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# BMJ Open

## **Exercise and Adiposity in Overweight and Obese Children and Adolescents: A Systematic Review with Network Meta-Analysis of Randomised Trials**

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Exercise and Adiposity in Overweight and Obese Children and Adolescents: A  
Systematic Review with Network Meta-Analysis of Randomised Trials

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## ABSTRACT

**Objectives:** Determine both the effects and hierarchy of exercise interventions (aerobic, strength training or both) on selected measures of adiposity (BMI in  $\text{kg}\cdot\text{m}^2$ , fat mass, and percent body fat) in overweight and obese children and adolescents.

**Design:** Network meta-analysis of randomised exercise intervention trials.

**Setting:** Any setting where a randomised trial could be conducted.

**Participants:** Overweight and obese male and/or female children and adolescents 2 to 18 years of age.

**Interventions:** Randomised exercise intervention trials  $\geq 4$  weeks which included direct and/or indirect evidence for aerobic, strength training, or combined aerobic and strength training.

**Primary outcomes:** Changes in BMI in  $\text{kg}/\text{m}^2$ , fat mass and percent body fat.

**Results:** Fifty-seven studies representing 127 groups (73 exercise, 54 control) and 2,792 participants (1,667 exercise, 1,125 control) met the criteria for inclusion. Length of training ( $\bar{X} \pm \text{SD}$ ) averaged  $14.1 \pm 6.2$  weeks, frequency,  $3.3 \pm 1.1$  days per week, and duration  $42.0 \pm 21.0$  minutes per session. Significant and clinically important reductions in BMI, fat mass, and percent body fat were observed in aerobic vs. control comparisons (BMI, mean, 95% CI, -1.0, -1.4 to -0.6; fat mass, -2.1, -3.3 to -1.0 kg; percent fat, -1.5, -2.2 to -0.9%) and combined aerobic and strength vs. control comparisons (BMI, -0.7, -1.4 to -0.1; fat mass, -2.5, -4.1 to -1.0 kg; percent fat, -2.2, -3.2 to -1.2%). A significant reduction in percent fat was also found for strength vs. control comparisons (-1.3, -2.5 to -0.1%). Combined aerobic and strength training was ranked



first for improving both fat mass (kg) and percent body fat while aerobic exercise was ranked first for improving BMI.

**Conclusions:** Aerobic and combined aerobic and strength training are associated with improvements in adiposity outcomes in overweight and obese children and adolescents.

**Trial registration number:** PROSPERO # CRD42017073103

**Strengths and limitations of this study**

- **Major Strengths**

- To the best of the authors' knowledge, this is the first network meta-analysis to examine the effects of exercise on adiposity outcomes in overweight and obese children and adolescents.
- This study included methods to determine the clinical relevance of the reported outcomes.

- **Potential Limitations**

- Since this was an aggregate data meta-analysis, the potential for ecological fallacy exists.
- Meta-regression results should be considered exploratory and thus, do not support causal inferences.

**Keywords:** exercise, overweight, obesity, children, adolescents, network meta-analysis

## 61 BACKGROUND

62 Overweight and obesity among children and adolescents is a major public health  
63 problem worldwide. Between 1980 and 2013, the worldwide prevalence of overweight  
64 and obesity in children and adolescents increased by 6.9%, from 16.9% to 23.8%, in  
65 boys and by 6.4%, from 16.2% to 22.6%, in girls from developed countries.[1] For  
66 developing countries, increases of 4.8%, from 8.1% to 12.9% for boys and 5%, from  
67 8.4% to 13.4% in girls, were reported.[1] In terms of absolute values, 41 million children  
68 under the age of 5 and more than 340 million children and adolescents aged 5-19 were  
69 considered to be overweight or obese in 2016.[2]

70 The deleterious consequences associated with obesity in children and adolescents are  
71 both immediate and long-term.[3] For example, a study of children and adolescents 5 to  
72 17 years of age found that approximately 70% of obese youth had at least one  
73 cardiovascular disease risk factor (high cholesterol, high blood pressure, etc.).[4]  
74 Obese children and adolescents are also at an increased risk for prediabetes,[5] as well  
75 as more prone to bone and joint problems, sleep apnea, and social and psychological  
76 issues that include stigmatization, low self-esteem, and low health-related quality-of-life.  
77 [6, 7] Long-term, childhood and adolescent overweight and obesity has been shown to  
78 track into adulthood,[8-12] thus placing overweight and/or obese adults at a greater risk  
79 for cardiovascular disease, type 2 diabetes, stroke, several types of cancer, and  
80 osteoarthritis.[3]

81 One approach to treating overweight and obesity is exercise. However, previous  
82 randomised trials limited to overweight and obese male and female children and  
83 adolescents have reached conflicting results with respect to exercise-induced changes

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84 in adiposity.[13-69] For body mass index (BMI in kg·m<sup>2</sup>), fat mass, and percent body fat,  
85 statistically significant decreases were reported for 45.2%, 50.0%, and 40.0% of  
86 findings, respectively, as a result of exercise (aerobic, strength training, or both).[13-69]  
87 When limited to studies that included aerobic exercise as an intervention,[13, 15-17, 19,  
88 21, 22, 24, 25, 29, 30, 32-34, 36, 38-46, 48, 50-53, 55, 57-64, 66, 67, 69] statistically  
89 significant decreases in BMI in kg·m<sup>2</sup>, fat mass, and percent body fat, were reported for  
90 43.2%, 66.7%, and 75.0% of findings. For strength training interventions,[14, 21, 28, 35,  
91 39, 40, 47, 53, 54, 56, 57] statistically significant decreases were reported for 9.1% (BMI  
92 in kg·m<sup>2</sup>), 25.0% (fat mass) and 63.6% (percent fat) of findings. Finally, when restricted  
93 to combined aerobic and strength training,[13, 18-21, 23, 26, 27, 31, 37, 45, 49, 51, 57,  
94 64, 67, 69] statistically significant decreases were reported for 78.6% (BMI in kg·m<sup>2</sup>),  
95 44.4% (fat mass) and 69.2% (percent fat) of results. While this may lead one to question  
96 the benefits of exercise for improving adiposity in overweight and obese children and  
97 adolescents, this would be shortsighted since it relies on the vote-counting approach,  
98 [70] an approach that has been shown to be less valid than the meta-analytic approach.  
99 [70, 71] To address these discrepancies in findings, several previous systematic  
100 reviews with aggregate data meta-analyses limited to randomised trials focused on the  
101 effects of exercise (aerobic, strength, or both) as an independent intervention on one or  
102 more measures of adiposity as primary outcomes (BMI in kg·m<sup>2</sup>, fat mass, percent fat)  
103 in overweight and obese children and adolescents have been conducted.[72-76] Across  
104 all intervention types, two [74, 76] of four [72, 74-76] reported statistically significant  
105 reductions in BMI in kg·m<sup>2</sup>, one of one reported a statistically significant reduction in fat  
106 mass,[75] and one [72] of two [72, 76] a statistically significant reduction in percent fat.

Another meta-analysis focused on combined aerobic and resistance training reported statistically significant reductions in BMI in  $\text{kg}\cdot\text{m}^2$ , fat mass, and percent fat.[73] A lack of meta-analytic data was available on the effects of aerobic and resistance training alone on BMI in  $\text{kg}\cdot\text{m}^2$  as well as fat mass and percent fat.[72-76] In addition, randomised trials without a control group, i.e., direct evidence studies that assessed the effects of exercise on adiposity outcomes, were absent.[72-76] Furthermore, there was an absence of an established hierarchy for determining which types of exercise (aerobic, strength training, or both) might be best for improving adiposity outcomes based on both direct and indirect evidence.[72-76] Network meta-analysis is an approach that includes both direct and indirect evidence as well as allowing for the ranking of treatments. To demonstrate the feasibility of this approach, the authors recently used the network meta-analytic approach to examine the effects of exercise (aerobic, strength training, or both) on BMI z-score in overweight and obese children and adolescents.[77, 78] Statistically significant reductions in BMI z-score were found for aerobic exercise and combined aerobic and strength exercise, but not strength training alone (mean, 95% CI: aerobic, -0.10, -0.15 to -0.05; aerobic and strength, -0.11, -0.19 to -0.03; strength, 0.04, -0.07 to 0.15).[78] Combined aerobic and strength training was ranked best, followed by aerobic exercise and then strength training.[78] It was concluded that combined aerobic exercise and strength training as well as aerobic exercise alone are associated with reductions in BMI z-score.[78] While these results are encouraging, BMI in  $\text{kg}/\text{m}^2$  continues to be the most frequently assessed and reported measure of adiposity across all ages in both the clinical and public health setting. Thus, an examination of such using the network meta-analytic approach is needed. In addition, since all types of BMI

measures as well as body weight do not capture changes in body composition (fat mass, percent body fat, etc.), the inclusion of such outcomes, as previously suggested, [78] is also necessary. Thus, given (1) the prevalence of overweight and obesity in children and adolescents, (2) the negative consequences associated with such, (3) the conflicting findings of previous randomised trials addressing the effects of exercise on adiposity outcomes in overweight and obese children and adolescents, and (4) the strengths of network meta-analysis, the two primary objectives of the current study were to conduct a systematic review with network meta-analysis of randomised trials to (1) determine the effects of exercise (aerobic, strength training, or both) on adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents, and (2) establish a hierarchy of exercise interventions (aerobic, strength training, or both) for treating adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents.

**METHODS**

**Overview**

This study followed the guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) extension statement for network meta-analyses of health care interventions.[79] The protocol for this network meta-analysis is registered in PROSPERO (trial registration number CRD42017073103) and has been published in a peer-reviewed journal.[80]

**Eligibility criteria**

The inclusion criteria for this proposed network meta-analysis were as follows: (1) direct evidence from randomised trials that compared two or more exercise

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3 153 interventions (aerobic, strength training, both) or indirect evidence from randomised  
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5 154 controlled trials that compared an exercise intervention group to a comparative control  
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7 155 group (non-intervention, attention control, usual care, wait-list control, placebo, etc.), (2)  
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9 156 exercise-only intervention (aerobic, strength training, or both), (3) studies lasting  $\geq 4$   
10  
11 157 weeks, (4) male and/or female children and adolescents 2 to 18 years of age, (5)  
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13 158 participants overweight or obese, as defined by the authors, (6) studies published in any  
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15 159 language up through 2018, (7) data available for BMI in kg/m<sup>2</sup>, fat mass or percent body  
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21 161 Studies were limited to randomised trials because it is the only way to control for  
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23 162 confounders that are not known or measured as well as the observation that non-  
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25 163 randomised controlled trials tend to overestimate the effects of healthcare interventions.  
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27 164 [81, 82] Indirect evidence studies were limited to randomised controlled trials with at  
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29 165 least one exercise arm that participated in either aerobic, strength training, or a  
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31 166 combination of aerobic and strength training exercise. Direct evidence studies were  
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33 167 limited to randomised trials that included at least two of the following exercise arms: (1)  
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35 168 aerobic, (2) strength training, (3) aerobic and strength training exercise.  
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40 169 For the purposes of this study, exercise, aerobic exercise and strength training were  
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42 170 defined according to the 2008 Physical Activity Guidelines for Americans,[83] that is,  
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44 171 movement that is “planned, structured, and repetitive and purposive in the sense that  
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46 172 the improvement or maintenance of one or more components of physical fitness is the  
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48 173 objective”, [83, 84] aerobic exercise as “exercise that primarily uses the aerobic energy-  
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50 174 producing systems, can improve the capacity and efficiency of these systems, and is  
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52 175 effective for improving cardiorespiratory endurance”, [83] and strength training as  
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176 “exercise training primarily designed to increase skeletal muscle strength, power,  
177 endurance, and mass”.<sup>[83]</sup> Four weeks was chosen as the lower cut point for  
178 intervention length based on previous research demonstrating improvements in  
179 adiposity over this period of time in 11-year olds.<sup>[85]</sup>

180 Participants were limited to overweight and obese children and adolescents, as  
181 defined by the original study authors, because it has been shown that this population is  
182 at an increased risk for premature morbidity and mortality throughout their lifetime.<sup>[86]</sup>

183 While some research has suggested that studies yielding statistically significant and  
184 positive results are more likely to be published in English-language versus non-English  
185 language journals,<sup>[87]</sup> other research has shown this to not be the case.<sup>[88]</sup> Given the  
186 former, studies from both English and non-English-language articles were included with  
187 the latter translated into English by the second author using the freely available web-  
188 based Babelfish and Bing translators.

