Presentar los efectos de una intervención ambiental relativamente modesta en los indicadores de riesgo cardiovascular biológicos. Un ensayo controlado, incluyendo dos centros de trabajo. Las mediciones (en decir, la composición corporal, la presión arterial y el colesterol en suero) se llevaron a cabo al inicio y a los 3 y 12 meses de seguimiento, la elección de alimentos saludables. Basándose en los resultados contrastantes, esta modesta intervención ambiental era ineficaz en la reducción de riesgo cardiovascular en una población de trabajadores de oficina. | La actividad física puede darse en la rutina diaria para evitar problemas de salud. | tener un buen ambiente de trabajo ayuda a la mejora de la calidad de vida | Caminatas, subir escaleras. | Aunque hay información, la costumbre frente a malos hábitos persiste, entrando así en conflictos. | http://www.sciencedirect.com/science/article/pii/S0091743506004658 | Los ensayos controlados frente a la prevención y promoción de hábitos saludables son de da en terminos de tiempos cortos. |
| 13 | Nutrition knowledge, diet quality and hypertension in a working population (Conocimiento de nutrición, calidad de la dieta e hipertensión en una población trabajadora). | ECA | Science direct | F. Geaney, S. Fitzgerald, J.M. Harrington, C. Kelly, B.A. Greiner, I.J. Perry | Preventive Medicine Reports 2 (2015) 165–113 | Irlanda | 628 empleados | Examinar si los empleados con mayores conocimientos sobre nutrición tienen una mejor calidad de la dieta y la prevalencia más baja de la hipertensión. Los datos del ensayo se obtuvieron de la intervención dietética en el lugar de, la elección de alimentos. Los participantes incluyeron a 828 empleados seleccionados al azar (18-64 años) reclutados de cuatro centros de trabajo de manufactura multinacionales en Irlanda en el 2013, los análisis multivariantes no eran compatibles con un efecto de la mediación la puntuación DASH sobre la asociación entre los conocimientos de nutrición y la presión arterial. | La actividad física no es un factor determinante en la salud. | la falta de conocimiento de los buenos habitos alimenticios y de actividad física impide que haya mejora en la calidad de vida | Caminatas. | La rutina y el estilo adquirido en el trabajo permite que se deriv-o no los cambios en la dieta y en los hábitos saludables, se evidencien bien o hay motivación cercana pero al no haberla se vuelven a las malas costumbres. | http://www.sciencedirect.com/science/article/pii/S2211335515000078 | El conocer sobre nutrición y dieta puede ayudar a la prevención de la hipertensión a la hoja, pero tampoco es que sea una norma o ley, porque tambien influyen las codiciones sociodecónomicas de las personas. |
| 14 | Physical Activity and Body Mass Index The Contribution of Age and Workplace Characteristics (La contribución de las características de la edad y el lugar de trabajo en la actividad física y el índice de masa corporal) | ECA | Pubmed | Candace C. Nelson, ScD, Gregory R. Wagner, MD, Alberto J. Caban-Martinez, DO, PhD, MPH, Erika M. Bratton, PhD, Christopher T. Kenward, MS, Erika L. Sabbath, ScD, Dean Hashimoto, MD, Karen Kopina, ScD, ANP-BC, Jennifer Allen, ScD, MPH, Glorian Sorensen, PhD, MPH | Am J Prev Med. 2014 Mar;46(3 Suppl 1):S42-51. doi: 10.1016/j.amepre.2013.10.005. | Estados unidos | 2000 trabajadores | El lugar de trabajo es un dominio importante para los adultos, y muchas intervenciones eficaces se han centrado en la actividad física y la dieta se pero se ha implementado en el lugar de trabajo. Sin embargo, la fuerza de trabajo de Estados Unidos está envejeciendo, y pocos estudios han examinado la relación de índice de masa corporal, la actividad física, y la edad en que se refieren a las características de lugar de trabajo. | La actividad física es una de las alternativas para mejorar el estado de nuestros cuerpos y mantener un peso saludable e ideal, la obesidad es evitable si hay practica de actividad física. | si no se trabajan actividades algorosas no habra un cambio significativo en la calidade vida | Rutinas de al menos 30 minutos de actividad cardiovascular y respiratoria, entrenamiento. | El lugar del trabajo estimulara la obesidad, de ahí que las personas se preocupen por reducir su IMC con actividad física y hábitos saludables. | http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4006748/ | En el lugar de trabajo se pueden adquirir hábitos alimenticios y rutinas de actividad física que favorezcan el IMC, las personas suelen señalar a los obesos, de ahí que la presión social sea la motivación para reducir el peso. |
| 15 | Physical Inactivity and Overweight Among Los Angeles County workers' Adults (La inactividad física y el sobrepeso en los adultos trabajadores del condado de Los Angeles) | ECA | Science direct | Antoinette K. Yancey, MD, MPH, Cheryl M. Wold, MPH, William J. McCarthy, PhD, Mark D. Weber, PhD, Benedict Lee, PhD, Paul A. Simon, MD, MPH, Jonathan E. Fielding, MD, MBA, MPH | Am J Prev Med 2004;27(2):146–152 | Estados unidos | 9353 adultos | El estudio examina características sociodemográficas, estado de salud, conductas y autopercepción relacionada con la salud y la correlación de inactividad física en una grande y multiétnica urbana población. La prevalencia de adultos sedentarios fue del 41%, con menor nivel educativo, mujeres, de edad avanzada, con sugiere de nacimiento diferentes, en población más pobre, la percepción de salud conlleva a depresión, el tabaquismo, uso de la televisión en el tiempo libre, y la recepción de un diagnóstico de la diabetes se relacionaron significativamente con el | La actividad física ayuda reducir los índices de obesidad y evita enfermedades cardiovasculares | la calidad de vida se mide por las relaciones y las influencias que pueda llegara tener la persna en su sitio de trabajo | Caminatas, rutinas de al menos 15 minutos. | La edad influyen en los niveles de sedentarismo, y esta suele estar asociada a los problemas psicológicos de las personas según los nuevos modelos de rutinas. | http://www.sciencedirect.com/science/article/pii/S1047279704000554 | El sedentarismo aporta al incremento de la obesidad, pero esta no solo se da en personas mayores, en los jóvenes sentiben debido a los nuevos estilos de vida, el uso de la TV, así como la alimentación que incide significativamente en la rutian diaria de las personas. |