189 Body mass index in kg·m<sup>2</sup> was included as one of the three primary adiposity  
190 outcomes because it is the most commonly used and understood variable by  
191 practitioners as well as others and can be easily measured from body weight and  
192 height. However, because BMI is an indirect measure of adiposity, fat mass and percent  
193 body fat were included because they are more direct measures of adiposity. The  
194 inclusion of fat mass and percent body fat may be especially relevant for studies that  
195 include strength training given that decreases in adiposity as measured by BMI may be  
196 offset by increases in muscle mass, a secondary outcome that was included.

197 **Information sources**

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3 198 The following seven electronic databases were searched: (1) PubMed, (2) Web of  
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5 199 Science, (3) Cochrane Central Register of Controlled Trials (CENTRAL), (4) Cumulative  
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7 200 Index to Nursing and Allied Health Literature (CINAHL), (5) Sport Discus, (6) Translating  
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9 201 Research into Practice (TRIP) and (7) ProQuest Dissertations and Theses. In addition  
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11 202 to electronic database searches, cross-referencing was conducted by examining the  
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13 203 reference lists of previous review articles as well as each included study for potential  
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15 204 articles that met the inclusion criteria. Upon completion of initial searches, the third  
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17 205 author examined the reference list for thoroughness and completeness.  
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## 22 **Search strategy**

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24 207 Search strategies specific to each database were developed by the investigative team.  
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26 208 Major keywords, or forms of keywords to include were “random”, “children”,  
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28 209 “adolescents”, “overweight”, “obese”, “exercise”, “physical fitness”, “body composition”,  
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30 210 “fat mass”, “body fat”, “body composition”, “body mass index”, “adiposity”. A copy of  
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32 211 one of the databases searched (PubMed) is shown in Supplementary file 1. All  
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34 212 database searches and article retrieval were conducted by the second author with  
35  
36 213 oversight from the first author.  
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## 40 **Study records**

### 41 **Study selection**

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44 216 All studies screened were imported into EndNote (version X8; New York, NY:  
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46 217 Thomson-Reuters; 2016) and duplicates removed electronically and then manually by  
47  
48 218 the second author. A copy of the database was then provided to the first author for  
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50 219 duplicate screening. To minimize selection bias, the first and second authors selected all  
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52 220 studies independent of each other. They then reviewed their selections for agreement.  
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221 The full report for each article was retrieved for all titles and abstracts that appeared to  
222 meet the inclusion criteria as well as those where uncertainty existed. Multiple reports  
223 for the same study were addressed by including the most recently published article and  
224 drawing from prior reports, assuming the same methods and sample sizes were  
225 reported. Based on previous research suggesting neither a clinically nor statistically  
226 significant effect on results, blinding to journal titles, study authors, or institutions of the  
227 authors were not used during the screening and data abstraction processes.[89]  
228 Reasons for excluded studies were recorded using the following categories: (1)  
229 inappropriate population, (2) inappropriate intervention, (3) inappropriate comparison(s),  
230 (4) inappropriate outcome(s), (5) inappropriate study design, and (6) other. Upon  
231 completion of screening, the first and second authors met and reviewed all selections.  
232 Cohen's kappa statistic ( $\kappa$ ) was used to measure inter-selection agreement.[90] Any  
233 discrepancies were resolved by discussion. If agreement could not be reached, the third  
234 author served as an arbitrator. Upon selecting the final number of studies to include, the  
235 overall precision of the searches was computed by dividing the number of included  
236 studies by the total number of studies screened after removing duplicates.[91] The  
237 number needed-to-read (NNR) was then calculated as the reciprocal of the precision.  
238 [91]  
239 Data abstraction  
240 For this project, Microsoft Excel (version 2016; Redmond, WA: Microsoft Corporation;  
241 2016) was used to develop comprehensive electronic codebooks that could hold up to  
242 1,475 items from each study. The codebook was created by the first two authors with  
243 feedback from the third author. The major categories of variables coded included (1)

study characteristics (author, journal, year of publication, etc.), (2) participant characteristics (age, gender, height, body weight, etc.), (3) intervention characteristics (type, length, frequency, intensity, duration, compliance, etc.), and (4) data for primary and secondary outcomes (sample sizes, baseline and post-exercise means and standard deviations, etc.). To avoid data abstraction bias, the first two authors independently coded (dual-coding) all studies. The first two authors then met to review their decisions. Any disagreement in the items coded were discussed until mutual agreement was achieved. If agreement could not be reached, the third author provided a recommendation. Using Cohen's kappa statistic ( $\kappa$ ),<sup>[90]</sup> inter-rater agreement prior to correcting discrepant items was 0.95.

### **Outcomes and prioritization**

The a priori primary outcomes in this study were changes in BMI in  $\text{kg}/\text{m}^2$ , fat mass, and percent body fat in overweight and obese children and adolescents. Secondary a priori outcomes included body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, maximum oxygen consumption ( $\text{VO}_{2\text{max}}$  in  $\text{ml}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$ ), muscular strength, resting systolic and diastolic blood pressure, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated hemoglobin, fasting and non-fasting glucose and insulin. Missing data for primary outcomes were requested via electronic mail. Post hoc, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, muscular strength, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, glycosylated

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hemoglobin and non-fasting glucose and insulin were not examined because of a lack of data across the three treatments.

**Risk of bias assessment in individual studies**

Risk of bias for included studies was assessed using the Cochrane Risk of Bias Instrument.[92] Judgments of low, high or unclear risk of bias were made across six defined domains: (1) sequence generation, (2) allocation sequence concealment, (3) blinding of participants and personnel, (4) blinding of outcome assessors, (5) incomplete outcome data, and (6) selective outcome reporting. A seventh domain, whether participants were exercising regularly, as defined by the original study authors prior to taking part in the study, was also assessed using the same approach as for the other six domains. The risk of bias approach has been recommended over the use of study quality rating scales given the lack of empirical evidence to support the latter.[82, 93, 94] Assessment for risk of bias was limited to the primary outcomes of interest (changes in BMI in kg·m<sup>2</sup>, fat mass, and percent body fat). All studies were classified as high risk of bias with respect to the category “blinding of participants and personnel” given that it’s virtually impossible to blind participants to group assignment in exercise intervention protocols. Because it is difficult to distinguish between the quality in the reporting of a study versus the quality in the conduct of a study, no trial was excluded based on risk of bias results.[95] The first two authors independently assessed risk of bias (dual-coding) for all studies. Any disagreements in the items coded were discussed until mutual agreement was reached. If mutual agreement could not be achieved, the third author served as an arbitrator. Using Cohen’s kappa statistic (κ),[90] inter-rater agreement prior to resolving disagreements was 0.72.

## 290 Data Synthesis

### 291 Calculation of effect sizes

292 Changes in outcomes for randomised controlled trials were calculated by subtracting  
293 the change outcome difference in the exercise group minus the change outcome  
294 difference in the control group. Variances were computed using the pooled standard  
295 deviations of change scores in the exercise and control groups. If change score  
296 standard deviations were not available, they were calculated from 95% confidence  
297 intervals (CI) for either change outcome or treatment effect differences as well as pre  
298 and post standard deviation values, the latter according to procedures developed by  
299 Follmann et al.[96] For direct comparisons, i.e., randomised trials with no control arm,  
300 the same procedures were used as for randomised controlled trials by taking the  
301 differences and variances between the two treatment groups. Ninety-five percent CI and  
302 z-alpha values were calculated for each outcome from each study. For studies in which  
303 adiposity outcomes were assessed at multiple intervention time points, for example, 0,  
304 8, and 16 weeks, only data from the initial and last assessment were used. A post-hoc  
305 decision was made to not analyze follow-up data because of the lack of available  
306 endpoints. Cross-over trials were handled by using all assessments from the  
307 intervention and control periods and analyzing them similar to a parallel group trial.[97]

### 308 Pooled estimates for changes in outcomes

309 Network (geometry) plots were used to provide a visual representation of the evidence  
310 base with nodes (circles) weighted by the number of participants randomised to each  
311 treatment and edges (lines) weighted by the number of studies evaluating each pair of  
312 treatments.[98, 99]

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Transitivity, i.e., similarity in the distribution of potential effect modifiers across the different pairwise comparisons for each outcome,[100] was examined using chi-square tests for categorical variables and one-way-ANOVA tests for continuous variables. If statistically significant differences were found, follow-up tests were conducted, when necessary, using the Bonferroni approach for continuous data and 2 x 2 chi-square tests for categorical data. A two-tailed alpha value  $\leq 0.05$  was considered to be statistically significant. Variables analysed between treatment contrasts included risk of bias variables (sequence generation, allocation concealment, blinding of outcome assessors, incomplete outcome data, selective reporting, physical activity), type of control group, age, gender, training program characteristics (length, frequency, intensity, duration, compliance, exercise supervision status), baseline values for the outcome of interest, and method for assessing the outcome of interest.

Network meta-analysis was performed using random-effects, multivariate, restricted maximum likelihood models performed within a frequentist setting and which allowed for the inclusion of potential covariates while accounting for the correlations from multi-arm trials.[101, 102] A two-tailed alpha value  $\leq 0.05$  and non-overlapping 95% CI were considered to represent statistically significant changes. In addition, 95% prediction intervals were generated in order to examine the interval in which the outcome of interest in a future study would lie.[103] Global inconsistency across each network was examined using the Wald test,[104] with an alpha value  $\leq 0.05$  considered to represent statistically significant inconsistency. Small-study-effects (publication bias, etc.) across all comparisons were conducted using funnel plots and Egger’s regression-intercept

test.[105, 106] An alpha value  $\leq 0.05$  was considered to represent statistically significant small-study effects.