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## CONCLUSIONES

Para logar un cambio en la calidad de vida de las personas trabajadoras no requiere de solo ingresar a un programa de actividad física sino complementarlo con una alimentación balanceada y adoptar nuevos estilos de vida en el trabajo no solo en casa sino en cualquier lugar ya que los trabajadores tienen mayor tendencia a sufrir de las conocidas ECNT por los horarios que manejan suelen tener desórdenes alimenticios y llegan tan cansados que lo último que quieren hacer es algún tipo de actividad física y llegan a comer lo que encuentran sin tener en cuenta nada solo satisfacer una necesidad.

La práctica de actividad física debe estar integrada en un programa de ejercicio planificado y guiado cuya finalidad sea crear un estilo de vida saludable, es decir, mejorar la calidad de vida del sujeto. A través de esos programa se pretende, de forma genérica, mejorar la condición física y la salud, previniendo el desarrollo de ciertas epatologias o volver a padecer alguna que se haya tenido o se este mejorando dependiendo su motivación al tema de meroja de calidad de vida.

La actividad física es una herramienta eficaz y efectiva en la promoción de la salud siempre y cuando se incluyan aspectos inherentes al ser humano y no solamente la optimización del espacio físico en el lugarde trabajo como elemento primordial de las estrategias de promoción de la salud; de igual forma, se hace necesario el empoderamiento de la empresa de espacios y políticas que contemplan su manejo y conocimiento, así como la educación de las peronas involucradas, que debe estar encaminada hacia el beneficio individual y colectivo a través de la concientización de la disminución de los factores de riesgo que posibilitan la adquisición de enfermadades que traerán a largo plazo deterioro de su calidad de vida.

Las costumbres de las personas pueden ser modificadas ya que no son fijas, solo es necesario recibir información y acompañamiento para mantener rutinas saludables de actividad física y una alimentación balanceada, aunque si no se recibe esta información influye mucho para poder

acceder a dichos programas, la condición socioeconómica de cada trabajador depende un poco para que accedan a dicha información; La incidencia de costumbres como el habito de fumar y las barreas internas frente a la práctica de la actividad física no permite que se mejoren los estilos de vida saludables, ya que las personas se encierran en una barrera y no dejan que nada más les ayude sino que prefieren estos malos hábitos creyendo que funcionaran en algún momento sin tener en cuenta que lo único que hacen es hacerse daño. A demás tienen creencias poco convencionales y se escudan en estos vicios para no afrontar el problema de salud tan grave que hay cada vez más en la sociedad.

Encuanto a la calidad de los artículos se reflejo que la gran mayoría eran artículos que no contaban con los requerimientos pedidos por los fomratos Consort y escala Pedro, por tal razón solo 18 artículos ECA, aportaron de forma deacuada a èsta investigación. Esto evidencia que hace falta mas investigación en el campo de la actividad física y el impacto que èsta pueda tener en la calidad de vida de adultos trabajadores.

Con respecto a las investigaciones que fueron excluidas, en esta revisión sistematica de la literatura, se pudo obervar que en cuanto a un ítem espeficio de la eslaca Pedro, el cual fue: la asignación fue enmascarada, en su mayoría de artículos rechazados tuvieron la respuesta (NO) dando un puntaje de 0 a ese ítem, esto quiere decir que presentaban una baja calidad metodológica, al igual que una alta probabilidad de que existiese un sesgo.

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**ANEXOS**

## CONSORT 2010

### Checklist of information to include when reporting a randomised trial

"Efficacy of 'Tailored Physical Activity' on reducing sickness absence among health care workers: a 3-months randomised controlled trial"

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 0 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 1 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 2 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 3,4,5,6 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 3,4,5,6 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 3,4,5,6 |
| | 4b | Settings and locations where the data were collected | Yes. Page 3,4,5,6 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 3,4,5,6 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 3,4,5,6 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 3,4,5,6 |
| Sample size | 7a | How sample size was determined | Yes. Page 3,4,5,6 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 3,4,5,6 |
| Randomisation: | | | Yes. Page 3,4,5,6 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 3,4,5,6 |

| | | | |
|---|---|---|---|
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 3,4,5,6 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 3,4,5,6 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 3,4,5,6 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 3,4,5,6 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 3,4,5,6 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 3,4,5,6 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 3,4,5,6 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 6,7 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 6,7 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 6,7 |
| | 14b | Why the trial ended or was stopped | Yes. Page 6,7 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 6,7 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 6,7 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 6,7 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 6,7 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 6,7 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 6,7 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 7,8,9 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 7,8,9 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 7,8,9 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |

| | | | |
|---|---|---|---|
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

## An Open Trial of an Acceptance-Based Behavioral Intervention for Weight Loss

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 223 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | No |
| **IntroductionNo** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | No |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 225,226,227 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 225,226,227 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 225,226,227 |
| | 4b | Settings and locations where the data were collected | Yes. Page 225,226,227 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 225,226,227 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 225,226,227 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 225,226,227 |
| Sample size | 7a | How sample size was determined | Yes. Page 225,226,227 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 225,226,227 |
| Randomisation: | | | |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 225,226,227 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 225,226,227 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 225,226,227 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 225,226,227 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) | Yes. Page 225,226,227 |

| | | | |
|---|---|---|---|
| | | and how | |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 225,226,227 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 228 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 228 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 230,231 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 230,231 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 230,231 |
| | 14b | Why the trial ended or was stopped | Yes. Page 230,231 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 230,231 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 230,231 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 230,231 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 230,231 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 230,231 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 230,231 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 231,232 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 231,232 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 231,232 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | |

**A translational worksite diabetes prevention trial improves psychosocial status, dietary intake, and step counts among employees with prediabetes: A randomized controlled trial**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 118 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 118 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 118, 119 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 119, 120,121 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 119, 120,121 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 119, 120,121 |
| | 4b | Settings and locations where the data were collected | Yes. Page 119, 120,121 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 119, 120,121 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 119, 120,121 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 119, 120,121 |
| Sample size | 7a | How sample size was determined | Yes. Page 119, 120,121 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 119, 120,121 |
| Randomisation: | | | |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 119, 120,121 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 119, 120,121 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 119, 120,121 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled | Yes. Page 119, |

| | | | |
|---|---|---|---|
| | | participants, and who assigned participants to interventions | 120,121 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 119, 120,121 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 119, 120,121 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 119, 120,121 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 119, 120,121 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 122,123,124,125 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 122,123,124,125 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 122,123,124,125 |
| | 14b | Why the trial ended or was stopped | Yes. Page 122,123,124,125 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 122,123,124,125 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 122,123,124,125 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 122,123,124,125 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 122,123,124,125 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 122,123,124,125 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 122,123,124,125 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 125,126 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 125,126 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 125,126 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | |

**Association between physical activity and metabolic syndrome among Malay adults in a developing country, Malaysia**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 195 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 195 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 195, 196 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 196 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 196 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 196 |
| | 4b | Settings and locations where the data were collected | Yes. Page 196 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 196 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 196 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 196 |
| Sample size | 7a | How sample size was determined | Yes. Page 196 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 196 |
| Randomisation: | | | |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 196 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 196 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 196 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled | Yes. Page |

| | | | |
|---|---|---|---|
| | | participants, and who assigned participants to interventions | 196 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 196 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 196 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 196 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 196 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 196, 197 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 196, 197 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 196, 197 |
| | 14b | Why the trial ended or was stopped | Yes. Page 196, 197 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 196, 197 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 196, 197 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 196, 197 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 196, 197 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 196, 197 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 196, 197 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 196,197,198 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 196,197,198 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 196,197,198 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | |

**Baseline reach and adoption characteristics in a randomized controlled trial of two weight loss interventions translated into primary care: A structured report of real-world applicability**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 126 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 126 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 127 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 127, 128,129 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 127, 128,129 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 127, 128,129 |
| | 4b | Settings and locations where the data were collected | Yes. Page 127, 128,129 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 127, 128,129 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 127, 128,129 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 127, 128,129 |
| Sample size | 7a | How sample size was determined | Yes. Page 127, 128,129 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 127, 128,129 |
| Randomisation: | | | |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 127, 128,129 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 127, 128,129 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 127, 128,129 |

| | | | |
|---|---|---|---|
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 127, 128,129 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 127, 128,129 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 127, 128,129 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 127, 128,129 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 127, 128,129 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 129,130,131, 132 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 129,130,131, 132 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 129,130,131, 132 |
| | 14b | Why the trial ended or was stopped | Yes. Page 129,130,131, 132 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 129,130,131, 132 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 129,130,131, 132 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 129,130,131, 132 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 129,130,131, 132 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 129,130,131, 132 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 129,130,131, 132 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 132,133 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 132,133 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 132,133 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), | |

| | | | |
|---|---|---|---|
| | | role of funders | |

**Choice of commuting mode among employees: ¿Do home neighborhood environment, worksite neighborhood environment, and worksite policy and supports matter?**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 1 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 1 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 1,2 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 1,2,3,4 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 1,2,3,4 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 1,2,3,4 |
| | 4b | Settings and locations where the data were collected | Yes. Page 1,2,3,4 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 1,2,3,4 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 1,2,3,4 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 1,2,3,4 |
| Sample size | 7a | How sample size was determined | Yes. Page 1,2,3,4 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 1,2,3,4 |
| Randomisation: | | | |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 1,2,3,4 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 1,2,3,4 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 1,2,3,4 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 1,2,3,4 |

| | | | |
|---|---|---|---|
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 1,2,3,4 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 1,2,3,4 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 1,2,3,4 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 1,2,3,4 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 4 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 4 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 4 |
| | 14b | Why the trial ended or was stopped | Yes. Page 4 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 4 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 4 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 4 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 4 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 4 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 4 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 4,5,6 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 4,5,6 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 4,5,6 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | |

**Effect of Fresh Fruit Availability at Worksites on the Fruit and Vegetable Consumption of Low-Wage Employees**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 113 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 113 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 113,114 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 115,116,117 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 115,116,117 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 115,116,117 |
| | 4b | Settings and locations where the data were collected | Yes. Page 115,116,117 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 115,116,117 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 115,116,117 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 115,116,117 |
| Sample size | 7a | How sample size was determined | Yes. Page 115,116,117 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 115,116,117 |
| Randomisation: | | | Yes. Page 115,116,117 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 115,116,117 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 115,116,117 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 115,116,117 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 115,116,117 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) | Yes. Page 115,116,117 |

| | | | |
|---|---|---|---|
| | | and how | |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 115,116,117 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 115,116,117 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 115,116,117 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 117,118 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 117,118 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 117,118 |
| | 14b | Why the trial ended or was stopped | Yes. Page 117,118 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 117,118 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 117,118 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 117,118 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 117,118 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 117,118 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 117,118 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 118,119 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 118,119 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 118,119 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | Yes. Page 120 |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | Yes. Page 118,119 |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | Yes. Page 118,119 |