Potential covariates were examined by conducting simple meta-regression for statistically significant associations between covariates and changes in the primary outcomes (BMI in kg/m<sup>2</sup>, fat mass, percent fat). A list of covariates examined using simple meta-regression is shown in Supplementary file 2. A post hoc decision was made to not conduct any type of multiple meta-regression because of missing data for different variables from different studies.

To establish a hierarchy of exercise interventions for all outcomes in the current meta-analysis, ranking analysis, that is, the ability to rank all interventions for a single outcome, for example changes in BMI in kg·m<sup>2</sup>, was calculated based on probabilities. However, because the ranking of treatments based exclusively on the probability of each treatment being the best should be avoided given that it does not account for the uncertainty in the relative treatment effects and the possibility for assigning higher ranks for treatments in which little evidence is available, separate rankograms and cumulative ranking probability plots were used to present ranking probabilities along with their uncertainty for changes in primary and secondary outcomes.[98, 107] The surface under the cumulative ranking curve (SUCRA), a transformation of the mean rank, was used to establish a hierarchy of exercise interventions (aerobic, strength, both) while accounting for the location and variance of all treatment effects.[98, 107] Larger SUCRA values indicate better ranks for the treatment.[98, 107] Interpretation of all rankings was approached from the perspective of both absolute and relative treatment effects.[99]

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358 Confidence in cumulative evidence

359 The a priori plan was to examine for the strength of evidence for network meta-  
360 analyses using the approach described by Salanti et al.[108] However, since that time,  
361 an alternative approach has been suggested,[109] with no clear consensus and  
362 continuing controversy on the best approach for network meta-analysis, including the  
363 validity and reliability of these assessment tools. Therefore, a post hoc decision was  
364 made to use a qualitative approach versus a formal assessment instrument to examine  
365 for the strength of the evidence.

366 Software used for statistical analysis

367 All data were analysed using Stata (V.14.1; Stata/SE for Windows, version 14.0.  
368 College Station, TX: Stata Corporation LP; 2015), Microsoft Excel (version 2016;  
369 Redmond, WA: Microsoft Corporation; 2016), and two add-ins for Excel, SSC-Stat  
370 (V.2.18; SSC-Stat, version 3.0. University of Reading, United Kingdom: Statistical  
371 Services Center; 2007), and EZ-Analyze (V.3.0; EZ Analyze, version 3.0. TA Poynton;  
372 2007).

373 **RESULTS**

374 **Study Characteristics**

375 Of the 6,478 citations screened after removing duplicates both electronically and  
376 manually, 57 studies representing 127 groups (73 exercise, 54 control) and 2,792  
377 participants (1,667 exercise, 1,125 control) met the criteria for inclusion.[13-37, 39, 40,  
378 42-69, 110, 111] The number needed to screen was 0.88% while the NNR was 114.  
379 Reasons for exclusion, in order of prevalence, included inappropriate study design  
380 (48.4%), inappropriate population (20.5%), inappropriate intervention (13.6%), other, for



example, editorials (9.6%), inappropriate outcome (6.9%), inappropriate comparison (1.0%), and unable to retrieve data (0.03%). A flow diagram that depicts the search process is shown in Figure 1 while a list of the 6,421 excluded studies, including the reasons for exclusion, can be found in Supplementary File 3. A total of 4 different requests for data were made to authors, 2 (50%) of which provided such.

General study characteristics are shown in Supplementary file 4. The included studies were published in 45 different journals since 1997 ( $\bar{X} \pm SD = 2011 \pm 4$ , Median = 2012). Fifty-two studies (91.2%) were published in the English language,[13, 14, 16-18, 20, 22, 24-37, 39, 40, 42-69, 110] while the remaining 5 (8.8%) were published in either Chinese [19, 21, 23, 111] or Spanish.[15] The location in which studies were conducted included 20 different countries, 12 in the United States,[24, 30, 34, 35, 39, 40, 46, 48, 52, 56, 60, 66] 8 in China,[19-23, 61, 62, 110, 111] 6 in Brazil,[13, 15, 45, 47, 58, 63] 5 in South Korea,[36, 37, 49, 55, 59] 4 in Tunisia,[17, 25, 50, 51] 3 each in Australia,[54, 64, 65] Canada,[14, 32, 57] and Iran,[27, 29, 69] 2 in Turkey,[33, 53] and 1 each in either France,[16] Germany,[44] Italy,[28] Lebanon,[68] New Zealand,[42] Norway,[18] Singapore,[67] Sweden,[31] Switzerland,[26] Taiwan,[22] or the United Kingdom [43]. Of the 57 included studies, 45 (78.9%) were two-arm randomised controlled trials limited to 1 exercise and 1 control group that met all eligibility criteria,[14-20, 22, 23, 25-27, 29-31, 33-37, 42-44, 46-49, 52-56, 58-69, 111] seven (12.3%) were three-arm randomised controlled trials that included 2 exercise arms,[24, 32, 39, 40, 50, 51, 110] and two (3.5%) were four-arm randomised controlled trials that included three exercise arms.[21, 57] The remaining three studies (5.3%) were randomised trials that compared two or more different exercise interventions directly but did not include an eligible control



group.[13, 28, 45] Ten of 57 studies (17.5%) included matching procedures according to either race/ethnicity,[60] age, sex and BMI,[34] age and sex,[45] BMI,[45] sex and BMI, [13] race/ethnicity and sex,[24, 42, 48] sex [49] or sex and degree of overweight.[57] Two studies (3.5%) used a crossover design.[64, 65] With respect to the statistical analysis of data, 39 studies (68.4%) used the per protocol approach,[13, 14, 16, 17, 19-23, 25, 27-31, 33-37, 44, 46-48, 50-53, 55, 56, 58, 59, 63-65, 67-69, 110] 11 (19.3%) used intention-to-treat or reported that all subjects completed the study,[18, 24, 42, 43, 45, 49, 54, 61, 62, 66, 111] while 7 (12.3%) used both per protocol and intention-to-treat analyses.[15, 26, 32, 39, 40, 57, 60] Only 18 studies (31.6%) reported sample size estimates for their primary outcome(s) of interest.[15, 18, 22, 24, 26, 32, 35, 39, 42, 45, 48, 49, 54, 57, 59, 63, 65, 66] In relation to funding, 42 studies (73.7%) reported receiving financial support for their research.[13, 14, 17, 18, 20, 22, 24-26, 30-32, 34-37, 39, 40, 42, 44-52, 54-57, 59-61, 63-68, 110] 16 from government sources,[17, 18, 22, 24, 25, 30, 31, 47, 50, 51, 54, 55, 60, 61, 66, 68] 4 from private sources,[45, 52, 64, 65] 8 from universities,[14, 20, 37, 44, 49, 59, 67, 110] 8 from both government and private sources,[32, 34, 39, 40, 42, 46, 48, 63-68] 3 from government and university sources,[13, 26, 35] 2 from government, university and private sources,[56, 57] and 1 from university and private sources.[36] None of the studies reported any information on the cost-effectiveness of their interventions. Overweight and obesity was most commonly defined using age and sex-specific BMI cutpoints.

**Participant Characteristics**

Baseline characteristics of the participants are shown in Supplementary file 4 and Table 1. More than half the studies (57.1%) included both males and females,[13-18, 20, 22,

24, 26, 28, 30-32, 34, 42-46, 48, 49, 52, 57, 58, 61-65, 68, 110] followed by those limited to males (32.1%),[19, 23, 25, 27, 29, 33, 35-37, 39, 47, 54-56, 59, 67, 69, 111] and females (10.7%).[40, 50, 51, 53, 60, 68] Participants included those across all five stages of puberty.[13, 14, 16, 17, 24-26, 32, 34, 35, 39, 40, 43, 50, 56, 57, 63, 64, 68, 69] For those studies that reported race/ethnicity,[16-20, 23, 24, 30, 32, 35, 39, 40, 42, 48, 52, 56, 57, 59-62, 65, 66, 111] and as reported by the authors, participants included Whites, Blacks/African Americans, Asians, Hispanics/Latinos, Native Hawaiian/Pacific Islander, Maori, Aboriginal, ZN Euro, Arabic, Chinese, Koreans, French, Norwegian, Tunisian and native Canadian. Some studies included one or more participants with hyperlipidemia,[17, 26, 52] hypertension,[26, 56] metabolic syndrome,[17, 34, 46, 56] and/or asthma.[46, 52] For those studies in which data were available, none reported that any of the participants smoked cigarettes [19, 27, 39, 40, 44, 64, 65, 67-69, 111] or consumed alcohol.[13, 111] For the 31 studies (54.4%) that reported data by group,[15, 20, 22, 24, 26, 28, 32, 34, 35, 37, 39, 40, 42, 44, 45, 48-51, 54-58, 60-63, 66, 68, 111] dropouts ranged from 0% to 60.9% in the exercise groups ( $\bar{X} \pm SD$ ,  $15.2 \pm 14.5$ , Median = 12.5) and 0% to 61.5% in the control groups ( $\bar{X} \pm SD$ ,  $14.9 \pm 14.9$ , Median = 13.8). Reasons for dropouts in the exercise group were varied, consisting of such things as lack of time, personal reasons, dissatisfaction with program and logistics. For the control groups, reasons included such things as unhappiness with group assignment and logistics. Of the 11 studies (19.3%) that reported data on adverse events,[24, 32, 42, 47, 51, 57, 60, 62, 64-66] only one reported a serious adverse event (one foot fracture). [24]