**Effects of a group physical activity program on physical fitness and quality of life in individuals with schizophrenia**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 155 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 155 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 155,156 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 156,157,158 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 156,157,158 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 156,157,158 |
| | 4b | Settings and locations where the data were collected | Yes. Page 156,157,158 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 156,157,158 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 156,157,158 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 156,157,158 |
| Sample size | 7a | How sample size was determined | Yes. Page 156,157,158 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 156,157,158 |
| Randomisation: | | | Yes. Page 156,157,158 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 156,157,158 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 156,157,158 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 156,157,158 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 156,157,158 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) | Yes. Page 156,157,158 |

| | | | |
|---|---|---|---|
| | | and how | |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 156,157,158 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 156,157,158 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 156,157,158 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 158,159 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 158,159 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 158,159 |
| | 14b | Why the trial ended or was stopped | Yes. Page 158,159 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 158,159 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 158,159 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 158,159 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 158,159 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 158,159 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 158,159 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 159,160 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 159,160 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 159,160 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

**Efficacy of a workplace-based weight loss program for overweight male shift workers: The Workplace POWER (Preventing Obesity Without Eating like a Rabbit) randomized controlled trial**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 317 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 317 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 317,318 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 318,319,320 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 318,319,320 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 318,319,320 |
| | 4b | Settings and locations where the data were collected | Yes. Page 318,319,320 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 318,319,320 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 318,319,320 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 318,319,320 |
| Sample size | 7a | How sample size was determined | Yes. Page 318,319,320 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 318,319,320 |
| Randomisation: | | | Yes. Page 318,319,320 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 318,319,320 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 318,319,320 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 318,319,320 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 318,319,320 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for | Yes. Page |

| | | | |
|---|---|---|---|
| | | example, participants, care providers, those assessing outcomes) and how | 318,319,320 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 318,319,320 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 318,319,320 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 318,319,320 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 320 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 320 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 320 |
| | 14b | Why the trial ended or was stopped | Yes. Page 320 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 320 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 320 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 320 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 320 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 320 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 320 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 321,322,323,324 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 321,322,323,324 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 321,322,323,324 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

## Equity-Specific Effects of 26 Dutch Obesity-Related Lifestyle Interventions

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 61 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 61 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 61,62 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 62,63,64 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 62,63,64 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 62,63,64 |
| | 4b | Settings and locations where the data were collected | Yes. Page 62,63,64 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 62,63,64 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 62,63,64 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 62,63,64 |
| Sample size | 7a | How sample size was determined | Yes. Page 62,63,64 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 62,63,64 |
| Randomisation: | | | Yes. Page 62,63,64 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 62,63,64 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 62,63,64 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 62,63,64 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 62,63,64 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 62,63,64 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page |

| | | | |
|---|---|---|---|
| | | | 62,63,64 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 62,63,64 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 62,63,64 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 64,65,66 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 64,65,66 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 64,65,66 |
| | 14b | Why the trial ended or was stopped | Yes. Page 64,65,66 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 64,65,66 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 64,65,66 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 64,65,66 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 64,65,66 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 64,65,66 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 64,65,66 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 66,67,68 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 66,67,68 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 66,67,68 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

## Evaluation of a community-based weight control program

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 855 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 855 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 855,856 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 856,857 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 856,857 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 856,857 |
| | 4b | Settings and locations where the data were collected | Yes. Page 856,857 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 856,857 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 856,857 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 856,857 |
| Sample size | 7a | How sample size was determined | Yes. Page 856,857 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 856,857 |
| Randomisation: | | | Yes. Page 856,857 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 856,857 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 856,857 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 856,857 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 856,857 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 856,857 |

| | | | |
|---|---|---|---|
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 856,857 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 856,857 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 856,857 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 857,858 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 857,858 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 857,858 |
| | 14b | Why the trial ended or was stopped | Yes. Page 857,858 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 857,858 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 857,858 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 857,858 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 857,858 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 857,858 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 857,858 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 859,860 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 859,860 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 859,860 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

**Factors associated with non-participation in a physical activity promotion trial**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. page 309 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. page 309 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. page 310 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. page 310 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. page 310 |
| Participants | 4a | Eligibility criteria for participants | Yes. page 310 |
| | 4b | Settings and locations where the data were collected | Yes. page 310 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. page 311 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. page 311 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. page 311 |
| Sample size | 7a | How sample size was determined | Yes. page 311 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. page 311 |
| Randomisation: | | | |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. page 311 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. page 313,314, 315, 316 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. page 313,314, 315, 316 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. page 313,314, 315, 316 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. page 313,314, 315, 316 |
| | 11b | If relevant, description of the similarity of interventions | Yes. page 313,314, |

| | | | |
|---|---|---|---|
| | | | 315, 316 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. page 313,314, 315, 316 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. page 313,314, 315, 316 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. page 317 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. page 317 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. page 317 |
| | 14b | Why the trial ended or was stopped | Yes. page 317 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. page 317 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. page 317 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. page 317 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. page 317 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. page 317 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. page 317 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. page 318 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. page 318 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. page 318 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

**Health-Related Fitness Test Battery for Adults: Associations With Perceived Health, Mobility, and Back Function and Symptoms**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. page 559 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. page 559 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. page 559 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. page 560 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. page 3560 |
| Participants | 4a | Eligibility criteria for participants | Yes. page 560 |
| | 4b | Settings and locations where the data were collected | Yes. page 560 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. page 560 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. page 560 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. page 560 |
| Sample size | 7a | How sample size was determined | Yes. page 561 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. page 561 |
| Randomisation: | | | |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. page 561, 562 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. page 561, 562 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. page 561, 562 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. page 561, 562 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. page 561, 562 |
| | 11b | If relevant, description of the similarity of interventions | Yes. page 561, 562 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. page 561, 562 |

| | | | |
|---|---|---|---|
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. page 561, 562 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. page 562, 563, 564,565, 566 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. page 562, 563, 564,565, 566 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. page 562, 563, 564,565, 566 |
| | 14b | Why the trial ended or was stopped | Yes. page 562, 563, 564,565, 566 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. page 562, 563, 564,565, 566 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. page 562, 563, 564,565, 566 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. page 562, 563, 564,565, 566 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. page 562, 563, 564,565, 566 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. page 562, 563, 564,565, 566 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. page 562, 563, 564,565, 566 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. page 566, 567 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. page 566, 567 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. page 566, 567 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

**Measuring self-management of patients' and employees' health: Further validation of the Patient Activation Measure (PAM) based on its relation to employee characteristics**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 116 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 116 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 116 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 117, 118 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 117, 118 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 117, 118 |
| | 4b | Settings and locations where the data were collected | Yes. Page 117, 118 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 117, 118 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 117, 118 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 117, 118 |
| Sample size | 7a | How sample size was determined | Yes. Page 117, 118 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 117, 118 |
| Randomisation: | | | Yes. Page 117, 118 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 117, 118 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 117, 118 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 117, 118 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 117, 118 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing | Yes. Page 117, 118 |

| | | | |
|---|---|---|---|
| | | outcomes) and how | |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 117, 118 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 117, 118 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 117, 118 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 118,119,120 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 118,119,120 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 118,119,120 |
| | 14b | Why the trial ended or was stopped | Yes. Page 118,119,120 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 118,119,120 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 118,119,120 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 118,119,120 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 118,119,120 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 118,119,120 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 118,119,120 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 120, 121 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 120, 121 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 120, 121 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

**Modest effects of a controlled worksite environmental intervention on cardiovascular risk in office workers**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 356 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 356 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 356 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 357 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 357 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 357 |
| | 4b | Settings and locations where the data were collected | Yes. Page 357 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 357 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 357 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 357 |
| Sample size | 7a | How sample size was determined | Yes. Page 357 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 357 |
| Randomisation: | | | Yes. Page 357 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 357 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 357 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 357 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 357 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 357 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 357 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 357 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 357 |

| | | | |
|---|---|---|---|
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 357,358,359 |
| | 13b | For each group, losses and exclusions after randomisation,together with reasons | Yes. Page 357,358,359 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 357,358,359 |
| | 14b | Why the trial ended or was stopped | Yes. Page 357,358,359 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 357,358,359 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 357,358,359 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 357,358,359 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 357,358,359 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 357,358,359 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 357,358,359 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 359,360,361 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 359,360,361 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 359,360,361 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 105 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 105 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 105 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 106,107 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 106,107 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 106,107 |
| | 4b | Settings and locations where the data were collected | Yes. Page 106,107 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 106,107 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 106,107 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 106,107 |
| Sample size | 7a | How sample size was determined | Yes. Page 106,107 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 106,107 |
| Randomisation: | | | Yes. Page 106,107 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 106,107 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 106,107 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 106,107 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 106,107 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 106,107 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 106,107 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 106,107 |

| | | | |
|---|---|---|---|
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 106,107 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 107,108,109,110 |
| | 13b | For each group, losses and exclusions after randomisation, together with reasons | Yes. Page 107,108,109,110 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 107,108,109,110 |
| | 14b | Why the trial ended or was stopped | Yes. Page 107,108,109,110 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 107,108,109,110 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 107,108,109,110 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 107,108,109,110 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 107,108,109,110 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 107,108,109,110 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 107,108,109,110 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 110,111,112 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 110,111,112 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 110,111,112 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 496 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | No |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 496 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 497,498,499 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 497,498,499 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 497,498,499 |
| | 4b | Settings and locations where the data were collected | Yes. Page 497,498,499 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 497,498,499 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 497,498,499 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 497,498,499 |
| Sample size | 7a | How sample size was determined | Yes. Page 497,498,499 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 497,498,499 |
| Randomisation: | | | Yes. Page 497,498,499 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 497,498,499 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 497,498,499 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 497,498,499 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 497,498,499 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 497,498,499 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 497,498,499 |
| Statistical | 12a | Statistical methods used to compare groups for primary | Yes. Page |

| | | | |
|---|---|---|---|
| methods | | and secondary outcomes | 497,498,499 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 497,498,499 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 499,500,501,502 |
| | 13b | For each group, losses and exclusions after randomisation, together with reasons | Yes. Page 499,500,501,502 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 499,500,501,502 |
| | 14b | Why the trial ended or was stopped | Yes. Page 499,500,501,502 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 499,500,501,502 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 499,500,501,502 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 499,500,501,502 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 499,500,501,502 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 499,500,501,502 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 499,500,501,502 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 502,503 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 502,503 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 502,503 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 42 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 42 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 42,43 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 43,44 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 43,44 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 43,44 |
| | 4b | Settings and locations where the data were collected | Yes. Page 43,44 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 43,44 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 43,44 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 43,44 |
| Sample size | 7a | How sample size was determined | Yes. Page 43,44 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 43,44 |
| Randomisation: | | | Yes. Page 43,44 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 43,44 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 43,44 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 43,44 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 43,44 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 43,44 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 43,44 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 43,44 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 43,44 |
| **Results** | | | |
| Participant flow (a | 13a | For each group, the numbers of participants who were | Yes. Page 44 |

| | | | |
|---|---|---|---|
| diagram is strongly recommended) | | randomly assigned, received intended treatment, and were analysed for the primary outcome | |
| | 13b | For each group, losses and exclusions after randomisation, together with reasons | Yes. Page 44 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 44 |
| | 14b | Why the trial ended or was stopped | Yes. Page 44 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 44 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 44 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 44 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 44 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 44 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 44 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 44,45,46,47,48,49 ,50 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 44,45,46,47,48,49 ,50 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 44,45,46,47,48,49 ,50 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 146 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 146 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 146 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 147,148 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 147,148 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 147,148 |
| | 4b | Settings and locations where the data were collected | Yes. Page 147,148 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 147,148 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 147,148 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 147,148 |
| Sample size | 7a | How sample size was determined | Yes. Page 147,148 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 147,148 |
| Randomisation: | | | Yes. Page 147,148 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 147,148 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 147,148 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 147,148 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 147,148 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 147,148 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 147,148 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 147,148 |