Table 1. Baseline physical characteristics of participants.\*

Variable	S/G/P (#)	Exercise			Control			
		$\bar{X} \pm SD$	Mdn	Range	S/G/P (#)	$\bar{X} \pm SD$	Mdn	Range
Age (years)	51/65/1666	13.1 $\pm$ 2.6	14	8-17	49/49/1117	12.7 $\pm$ 2.6	13	8-17
Height (cm)	44/55/1342	157.7 $\pm$ 11.3	163	130-176	42/42/910	156.5 $\pm$ 12.2	161	127-175
Body Weight (kg)	52/65/1371	76.3 $\pm$ 17.2	79	35-107	49/49/906	75.4 $\pm$ 17.3	75	34-103
BMI (kg/m <sup>2</sup> )	52/66/1451	29.4 $\pm$ 3.9	29	21-38	48/48/929	29.3 $\pm$ 3.7	29	21-37
Fat mass (kg)	31/40/867	33.4 $\pm$ 11.5	31	15-60	29/29/567	31.2 $\pm$ 10.2	30	15-56
Body fat (%)	46/59/1364	38.1 $\pm$ 6.8	38	27-52	42/42/840	37.0 $\pm$ 6.6	37	23-51
Fat-free mass (kg)	33/42/764	46.6 $\pm$ 11.1	48	25-64	29/29/435	45.8 $\pm$ 11.1	47	25-64
WC (cm)	23/34/757	95.1 $\pm$ 9.2	94	76-115	21/21/445	95.5 $\pm$ 8.8	95	80-111
VO <sub>2max</sub> (ml·kg <sup>-1</sup> ·min <sup>-1</sup> )	28/38/980	30.7 $\pm$ 4.9	31	20-41	26/26/524	30.5 $\pm$ 6.1	30	20-44
SBP (mmHg)	20/24/484	118.2 $\pm$ 8.7	118	98-139	19/19/330	119.4 $\pm$ 9.1	118	100-134
DBP (mmHg)	19/23/450	69.8 $\pm$ 6.8	68	56-81	18/18/296	69.7 $\pm$ 8.1	70	52-85
TC (mg/dl)	21/27/454	157.8 $\pm$ 16.3	160	110-200	20/20/301	163.1 $\pm$ 19.7	163	114-220
HDL (mg/dl)	25/30/523	42.9 $\pm$ 5.2	43	34-56	23/23/371	44.0 $\pm$ 6.3	45	33-59
LDL (mg/dl)	24/29/507	96.5 $\pm$ 11.4	98	75-124	22/22/354	100.4 $\pm$ 14	98	81-142
TG (mg/dl)	25/30/521	111.6 $\pm$ 27.2	107	53-173	22/22/351	109.9 $\pm$ 27.4	102	102-187

Fasting Glucose	25/33/684	88.5 ± 5.6	90	76-98	24/24/360	88.4 ± 5.3	88	74-97
(mg/dl)								
Fasting Insulin	18/27/586	21.1 ± 9.2	21	6-46	17/17/230	21.0 ±	19	6-48
(uU/ml )						11.0		

Notes: \*, Descriptive data for exercise characteristics calculated based on number of groups (G); S/G/P (#), number of studies/groups/participants;  $\bar{X} \pm SD$ , mean  $\pm$  standard deviation; Mdn, median; BMI, body mass index; WC, waist circumference; WHR, waist-to-hip ratio;  $VO_{2max}$ , maximum oxygen consumption; SBP, resting systolic blood pressure; DBP, resting diastolic blood pressure; TC, total cholesterol; HDL, high-density lipoprotein cholesterol; LDL, low-density lipoprotein cholesterol; TG, triglycerides; non-HDL, non-high-density lipoprotein cholesterol, calculated as total cholesterol minus high-density lipoprotein cholesterol; HbA1c, glycated hemoglobin.

### Exercise Intervention Characteristics

Characteristics of the exercise interventions are shown in Supplementary file 4 and Table 2. Forty-one studies (71.9%) included aerobic exercise,[13, 15-17, 19, 21-25, 28-30, 32-34, 36, 39, 40, 42-46, 48, 50-53, 55, 57-63, 65, 66, 68, 69, 110, 111] 9 (15.8%) included strength training,[21, 28, 35, 39, 40, 47, 54, 56, 57] and 17 (29.8%) included combined aerobic and strength training.[13, 14, 18, 20, 21, 23, 26, 27, 31, 37, 45, 49, 57, 58, 64, 67, 69] While methods for assessing the intensity of training for both aerobic and resistance exercise varied between the 38 studies (66.7%) that reported such information,[14, 17, 19-22, 24, 26-28, 30, 32-34, 37, 39, 40, 45, 48-51, 53, 55-59, 61-65, 67-69, 110, 111] the intensities most commonly reported ranged from moderate to vigorous based on American College of Sports Medicine cutpoints.[112] Specific types of activities performed included, but were not necessarily limited to, various non-video games (soccer, dodgeball, basketball, etc.), active video games, walking, running,

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3 470 cycling, swimming, stairclimbing, jumping rope, dance, and resistance training, including  
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5 471 circuit training.[13-29, 31-34, 36, 37, 39, 40, 42-52, 54-69, 110, 111]  
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8 Table 2. Exercise program characteristics.\*

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Variable	S/G/P	$\bar{X} \pm SD$	Mdn	Range
Length (weeks)	57/73/1663	14.1 $\pm$ 6.2	12	6-36
Frequency (days/week)	56/72/1655	3.3 $\pm$ 1.1	3	1-7
Duration (min/session)	53/55/1251	42 $\pm$ 21	40	6-90
Compliance (%)	19/25/580	81.9 $\pm$ 18.8	87	42-100
Minutes per week**	37/46/1092	132.6 $\pm$ 73.2	125	18-360
Minutes per week (adj)**	16/18/568	133.1. $\pm$ 74.2	124	39-360

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23 472 Notes: Notes: \*, Descriptive data for exercise characteristics calculated based on number of groups (G);  
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25 473 S/G/P (#), number of studies/groups/participants;  $\bar{X} \pm SD$ , mean  $\pm$  standard deviation; Mdn, median; min,  
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27 474 minutes; \*\*, limited to aerobic exercise; Minutes per week of exercise, calculated as frequency per week x  
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29 475 duration per session in minutes; Minutes per week (adj) of exercise, calculated as frequency per week x  
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31 476 duration per session in minutes x compliance, defined as the percentage of exercise sessions attended.  
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33 477 For those studies that included resistance training and provided additional data, [13, 14,  
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35 478 18, 20, 21, 23, 26-28, 31, 35, 37, 39, 40, 45, 47, 49, 51, 54, 56, 57, 64, 67, 69] the  
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37 479 number of sets ranged from 1 to 3 ( $\bar{X} \pm SD$ , 2  $\pm$  1, Median = 3), repetitions from 5 to 17 (  
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39 480  $\bar{X} \pm SD$ , 11  $\pm$  5, Median = 11), and exercises from 3 to 13 ( $\bar{X} \pm SD$ , 9  $\pm$  3, Median = 9).  
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41 481 Types of resistance included one's own body weight, heavy balls, elastic bands, free  
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43 482 weights and machine weights. For the 56 studies (98.2%) that provided data on  
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45 483 exercise delivery,[13-15, 17-37, 39, 40, 42-69, 110, 111] 51 (91.1%) were  
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47 484 supervised,[13-15, 17-34, 36, 37, 39, 40, 43-45, 47-51, 53-56, 58-69, 110, 111] 4 (7.1%)  
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49 485 were unsupervised,[35, 42, 46, 52] and 1 (1.8%) included both [57].  
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56 487 **Risk of Bias Assessment**  
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Summary results using the Cochrane Risk of Bias Instrument [92] are shown in Figure 2 while study-level results are shown in Supplementary file 5. With the exception of blinding of participants and personnel, the number of studies rated as being at a high risk of bias ranged from only 2% to 18%, with 5 of the 6 items being less than 10%. All studies were considered to be at a high risk of bias for blinding of participants and personnel because it is virtually impossible to blind participants to group assignment in exercise intervention studies. In contrast, the vast majority of studies (97%) were considered to be at a low risk of bias for random sequence generation. Finally, with the exception of random sequence generation and blinding of participants and personnel, 42% to 75% of studies were rated as being at an unclear risk of bias for the remaining 5 items.

## Data Synthesis

### Primary Outcomes

Body mass index. Data from 50 studies representing 67 effect sizes were included in the BMI in kg·m<sup>2</sup> analyses.[13-17, 19-23, 25-29, 31-37, 39, 40, 42-47, 49, 52-59, 61-69, 110, 111] The network geometry plot for BMI in kg·m<sup>2</sup> is shown in Figure 3. The most common group was the control group followed by the aerobic group. The most common comparison was aerobic versus control (n = 35) followed by combined aerobic and strength versus control (n = 11), strength versus control (n = 8), strength versus aerobic (n = 7), combined aerobic and strength versus aerobic (n = 4), and combined aerobic and strength versus strength (n = 2). An examination for transitivity found no statistically significant differences for potential effect modifiers across treatment comparisons (p > 0.05 for all).

An interval plot for changes in BMI in kg·m<sup>2</sup> is shown in Figure 4 while a study-level network forest plot that includes each comparison-specific effect size can be found in Supplementary file 6. As can be seen by the non-overlapping 95% confidence intervals in Figure 4, statistically significant reductions in BMI in kg·m<sup>2</sup> were found for the aerobic versus control as well as the combined aerobic and strength versus control comparisons ( $p < 0.05$  for both). Changes were equivalent to relative reductions of 3.8% for the aerobic versus control comparison and 2.4% for the combined aerobic and strength training versus control comparison. However, all 95% prediction intervals were overlapping. No statistically significant differences were observed for direct comparisons. In addition, the overall test for inconsistency was not statistically significant ( $\chi^2 = 4.4$ ,  $p = 0.74$ , Supplementary file 6). No statistically significant small-study effects (publication bias, etc.) were found ( $p = 0.51$ , Supplementary file 7).

The ranking of treatments for BMI in kg·m<sup>2</sup> is shown in Table 3. As can be seen, aerobic exercise had the highest probability of being ranked as the best treatment. This was followed by combined aerobic and strength training and then strength training alone. Meta-regression results for BMI are shown in Supplementary file 8. For aerobic exercise, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in BMI as a result of (1) studies conducted in countries other than those in the United States, (2) unfunded versus funded studies, (3) greater compliance to the exercise intervention, (4) greater number of total minutes of exercise per week, and (5) greater number of total minutes per week of exercise after adjusting for compliance. For

Table 3. Ranking analyses for treatments.

Variable	Best (%)	2 <sup>nd</sup> (%)	3 <sup>rd</sup> (%)	Worst (%)	$\bar{X}$ Rank	SUCRA
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BMI kg·m <sup>2</sup>						
- Aerobic	78.0	21.6	0.4	0.0	<b>1.2</b>	<b>0.9</b>
- Strength	0.9	8.9	55.3	34.9	3.2	0.3
- Both	21.1	69.1	9.1	0.7	1.9	0.7
- Control	0	0.4	35.3	64.4	3.6	0.1
Fat mass (kg)						
- Aerobic	27.9	52.3	19.7	0	1.9	0.7
- Strength	11.3	18.7	61.6	8.4	2.7	0.4
- Both	<b>60.7</b>	29.0	10.3	0	<b>1.5</b>	<b>0.8</b>
- Control	0	0	8.4	91.6	3.9	0
Body fat (%)						
- Aerobic	9.9	57.0	33.1	0	2.2	0.6
- Strength	10.2	27.6	60.3	1.9	2.5	0.5
- Both	79.7	15.4	4.7	0	<b>1.2</b>	<b>0.9</b>
- Control	0	0	1.9	98.1	4	0

Notes: SUCRA, surface under the cumulative ranking curve analysis; **Boldface** values indicate best treatment;  $\bar{X}$  Rank, mean rank.

strength training, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in BMI and (1) studies at a low versus unclear risk of bias with respect to participants being physically inactive prior to study initiation, (2) supervised versus unsupervised exercise, and (3) facility versus home-based exercise. No other statistically significant associations were observed.