| | | | |
|---|---|---|---|
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 147,148 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 148,149,150 |
| | 13b | For each group, losses and exclusions after randomisation, together with reasons | Yes. Page 148,149,150 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 148,149,150 |
| | 14b | Why the trial ended or was stopped | Yes. Page 148,149,150 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 148,149,150 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 148,149,150 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 148,149,150 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 148,149,150 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 148,149,150 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 148,149,150 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 150,151 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 150,151 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 150,151 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. page 109 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. page 109 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. page 109, 110 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. page 110,111 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. page 110,111 |
| Participants | 4a | Eligibility criteria for participants | Yes. page 110,111 |
| | 4b | Settings and locations where the data were collected | Yes. page 110,111 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. page 110,111 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. page 110,111 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. page 110,111 |
| Sample size | 7a | How sample size was determined | Yes. page 110,111 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. page 110,111 |
| Randomisation: | | | |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. page 110,111 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. page 110,111 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. page 110,111 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. page 110,111 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. page 110,111 |
| | 11b | If relevant, description of the similarity of interventions | Yes. page 110,111 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. page 110,111 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. page 110,111 |
| **Results** | | | |
| Participant flow (a diagram is strongly | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and | Yes. page 111,112 |

| | | | |
|---|---|---|---|
| recommended) | | were analysed for the primary outcome | |
| | 13b | For each group, losses and exclusions after randomisation, together with reasons | Yes. page 111,112 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. page 111,112 |
| | 14b | Why the trial ended or was stopped | Yes. page 111,112 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. page 111,112 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. page 111,112 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. page 111,112 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. page 111,112 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. page 111,112 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. page 111,112 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. page 112, 113,114 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. page 112, 113,114 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. page 112, 113,114 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

**Sustained body weight reduction by an individual-based lifestyle intervention for workers in the construction industry at risk for cardiovascular disease: Results of a randomized controlled trial**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 240 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 240 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 240 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 241 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 241 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 241 |
| | 4b | Settings and locations where the data were collected | Yes. Page 241 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 241 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 241 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 241 |
| Sample size | 7a | How sample size was determined | Yes. Page 241 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 241 |
| Randomisation: | | | Yes. Page 241 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 241 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 241 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 241 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 241 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 241 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 241 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 241 |

| | | | |
|---|---|---|---|
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 241 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 241,242,243,244 |
| | 13b | For each group, losses and exclusions after randomisation, together with reasons | Yes. Page 241,242,243,244 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 241,242,243,244 |
| | 14b | Why the trial ended or was stopped | Yes. Page 241,242,243,244 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 241,242,243,244 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 241,242,243,244 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 241,242,243,244 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 241,242,243,244 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 241,242,243,244 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 241,242,243,244 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 244,245 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 244,245 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 244,245 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

## Workplace based mindfulness practice and inflammation: A randomized trial

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 145 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 145 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 145 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 146,147,148 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 146,147,148 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 146,147,148 |
| | 4b | Settings and locations where the data were collected | Yes. Page 146,147,148 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 146,147,148 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 146,147,148 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 146,147,148 |
| Sample size | 7a | How sample size was determined | Yes. Page 146,147,148 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 146,147,148 |
| Randomisation: | | | Yes. Page 146,147,148 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 146,147,148 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 146,147,148 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 146,147,148 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 146,147,148 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 146,147,148 |
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 146,147,148 |

| | | | |
|---|---|---|---|
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 146,147,148 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 146,147,148 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 149,150,151 |
| | 13b | For each group, losses and exclusions after randomisation, together with reasons | Yes. Page 149,150,151 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 149,150,151 |
| | 14b | Why the trial ended or was stopped | Yes. Page 149,150,151 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 149,150,151 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 149,150,151 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 149,150,151 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 149,150,151 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 149,150,151 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 149,150,151 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 151,152,153 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 151,152,153 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 151,152,153 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

**Worksite Opportunities for Wellness (WOW): Effects on cardiovascular disease risk factors after 1 year**

| Section/Topic | Item No | Checklist item | Reported on page No |
|---|---|---|---|
| **Title and abstract** | | | |
| | 1a | Identification as a randomised trial in the title | Yes. Page 108 |
| | 1b | Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts) | Yes. Page 108 |
| **Introduction** | | | |
| Background and objectives | 2a | Scientific background and explanation of rationale | Yes. Page 108 |
| | 2b | Specific objectives or hypotheses | No |
| **Methods** | | | |
| Trial design | 3a | Description of trial design (such as parallel, factorial) including allocation ratio | Yes. Page 109,110,111 |
| | 3b | Important changes to methods after trial commencement (such as eligibility criteria), with reasons | Yes. Page 109,110,111 |
| Participants | 4a | Eligibility criteria for participants | Yes. Page 109,110,111 |
| | 4b | Settings and locations where the data were collected | Yes. Page 109,110,111 |
| Interventions | 5 | The interventions for each group with sufficient details to allow replication, including how and when they were actually administered | Yes. Page 109,110,111 |
| Outcomes | 6a | Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed | Yes. Page 109,110,111 |
| | 6b | Any changes to trial outcomes after the trial commenced, with reasons | Yes. Page 109,110,111 |
| Sample size | 7a | How sample size was determined | Yes. Page 109,110,111 |
| | 7b | When applicable, explanation of any interim analyses and stopping guidelines | Yes. Page 109,110,111 |
| Randomisation: | | | Yes. Page 109,110,111 |
| Sequence generation | 8a | Method used to generate the random allocation sequence | Yes. Page 109,110,111 |
| | 8b | Type of randomisation; details of any restriction (such as blocking and block size) | Yes. Page 109,110,111 |
| Allocation concealment mechanism | 9 | Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned | Yes. Page 109,110,111 |
| Implementation | 10 | Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions | Yes. Page 109,110,111 |
| Blinding | 11a | If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how | Yes. Page 109,110,111 |