Fat Mass. Data from 31 studies representing 46 effect sizes were included in the fat mass (kg) analyses.[13, 14, 17, 18, 21, 23, 25, 27, 31, 34-37, 39, 40, 42, 45-48, 52, 55-57, 59, 60, 64, 67, 69, 110, 111] The network geometry plot for fat mass (kg) is shown in Figure 5. As can be seen, the control group was the most common followed by the



aerobic group. The most common comparison was aerobic versus control (n = 19) followed by combined aerobic and strength versus control (n = 10), strength versus control (n = 7), strength versus aerobic (n = 7), combined aerobic and strength versus aerobic (n = 4), and combined aerobic and strength versus strength (n = 2) comparisons. An examination for transitivity revealed a statistically significant overall difference between comparisons for frequency of training in days per week (p = 0.01). Post-hoc follow-up testing revealed that frequency of training was greater in the aerobic versus control versus combined aerobic and strength versus control comparisons (4.0 versus 2.4 days per week, p = 0.008). No other statistically significant between-comparison differences were observed (p > 0.05 for all).

An interval plot for changes in fat mass in kg is shown in Figure 6 while a network forest plot that includes each comparison-specific effect size can be found in Supplementary file 9. As can be seen by the non-overlapping 95% confidence intervals in Figure 6, statistically significant reductions in fat mass in kg were found for the aerobic versus control as well as the combined aerobic and strength versus control comparisons (p < 0.05 for both). Changes were equivalent to relative reductions of 8.3% for the aerobic versus control comparison and 8.4% for the combined aerobic and strength training versus control comparison. However, all 95% prediction intervals were overlapping. No statistically significant differences were observed for head-to-head comparisons. In addition, the overall test for inconsistency was not statistically significant ( $\chi^2 = 7.5$ , p = 0.27, Supplementary file 9). No statistically significant small-study effects (publication bias, etc.) were found (p = 0.10, Supplementary file 10).

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3 565 The ranking of treatments for fat mass in kg is shown in Table 3. As can be seen,  
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5 566 combined aerobic and strength training exercise had the highest probability of being  
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7 567 ranked as the best treatment followed by aerobic exercise.  
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10 568 Meta-regression results for fat mass (kg) are shown in Supplementary file 11. For  
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12 569 aerobic exercise, statistically significant associations ( $p < 0.05$ ) were found for greater  
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14 570 reductions in BMI as a result of (1) studies at an unclear versus low risk of bias for  
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16 571 selective reporting, (2) shorter interventions (weeks), (3) high versus moderate intensity  
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18 572 exercise, (4) greater compliance to the exercise protocol, and (5) greater total minutes  
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20 573 per week of exercise, adjusted for compliance. For combined aerobic and strength  
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22 574 training, statistically significant associations ( $p < 0.05$ ) were found for greater reductions  
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24 575 in fat mass and more recent year of publication as well as unfunded versus funded  
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26 576 studies. No other statistically significant associations were observed.  
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31 577 Percent Body Fat. Data from 45 studies representing 64 effect sizes were included in  
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33 578 the percent body fat analyses.[13, 14, 18-24, 26, 28-32, 34-37, 39, 40, 42, 44-48, 50-61,  
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35 579 63, 64, 67-69, 111] The network plot for fat mass (kg) is shown in Figure 5. As can be  
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37 580 seen, the control group was the most common followed by the aerobic group. The most  
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39 581 common comparison was the aerobic versus control group ( $n = 32$ ) followed by  
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41 582 combined aerobic and strength versus control ( $n = 12$ ), strength versus control ( $n = 12$ ),  
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43 583 strength versus aerobic ( $n = 6$ ), combined aerobic and strength versus aerobic ( $n = 4$ ),  
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45 584 and combined aerobic and strength versus strength ( $n = 2$ ) comparisons. An  
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47 585 examination for transitivity revealed a statistically significant difference between  
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49 586 comparisons with respect to the method used for the assessment of percent body fat ( $p$   
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51 587  $= 0.01$ ). Post-hoc follow-up testing revealed that the difference was between the  
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aerobic versus control and strength versus control comparisons ( $p = 0.01$ ) as well as aerobic versus control and combined aerobic and strength training versus aerobic comparisons ( $p = 0.03$ ). In addition, frequency of training was associated with specific comparisons ( $p = 0.02$ ). Post hoc follow-up testing showed that frequency of training was lower in the combined aerobic and strength training comparison (2.6 days per week) versus the aerobic and control comparison (3.8 days per week,  $p = 0.02$ ). No other statistically significant between-comparison differences were observed ( $p > 0.05$  for all).

An interval plot for changes in percent body fat is shown in Figure 8 while a network forest plot that includes each comparison-specific effect size can be found in Supplementary file 12. As can be seen by the non-overlapping 95% confidence intervals in Figure 8, statistically significant reductions in percent body fat were found for the aerobic versus control, strength versus control, and combined aerobic and strength versus control comparisons ( $p < 0.05$  for both). Changes were equivalent to relative reductions of 5.4% for the aerobic versus control comparison, 2.8% for the strength versus control comparison, and 6.0% for the combined aerobic and strength training versus control comparison. However, all 95% prediction intervals were overlapping. No statistically significant differences were observed for direct comparisons. In addition, the overall test for inconsistency was not statistically significant ( $\chi^2 = 11.9$ ,  $p = 0.10$ , Supplementary file 12). No statistically significant small-study effects (publication bias, etc.) were found ( $p = 0.65$ , Supplementary file 13).

The ranking of treatments for percent body fat is shown in Table 3. As can be seen, combined aerobic and strength training exercise had the highest probability of being

ranked as the best treatment followed by aerobic exercise alone and strength training alone.

Meta-regression results for percent body fat are shown in Supplementary file 14. For aerobic exercise, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in percent body fat as a result of (1) studies at an unclear versus low risk of bias for selective reporting, (2) unfunded versus funded studies, and (3) shorter interventions (weeks). For strength training, greater reductions were associated with low versus unclear risk of bias for participants being physically active prior to study initiation as well as unfunded versus funded studies. For combined aerobic and strength training, greater reductions in percent body fat were associated with unfunded versus funded studies. No other statistically significant associations were observed.

## Secondary Outcomes

The overall results for secondary outcomes are shown in Supplementary file 15.

Body weight. Statistically significant reductions in body weight were observed for both aerobic exercise and combined aerobic and strength training. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative reductions of 3.0% and 4.0% respectively, for aerobic and combined exercise. In addition greater reductions were observed for the combined aerobic and strength versus strength training only comparison ( $\bar{X}$ , -1.7, 95% CI, -3.3 to -0.07). The global test for inconsistency was not statistically significant ( $\chi^2 = 10.5$ ,  $p = 0.16$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.002$ ). For ranking of treatments, aerobic exercise was ranked as the best treatment followed by combined aerobic and strength training.

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3 634 Fat free mass. Statistically significant increases in fat free mass (kg) were observed for  
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5 635 combined aerobic exercise and strength training but none of the other interventions.  
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7 636 However, 95% prediction intervals for all comparisons included zero. Changes were  
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10 637 equivalent to relative reductions of 2.5%. In addition, increases in fat free mass were  
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12 638 greater for combined aerobic and strength versus aerobic comparisons ( $\bar{X}$ , 1.2, 95% CI,  
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14 639 0.1 to 2.3). The global test for inconsistency was not statistically significant ( $\chi^2 = 2.8$ ,  $p =$   
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16 640 0.90). Statistically significant small-study effects (publication bias, etc.) were observed  
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18 641 ( $p = 0.008$ ). For ranking of treatments, combined aerobic and strength training was  
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20 642 ranked first for increasing fat free mass.  
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23 643 Waist circumference. Statistically significant reductions in waist circumference were  
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25 644 found for aerobic exercise. However, 95% prediction intervals for all comparisons  
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27 645 included zero. Changes were equivalent to relative reductions of 2.2%. No statistically  
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29 646 significant differences were observed for head-to-head comparisons ( $p < 0.05$  for all).  
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31 647 The global test for inconsistency was not statistically significant ( $\chi^2 = 8.1$ ,  $p = 0.23$ ). No  
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33 648 statistically significant small-study effects (publication bias, etc.) were observed ( $p =$   
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35 649 0.39). For ranking of treatments, combined aerobic and strength training was ranked  
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37 650 first followed by aerobic exercise.  
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40 651 Maximum oxygen consumption. Statistically significant increases were found for  $VO_{2max}$   
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42 652 in  $ml \cdot kg^{-1} \cdot min^{-1}$  as a result of either aerobic exercise or combined aerobic exercise and  
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44 653 strength training. However, 95% prediction intervals for all comparisons included zero.  
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46 654 Changes were equivalent to relative increases of 12.2% and 8.9%, respectively for  
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48 655 aerobic exercise and combined aerobic and strength exercise. No statistically significant  
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50 656 differences were observed for the three direct comparisons. The global test for  
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inconsistency was also not statistically significant ( $\chi^2 = 10.0$ ,  $p = 0.12$ ). No statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.32$ ). For ranking of treatments, combined aerobic exercise was ranked first while combined aerobic and strength training was ranked second.

Systolic blood pressure. Statistically significant decreases were found for resting systolic blood pressure as a result of aerobic exercise. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to a relative reduction of 3.5%. No statistically significant differences were observed for the head-to-head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2 = 2.0$ ,  $p = 0.74$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.01$ ). For ranking of treatments, aerobic exercise was ranked first.

Diastolic blood pressure. Statistically significant decreases for resting diastolic blood pressure were found as a result of aerobic exercise. However, the 95% prediction intervals for all comparisons included zero. Changes were equivalent to a relative reduction of 3.4%. No statistically significant differences were observed for any of the head-to-head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2 = 0.53$ ,  $p = 0.97$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.001$ ). For ranking of treatments, aerobic exercise was ranked first.

Total cholesterol. Statistically significant decreases in total cholesterol were found as a result of aerobic exercise but none of the other interventions. However, the 95% prediction intervals for all comparisons included zero. Changes were equivalent to a relative reduction of 3.3%. No statistically significant differences were observed for the

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three head-to-head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2 = 1.8$ ,  $p = 0.87$ ). Furthermore, no statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.70$ ). For treatment rankings, aerobic exercise was ranked as best.

High-density lipoprotein cholesterol. Statistically significant increases were found for high-density lipoprotein cholesterol as a result of aerobic exercise only. Conversely, the 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative increases of 7.4%. No statistically significant differences were observed for any of the direct comparisons. The global test for inconsistency was not statistically significant ( $\chi^2 = 2.6$ ,  $p = 0.76$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.04$ ). For treatment rankings, combined aerobic exercise was ranked as the best.

Low-density lipoprotein cholesterol. Statistically significant decreases in low-density lipoprotein cholesterol were found as a result of aerobic exercise but none of the other interventions. In addition, the 95% prediction interval did not include zero. Changes were equivalent to a relative reduction of 6.0%. No statistically significant differences were observed for the three head-to-head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2 = 2.4$ ,  $p = 0.79$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.006$ ). For treatment rankings, aerobic exercise was ranked as best.

Triglycerides. Statistically significant decreases in triglycerides were found as a result of aerobic exercise as well as combined aerobic and strength exercise. In addition, the 95% prediction intervals did not include zero for both treatments. Changes were



equivalent to a relative reduction of 11.9% as a result of aerobic exercise and 14.4% as a result of combined aerobic and strength exercise. No statistically significant differences were observed for the three head-to-head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2 = 1.4$ ,  $p = 0.92$ ). No statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.44$ ). For treatment rankings, aerobic exercise was ranked best, followed by combined aerobic and strength training.

**Fasting Glucose.** Statistically significant decreases in fasting glucose were found as a result of combined aerobic and strength exercise. In addition, the 95% prediction interval did not include zero. Changes were equivalent to a relative reduction of 6.1%. For head-to-head comparisons decreases, were greater for combined aerobic and strength versus strength only interventions ( $\bar{X}$ , -4.9, 95% CI, -9.5 to -0.2). The global test for inconsistency was not statistically significant ( $\chi^2 = 2.2$ ,  $p = 0.90$ ). No statistically significant small-study effects (publication bias, etc.) were observed ( $p = 0.35$ ). For treatment rankings, combined aerobic and strength training was ranked as best.

**Fasting Insulin.** Statistically significant decreases in fasting insulin were observed for aerobic exercise, strength exercise, and combined aerobic and strength exercise as a result of combined aerobic and strength exercise. In addition, the 95% prediction interval did not include zero for any of the three intervention types. Changes were equivalent to relative reductions of 21.2% (aerobic exercise), 22.6% (strength exercise) and 17.1% (combined aerobic and strength exercise). No statistically significant differences were observed for the three head-to-head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2 = 5.6$ ,  $p = 0.59$ ). However, statistically



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significant small-study effects (publication bias, etc.) were observed ( $p = 0.008$ ). For treatment rankings, combined aerobic and strength training was ranked as best, followed by strength training and aerobic exercise.

**DISCUSSION**

**Overall Findings for Primary Outcomes**

The primary purpose of the current study was to conduct a network meta-analysis of randomised trials on the effects of exercise (aerobic, strength training, or both) on adiposity outcomes (BMI in  $\text{kg}\cdot\text{m}^2$ , fat mass, percent fat) in overweight and obese children and adolescents. The overall findings suggest that exercise is associated with statistically significant reductions in all three primary outcomes. More specifically, aerobic exercise as well as combined aerobic and strength exercise were shown to decrease BMI in  $\text{kg}\cdot\text{m}^2$ , fat mass and percent fat while decreases in strength training were limited to percent fat only. Of the three exercise interventions, combined aerobic and strength exercise was ranked as best for reducing fat mass and percent fat while aerobic exercise was ranked best for reducing BMI in  $\text{kg}\cdot\text{m}^2$ . These findings are further strengthened by the lack of global inconsistency for all three primary outcomes as well as the lack of small study effects (publication bias, etc.) observed for all three adiposity outcomes. Alternatively, the positive findings could be questioned given the overlapping 95% prediction intervals across all three treatments. These findings suggest that in a future setting, some participants would benefit while others would not.[113]

A major question to address is the clinical importance of the observed changes in adiposity as a result of exercise. Generally, reductions in adiposity of at least 5% may be considered clinically important.[114] Using this threshold, none of the treatments that

749 were found to be statistically significant in the current study would meet this cutpoint for  
750 changes in BMI in kg·m<sup>2</sup>. However, the reductions in fat mass as a result of aerobic  
751 exercise (8.3%) as well as combined aerobic and strength exercise (8.4%) appear to be  
752 clinically important. In addition, the reductions observed for percent body fat as a result  
753 of aerobic exercise (5.4%) as well as combined aerobic and strength exercise (6.0%)  
754 also appear to be clinically important. Thus, clinically relevant benefits were derived  
755 when more direct measures of adiposity (fat mass and percent body fat) were used.

### 756 **Meta-regression Findings**

757 Simple meta-regression analyses yielded several statistically significant associations  
758 for those treatments and outcomes in which the overall findings were statistically  
759 significant. First, the statistically significant association between greater reductions in  
760 BMI in kg·m<sup>2</sup> as a result of aerobic exercise for studies conducted in countries other than  
761 the United States may reflect a tendency for other countries to submit studies that yield  
762 larger improvements in BMI in kg·m<sup>2</sup>. Alternatively, this association may be confounded  
763 by other factors. Second, greater reductions as a result of aerobic exercise for both BMI  
764 in kg·m<sup>2</sup> and percent fat were associated with unfunded versus funded studies. This  
765 same association was found for fat mass and percent body fat congruent with combined  
766 aerobic and strength training interventions as well as for percent body fat and strength  
767 training. One possible and broad explanation for these associations may be that funded  
768 studies are of higher quality than unfunded studies. Third, greater compliance, defined  
769 as the percentage of exercise sessions attended, was associated with greater  
770 reductions in both BMI in kg·m<sup>2</sup> as well as fat mass as a result of aerobic exercise.  
771 These associations appear plausible given that greater reductions should be expected if

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exercise attendance is greater. Fourth, greater reductions in BMI in kg·m<sup>2</sup> were associated with greater total minutes of exercise per week as a result of aerobic exercise. When adjusted for compliance, total minutes of exercise per week were also associated with greater reductions in both BMI in kg·m<sup>2</sup> and fat mass as a result of aerobic exercise. These observed associations seem quite plausible. Fifth, larger reductions in both fat mass and percent fat were associated with studies that were at an unclear versus low risk of bias for selective reporting of study results. This might suggest a tendency for authors to selectively report results that are statistically significant. However, caution is warranted in the interpretation of these findings since a rating of unclear does not guarantee that selective reporting of results occurred, but rather, reflects a lack of available data to classify a study as either high or low risk. Sixth, the association between greater reductions in fat mass and percent fat as a result of shorter intervention length, i.e., weeks, as a result of aerobic exercise may represent a certain threshold in which no further benefits can be achieved. However, maintaining an exercise program is probably important as the cessation of training will most likely return adiposity levels back to their original values. Seventh, the association between greater reductions in fat mass as a result of high versus moderate-intensity aerobic exercise suggests that training regimes such as interval training may be optimal for reducing fat mass. However, this needs to be balanced with the possibility of placing the child and adolescent at an increased risk for injury as well as possible concerns about decreased compliance with high intensity exercise programs. Eighth, the association between greater reductions in fat mass and more recent year of publication as a result of combined aerobic and strength exercise may reflect higher quality studies. In

contrast, this may reflect an increased emphasis on investigators tending to report results that are large and statistically significant. Finally, the greater strength training reductions in percent fat as a result of studies that were at a low versus unclear risk of bias for participants not being physically active prior to study participation reflects the belief that those who are least active have the most to gain from an exercise program. Again however, a rating of unclear does not guarantee that subjects were physically active prior to study participation, but rather, reflects a lack of available data to classify a study as being at either a high or low risk of bias.

### **Overall Findings for Secondary Outcomes**

Across all three treatments, statistically significant improvements were observed for secondary outcomes. For aerobic exercise, these included reductions in body weight, waist circumference, resting systolic and diastolic blood pressure, total cholesterol, low density lipoprotein cholesterol, triglycerides, and fasting insulin, as well as increases in  $VO_{2max}$  in  $ml \cdot kg^{-1} \cdot min^{-1}$  and high-density lipoprotein cholesterol. For strength training, statistically significant reductions were limited to fasting insulin while combined aerobic and strength training resulted in statistically significant improvements in body weight, fat free mass,  $VO_{2max}$  in  $ml \cdot kg^{-1} \cdot min^{-1}$ , triglycerides, fasting glucose and fasting insulin. Thus, unlike most pharmacological interventions that are intended to target one condition and often include significant side effects, exercise, especially aerobic as well as combined aerobic and strength training, can yield significant improvements in both adiposity outcomes as well as a number of other outcomes in overweight and obese children and adolescents.

### **Implications for Research**

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818 There are several implications for reporting future randomised trials on exercise and  
819 adiposity in overweight and obese children and adolescents. First, given that reductions  
820 in adiposity are dependent on the balance between energy intake and expenditure,  
821 future randomised trials should track and report data on both energy intake and  
822 expenditure so that the independent effects of exercise on adiposity can be better  
823 quantified. Second, future studies should track and report the total physical activity  
824 levels of participants during the entire day in order to ensure that physical activity  
825 compensation is not occurring.[115] Third, a clear definition and accurate reporting of  
826 adverse events is needed so that the benefits and potential harms of exercise on  
827 adiposity in overweight and obese children can be more clearly delineated. Fourth, in  
828 order to better assess the quality of the study design, information should be provided  
829 about allocation concealment, blinding of outcome assessors, incomplete outcome data  
830 and reporting, as well as the physical activity levels of participants prior to taking part in  
831 the study. Fifth, given that less than half of the studies provided data on compliance to  
832 the exercise intervention, future studies should report this information since it can have  
833 a significant impact on outcomes. Along those lines, it is suggested that researchers  
834 adhere to the Consensus on Exercise Reporting Template (CERT) when designing their  
835 study and reporting exercise program information from their clinical trials.[116]  
836 In addition to reporting, there are several suggestions for the conduct of future  
837 research addressing the effects of exercise interventions on adiposity outcomes in  
838 overweight and obese children and adolescents. First, given the small number of direct  
839 studies included, a need exists for additional randomised trials that examine the effects  
840 of different exercise interventions head-to-head, as was done in the study by Sigal et al.

[57] Ideally, this would include an aerobic, strength, and combined aerobic and strength training group as well as a control group. Such an approach would provide additional and possibly more valid information regarding the effects of each intervention on adiposity outcomes. Third, given the lack of follow-up data, a need exists for future studies that include follow-up assessment several weeks and/or months after the intervention period has ended. This would allow one to track both changes in adiposity outcomes as well as continued participation in exercise. Fourth, given the potential of calorie restriction for improving adiposity outcomes and the need to identify the best treatment, a need exists for a network meta-analysis that includes the following treatment arms: exercise, calorie restriction, exercise and calorie restriction, control. This would allow one to examine both the separate and combined effects of exercise and caloric restriction on adiposity outcomes in overweight and obese children and adolescents. Finally, a need exists for cost-effectiveness analyses.

### **Implications for Practice**

The results of the current network meta-analysis have important implications for practice. First, given the statistically significant and clinically important improvements in adiposity outcomes, lack of adverse events for those that reported such data, and improvements observed for a number of secondary outcomes, exercise may be more vital than any other type of intervention for the overall physiological health of overweight and obese children and adolescents. While the current network meta-analysis was unable to determine the exact dose-response effects of exercise on adiposity in overweight and obese children and adolescents, it would appear reasonable to suggest that aerobic or combined aerobic and strengthening exercise would be optimal. Along

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those lines, it is suggested that adherence to the recent 2018 guidelines for exercise and physical activity in children and adolescents be followed.[117] These include at least 60 minutes per day of moderate to vigorous physical activity, including a minimum of 3 days of vigorous intensity activity, as well as muscle-strengthening activities at least three days per week.[117] More broadly, it is recommended that clinicians and other healthcare practitioners adhere to the recent recommendations from the United States Preventive Service Task Force regarding screening for obesity in children and adolescents.[114] These recommendations include screening for obesity in children and adolescents  $\geq 6$  years of age and offering or referring them to comprehensive, intensive behavioral interventions to promote improvements in weight status.[114] Multi-component behavioral interventions that include, but are not necessarily limited to, exercising, healthy eating, and reductions in screen time may be optimal.[114] Reducing adiposity in overweight and obese children and adolescents will probably require intensive efforts given the obesogenic environments in which most people reside today.