| | | | |
|---|---|---|---|
| | 11b | If relevant, description of the similarity of interventions | Yes. Page 109,110,111 |
| Statistical methods | 12a | Statistical methods used to compare groups for primary and secondary outcomes | Yes. Page 109,110,111 |
| | 12b | Methods for additional analyses, such as subgroup analyses and adjusted analyses | Yes. Page 109,110,111 |
| **Results** | | | |
| Participant flow (a diagram is strongly recommended) | 13a | For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome | Yes. Page 111, 112 |
| | 13b | For each group, losses and exclusions after randomisation, together with reasons | Yes. Page 111, 112 |
| Recruitment | 14a | Dates defining the periods of recruitment and follow-up | Yes. Page 111, 112 |
| | 14b | Why the trial ended or was stopped | Yes. Page 111, 112 |
| Baseline data | 15 | A table showing baseline demographic and clinical characteristics for each group | Yes. Page 111, 112 |
| Numbers analysed | 16 | For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups | Yes. Page 111, 112 |
| Outcomes and estimation | 17a | For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval) | Yes. Page 111, 112 |
| | 17b | For binary outcomes, presentation of both absolute and relative effect sizes is recommended | Yes. Page 111, 112 |
| Ancillary analyses | 18 | Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory | Yes. Page 111, 112 |
| Harms | 19 | All important harms or unintended effects in each group (for specific guidance see CONSORT for harms) | Yes. Page 111, 112 |
| **Discussion** | | | |
| Limitations | 20 | Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses | Yes. Page 112,113 |
| Generalisability | 21 | Generalisability (external validity, applicability) of the trial findings | Yes. Page 112,113 |
| Interpretation | 22 | Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence | Yes. Page 112,113 |
| **Other information** | | | |
| Registration | 23 | Registration number and name of trial registry | No |
| Protocol | 24 | Where the full trial protocol can be accessed, if available | No |
| Funding | 25 | Sources of funding and other support (such as supply of drugs), role of funders | No |

## FORMATOS PEDRO

1. Factors associated with non-participation in a physical activity promotion trial (Los factores asociados con la no participación en un ensayo de promoción de la actividad física).
   Chinn DJ1, White M, Howel D, Harland JO, Drinkwater CK.

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | | X | 0 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | | X | 0 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el “Análisis por intención a tratar”. | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

2. Association between physical activity and metabolic syndrome among Malay adults in a developing country, Malaysia (Asociación entre la actividad física y el síndrome metabólico entre los adultos malayos en un país en desarrollo: Malasia)
   Anne H.Y. Chua, F.M. Moya

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | X | | 1 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

3. A translational worksite diabetes prevention trial improves psychosocial status, dietary intake, and step counts among employees with prediabetes: A randomized controlled trial (Un ensayo de prevención de la diabetes el el lugar de trabajo traslacional mejora el estado psicosocial, la ingesta dietética y los pasos entre los empleados con prediabetes: un ensayo controlado aleatorio)

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | X | | 1 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

4. Choice of commuting mode among employees: Do home neighborhood environment, worksite neighborhood environment, and worksite policy and supports matter? (Elección del modo de conmutación entre los empleados: ¿El entorno familiar barrio, entorno de barrio lugar de trabajo, y la política de lugar de trabajo y apoyo son importantes?)
   Lin Yang, J. Aaron Hipp, Deepti Adlakha, Christine M. Marx, Rachel G. Tabak, Ross C. Brownson

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | | X | 0 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el “Análisis por intención a tratar”. | | X | 0 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

5. Design and implementation of a randomized controlled social and mobile weight loss trial for young adults (project SMART) (Diseño e implementación de un ensayo controlado aleatorio social y móvil de la pérdida de peso en los jóvenes adultos (proyecto SMART)
   K. Patrick , S.J. Marshall, E.P. Davila, J.K. Kolodziejczyk, J.H. Fowler , K.J. Calfas, J.S. Huang a,e,f , C.L. Rock , W.G. Griswold, A. Gupta, G. Merchant, G.J. Norman, F. Raab, M.C. Donohue, B.J. Fogg, T.N. Robinson

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el “Análisis por intención a tratar”. | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

6. Effect of fresh fruit availability at worksites on
the fruit and vegetable consumption of low-wage employees (Efecto de la disponibilidad de fruta fresca en los lugares de trabajo en el consumo de frutas y verduras de los empleados con salarios bajos).
Backman D, Gonzaga G, Sugerman S, Francis D, Cook S.

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | | X | 0 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | X | | 1 |
| Hubo enmascaramiento de todos los sujetos. | | X | 0 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | | X | 0 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | | X | 0 |
| Idoneidad del seguimiento | | X | 0 |
| Se reporta el "Análisis por intención a tratar". | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

7. Effects of a group physical activity program on physical fitness and quality of life in individuals with schizophrenia (Efectos de un programa de actividad física en un grupo sobre la aptitud física y la calidad de vida en las personas con esquizofrenia)
   Eluana Gomes, Tania Bastos, Michel Probst, Jose Carlos Ribeiro, Gustavo Silva, Rui Corredeira

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | | X | 0 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | | X | 0 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | | X | 0 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

8. Efficacy of a workplace-based weight loss program for overweight male shift workers: The Workplace POWER (Preventing Obesity Without Eating like a Rabbit) randomized controlled trial (Eficacia de un programa de pérdida de peso basado en el lugar de trabajo para los trabajadores de turno hombres con sobrepeso: El poder del lugar de trabajo (prevención de la obesidad sin comer como un conejo) ensayo controlado aleatorio)
   Philip J. Morgan, Clare E. Collins, Ronald C. Plotnikoff, Alyce T. Cook, Bronwyn Berthon, Simon Mitchell, Robin Callister