**Implications for Policy**

Evidence-based policies play a pivotal role in reducing childhood obesity.[118] The results of the current network meta-analysis provide evidence to support policies aimed at increasing the exercise and physical activity habits of overweight and obese children and adolescents. This is especially relevant for policy given that one of the main reasons for conducting a network meta-analysis is to identify the best treatment(s) for a disease or condition. Broadly, the development of policies aimed at making exercise and physical activity safer, easier, and more appealing might be best.[118] More specifically, policies directed towards increasing active transportation and recreation as



well as reducing sedentary behavior are probably important.[118] In addition, and most pertinent to the current network meta-analysis, policies aimed at increasing the number of overweight and obese children and adolescents who participate in exercise and physical activity programs that include aerobic and strength training according to current guidelines [117] is probably relevant. Finally, policies aimed at increasing exercise and physical activity for reducing childhood obesity should probably work in concert with food policies that aim to do the same.[118]

### **Strengths and Limitations**

There are several strengths to this study. First, to the best of the investigative team's knowledge, this is the largest as well as first systematic review to use the network meta-analytic approach to determine the effects as well as hierarchy of exercise interventions (aerobic, strength training, or both) on BMI in kg/m<sup>2</sup>, fat mass and percent body fat in overweight and obese children and adolescents. This work is important for determining which type of exercise treatment(s) is/are best for reducing adiposity. Second, the results of this systematic review with network meta-analysis should be useful to researchers with respect to the conduct and reporting of future research on this topic, including priority areas. Third, the findings of the current study should be useful to practitioners and policy-makers for making informed decisions regarding the use of exercise in the treatment of overweight and obesity in children and adolescents. For example, clinicians and other healthcare personnel can include this information along with their own clinical judgment and parent/child preferences when making evidence-based decisions regarding the use of exercise in the treatment of adiposity in overweight and obese children and adolescents.



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910 In addition to strengths, there are also several potential limitations. First, the number of  
911 effect sizes for some treatments and comparisons, for example strength training and fat  
912 mass, were small. As a result, there may have been a lack of statistical power to detect  
913 a true effect, assuming such an effect exists. Second, common to any type of aggregate  
914 data meta-analysis, meta-regression results do not support causal inferences because  
915 the included studies are not randomly assigned to covariates.[119] Thus, any of the  
916 associations observed in the current network meta-analysis should be tested in original  
917 randomised controlled trials. Third, because a large number of statistical tests were  
918 conducted, some of the statistically significant results observed may have been nothing  
919 more than the play of chance. However, common to most aggregate data meta-  
920 analyses, no adjustments for multiple testing were made because of concerns about  
921 missing possibly important findings that could be tested in original randomised  
922 controlled trials.[120] Fourth, the results for the secondary outcomes in the current study  
923 may be a biased sample since studies were only included if one or more measures of  
924 adiposity, our primary outcomes, were assessed. Finally, common to all aggregate data  
925 meta-analyses, there is the possibility of ecological fallacy, i.e., that group averages are  
926 not reflective of an individual's values for variables that were reported on the group  
927 versus individual level.[121]

928 **CONCLUSIONS**

929 The findings of the current network meta-analysis suggest that aerobic exercise as  
930 well as combined aerobic and strength training exercise are associated with clinically  
931 important reductions in selected measures of adiposity.

## 932 ORIGINAL PROTOCOL FOR STUDY

933 See Supplementary file 16.

## 934 CONTRIBUTORS

935 GAK is the guarantor. GAK, KSK and RRP drafted the manuscript. All authors  
936 contributed to the development of the data sources to search for relevant literature,  
937 including search strategy, selection criteria, data extraction criteria and risk of bias  
938 assessment strategy. GAK provided statistical expertise while RRP provided content  
939 expertise on exercise and adiposity in overweight and obese children and adolescents.  
940 All authors read, provided feedback and approved the final manuscript.

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## 946 COMPETING INTERESTS

947 None declared.

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## FIGURE LEGENDS

Figure 1. Flow diagram for selection of studies. Flow of information through the different phases of the systematic review and network meta-analysis.

Figure 2. Summary results for risk of bias. Grouped risk of bias results using the Cochrane Risk of Bias Instrument.

Figure 3. Network plot for BMI in  $\text{kg}\cdot\text{m}^2$ . Network plot for study comparisons included in the BMI in  $\text{kg}\cdot\text{m}^2$  network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

Figure 4. Interval plot for changes in BMI in  $\text{kg}\cdot\text{m}^2$ . Interval plot for changes in BMI  $\text{kg}\cdot\text{m}^2$  based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals.

The number of effect sizes/participants were 35/1533 (aerobic vs. control), 8/331 (strength versus control), 11/426 (combined aerobic and strength versus control), 7/232 (strength versus aerobic), 4/175 (combined aerobic and strength versus aerobic), 2/121 (combined aerobic and strength versus strength).

Figure 5. Network plot for fat mass (kg). Network plot for study comparisons included in the fat mass network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

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Figure 6. Interval plot for changes in fat mass (kg). Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 19/945 (aerobic vs. control), 7/271 (strength versus control), 10/376 (combined aerobic and strength versus control), 4/167 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

Figure 7. Network plot for percent body fat. Network plot for study comparisons included in the percent body fat network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

Figure 8. Interval plot for changes in percent body fat. Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 32/1602 (aerobic vs. control), 8/327 (strength versus control), 12/480 (combined aerobic and strength versus control), 6/201 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

## SUPPLEMENTARY FILES LIST

**Supplementary file 1.** Results of PubMed search.

**Supplementary file 2.** Planned covariates to examine for in meta-regression analyses.

**Supplementary file 3.** Reference list of excluded studies, including the reasons for exclusion.

**Supplementary file 4.** Characteristics of included studies.

**Supplementary file 5.** Cochrane risk of bias results for each element from each study.

**Supplementary file 6.** Network forest plot for changes in BMI in kg·m<sup>2</sup> based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as blue point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow green diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow red diamonds

**Supplementary file 7.** Funnel plot of small-study effects for changes in BMI in kg·m<sup>2</sup>.

**Supplementary file 8.** Simple meta-regression results for changes in BMI (kg·m<sup>2</sup>) and potential covariates.

**Supplementary file 9.** Network forest plot for changes in fat mass (kg) based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as blue point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow green diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow red diamonds

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**Supplementary file 10.** Funnel plot of small-study effects for changes in fat mass (kg).

**Supplementary file 11.** Simple meta-regression results for changes in fat mass (kg) and potential covariates.

**Supplementary file 12.** Network forest plot for changes in percent body fat based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as blue point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow green diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow red diamonds.

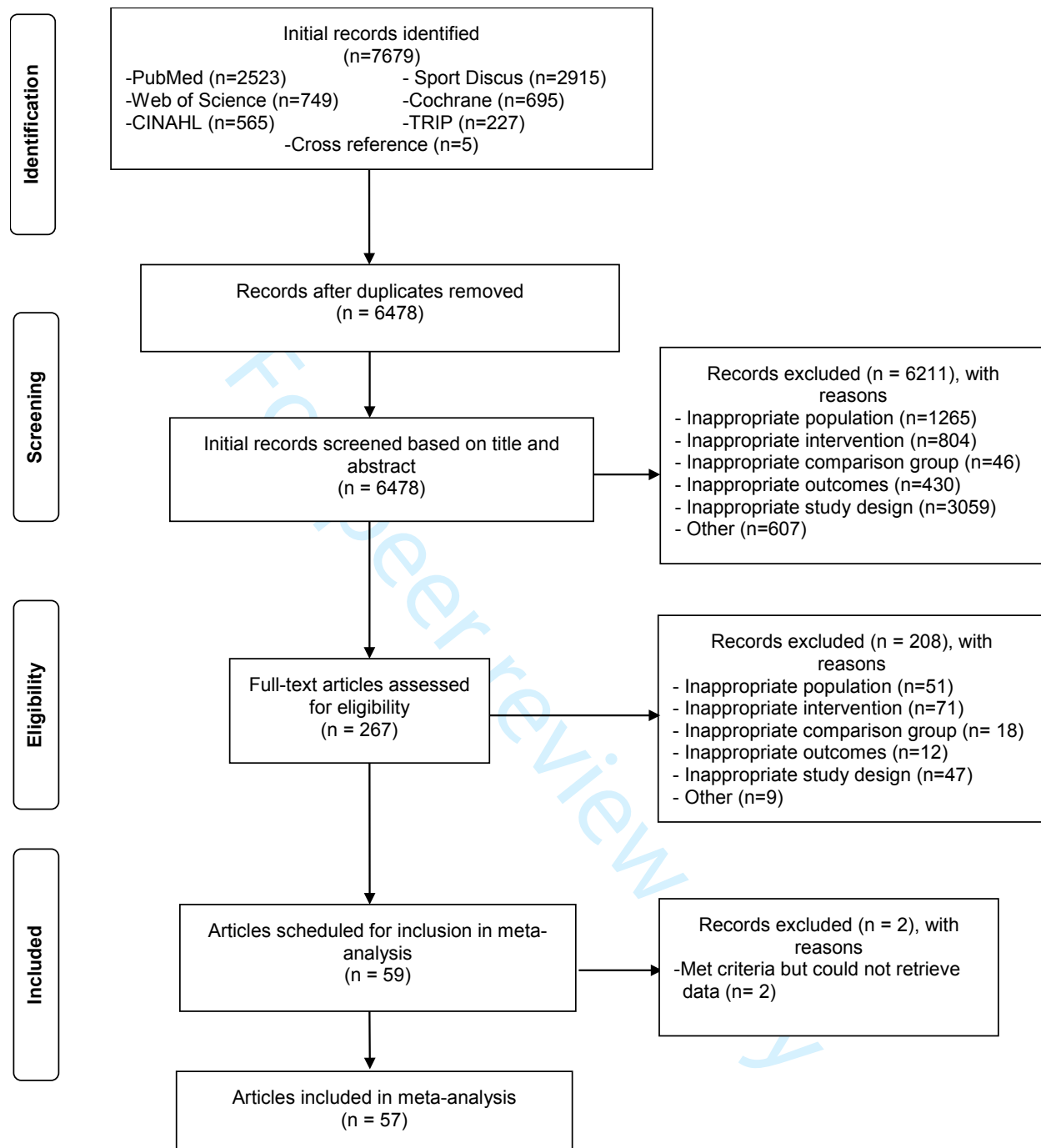
**Supplementary file 13.** Funnel plot of small-study effects for changes in percent body fat.