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el “Análisis por intención a tratar”. | | X | 0 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

9. Efficacy of 'Tailored Physical Activity' on reducing sickness absence among health care workers: a 3-months randomised controlled trial (Eficacia de 'Actividad Física AdaptadA' en la reducción de las bajas por enfermedad entre los trabajadores de la salud: un ensayo controlado aleatorio de tres meses)
   Lotte Nygaard Andersen, Birgit Juul-Kristensen, Kirsten Kaya Roessler, Lene Gram Herborg, Thomas Lund Sørensen, Karen Søgaard

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | | X | 0 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

10. Evaluation of a community-based weight control program (Evaluación de un programa de control de peso basado en la comunidad)
    S. Nicole Culos-Reed, Patricia K. Doyle-Baker, David Paskevich, Julia A. Devonish, Raylene A. Reimer

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

11. Measuring self-management of patients' and employees' health: Further validation of the Patient Activation Measure (PAM) based on its relation to employee characteristics (Medición de la autogestión de los pacientes y de los empleados de la salud: Además de validación de la medida de activación del paciente (PAM) en función de su relación con las características de los empleados)
    Jinnet Briggs Fowles, Paul Terry, Min Xi, Judith Hibbard, Christine Taddy Bloom, Lisa Harvey

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

12. Modest effects of a controlled worksite environmental intervention on cardiovascular risk in office workers (Efectos modestos de una intervención ambiental en el lugar de trabajo controlada y el riesgo cardiovascular en trabajadores de oficina)
Luuk H. Engbers, Mireille N.M. van Poppel, Willem van Mechelen

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | X | | 1 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

13. Nutrition knowledge, diet quality and hypertension in a working population (Conocimiento de nutrición, calidad de la dieta e hipertensión en una población activa) F. Geaney, S. Fitzgerald, J.M. Harrington, C. Kelly, B.A. Greiner, I.J. Perry

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | | X | 0 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | | X | 0 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | | X | 0 |
| Se reporta el "Análisis por intención a tratar". | | X | 0 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

14. Physical Activity and Body Mass Index The Contribution of Age and Workplace Characteristics (La contribución de las características de la edad y el lugar de trabajo en la actividad física y el índice de masa corporal)
    Candace C. Nelson, ScD, Gregory R. Wagner, MD, Alberto J. Caban-Martinez, DO, PhD, MPH, Orfeu M. Buxton, PhD, Christopher T. Kenwood, MS, Erika L. Sabbath, ScD, Dean M. Hashimoto, MD, Karen Hopcia, ScD, ANP-BC, Jennifer Allen, ScD, MPH, Glorian Sorensen, PhD, MPH

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | | X | 0 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

15. Physical Inactivity and Overweight Among Los Angeles County Adults (La inactividad física y el sobrepeso en los adultos del condado de Los Ángeles)
    Antronette K. Yancey, MD, MPH, Cheryl M. Wold, MPH, William J. McCarthy, PhD, Mark D. Weber, PhD, Benedict Lee, PhD, Paul A. Simon, MD, MPH, Jonathan E. Fielding, MD, MBA, MPH

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el “Análisis por intención a tratar”. | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | | X | 0 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

16. Sustained body weight reduction by an individual-based lifestyle intervention for workers in the construction industry at risk for cardiovascular disease: Results of a randomized controlled trial (Reducción de peso corporal sostenido por una intervención en el estilo de vida para los trabajadores de la industria de la construcción en situación de riesgo de una enfermedad cardiovascular: resultados de un ensayo controlado aleatorio de manera individual)
    Iris F. Groeneveld, Karin I. Proper, Allard J. van der Beek, Willem van Mechelen

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | | X | 0 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | X | | 1 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | | X | 0 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | | X | 0 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el “Análisis por intención a tratar”. | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la | X | | 1 |

| | | | |
|---|---|---|---|
| variabilidad para el menos un criterio de valoración clave. | | | |

17. Workplace based mindfulness practice and inflammation: A randomized trial (Las prácticas en el lugar de trabajo basadas en la atención plena y la inflamación: Un ensayo aleatorio)
    William B. Malarkey, David Jarjoura, Maryanna Klatt

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | | X | 0 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | | X | 0 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | | X | 0 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | X | | 1 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |

18. Worksite Opportunities for Wellness (WOW): Effects on cardiovascular disease risk factors after 1 year (Oportunidades de bienestar para el lugar de trabajo (WOW): Efectos sobre los factores de riesgo de enfermedades cardiovasculares después de 1 año)
Susan B. Racette, Susan S. Deusinger, Cindi L. Inman, Tamara L. Burlis, Gabrielle R. Highstein, Trent D. Buskirk, Karen Steger-May, Linda R. Peterson

| DOMINIO | SI | NO | PUNTUACIÓN |
|---|---|---|---|
| Los sujetos fueron asignados aleatoriamente a los grupos. | X | | 1 |
| La asignación fue enmascarada. | X | | 1 |
| Los grupos eran similares en el momento basal con respeto a los indicadores pronósticos más importantes. | | X | 0 |
| Hubo enmascaramiento de todos los sujetos. | X | | 1 |
| Hubo enmascaramiento de todos los terapeutas que administraron el tratamiento (p.e: terapeutas, entrenadores, etc). | X | | 1 |
| Hubo enmascaramiento de todos los asesores que midieron al menor un criterio de valoración clase (p.e: asesores/evaluadores) idoneidad del seguimiento. | X | | 1 |
| Idoneidad del seguimiento | X | | 1 |
| Se reporta el "Análisis por intención a tratar". | | X | 0 |
| Se presentan los resultados de comparaciones estadísticas entre grupos para al menos un criterio de valoración clave. | X | | 1 |
| El estudio aporta medidas puntuales y medidas de la variabilidad para el menos un criterio de valoración clave. | X | | 1 |