**Supplementary file 14.** Simple meta-regression results for changes in percent body fat and potential covariates.

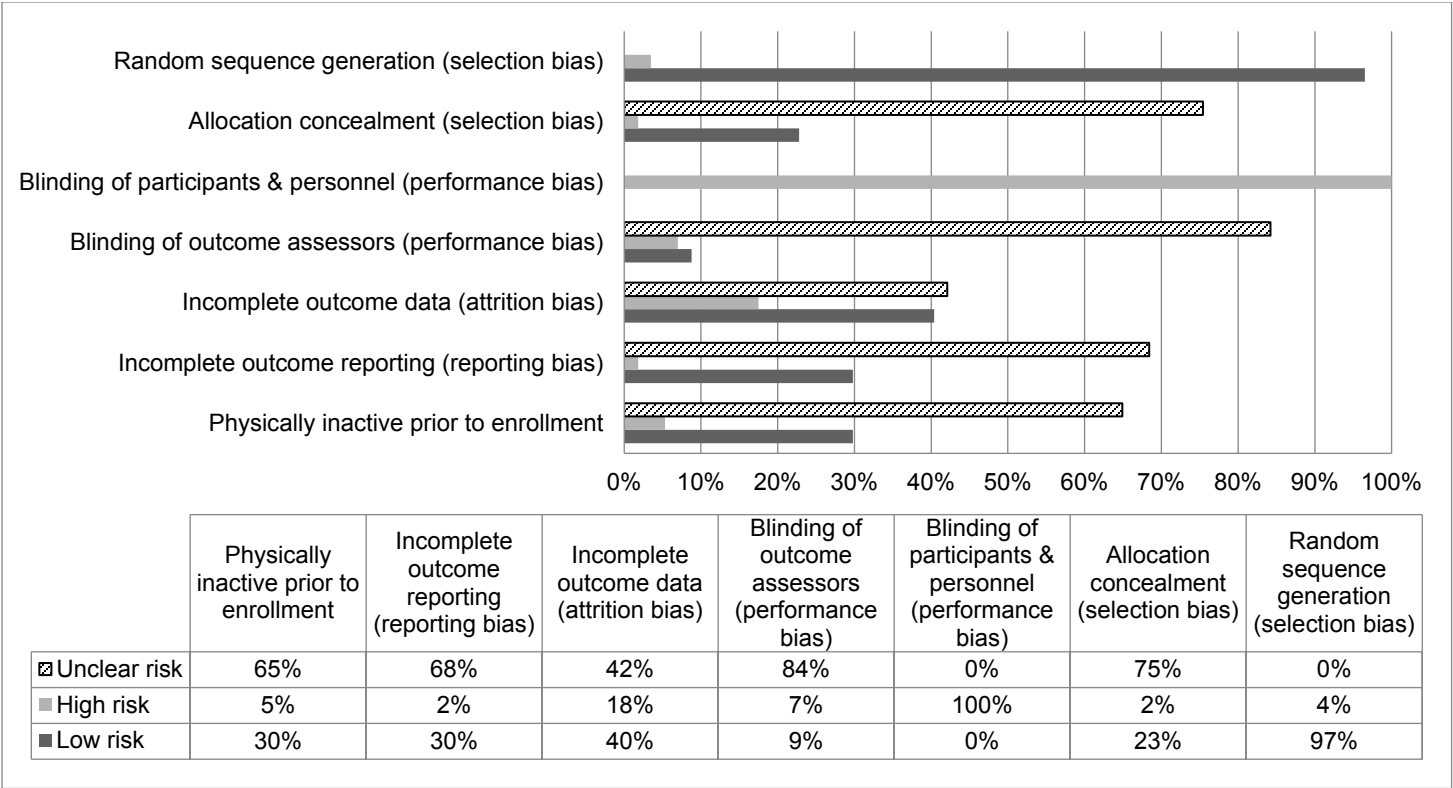
**Supplementary file 15.** Treatment-specific changes in secondary outcomes.

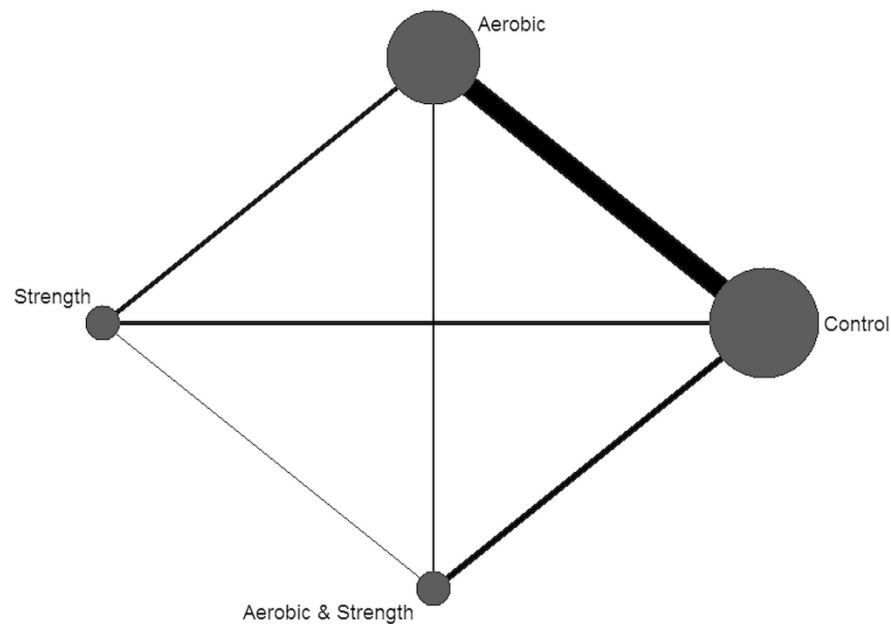
**Supplementary file 16.** Original published protocol for study.

**Supplementary file 17.** PRISMA protocol checklist for a network meta-analysis.



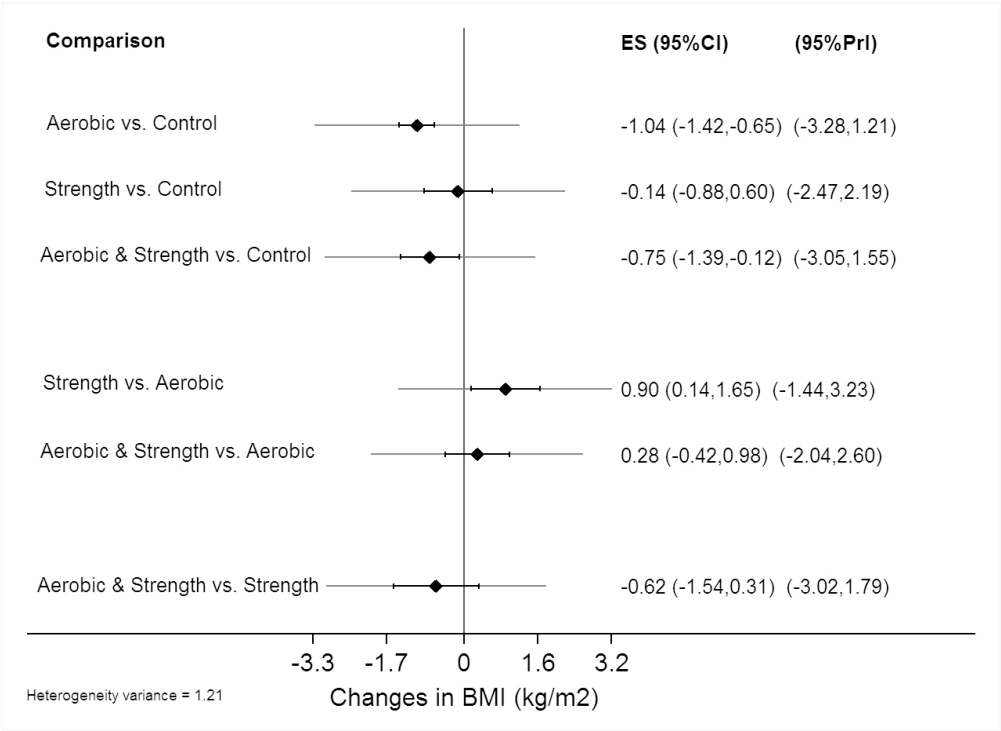






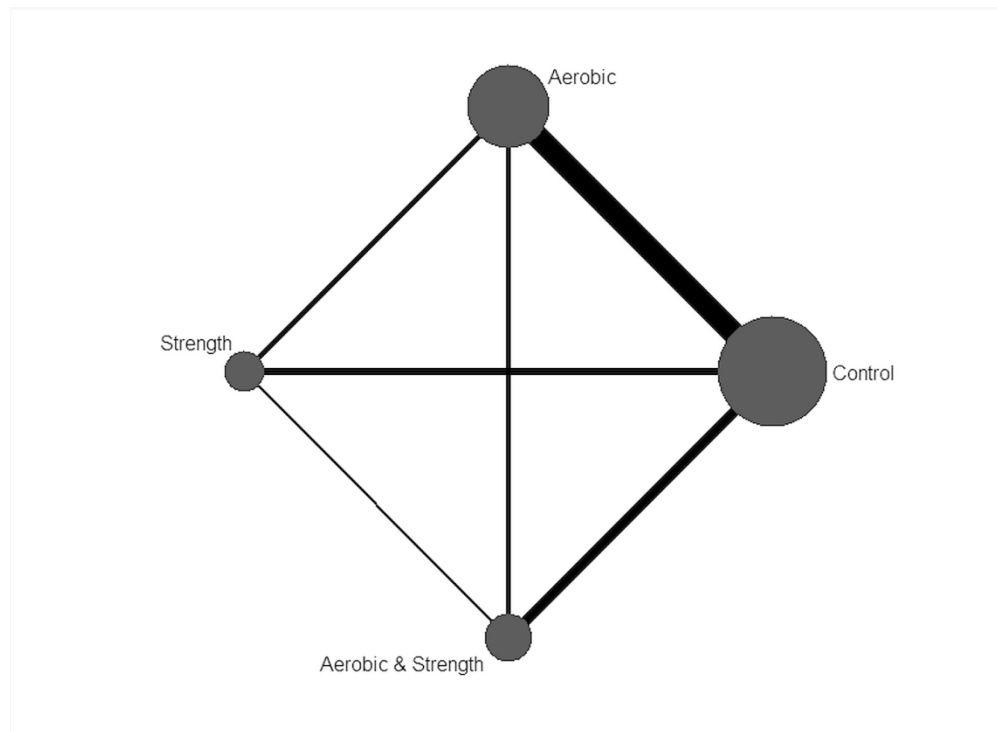
Network plot for BMI in kg.m2. Network plot for study comparisons included in the BMI in kg.m2 network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

173x126mm (300 x 300 DPI)



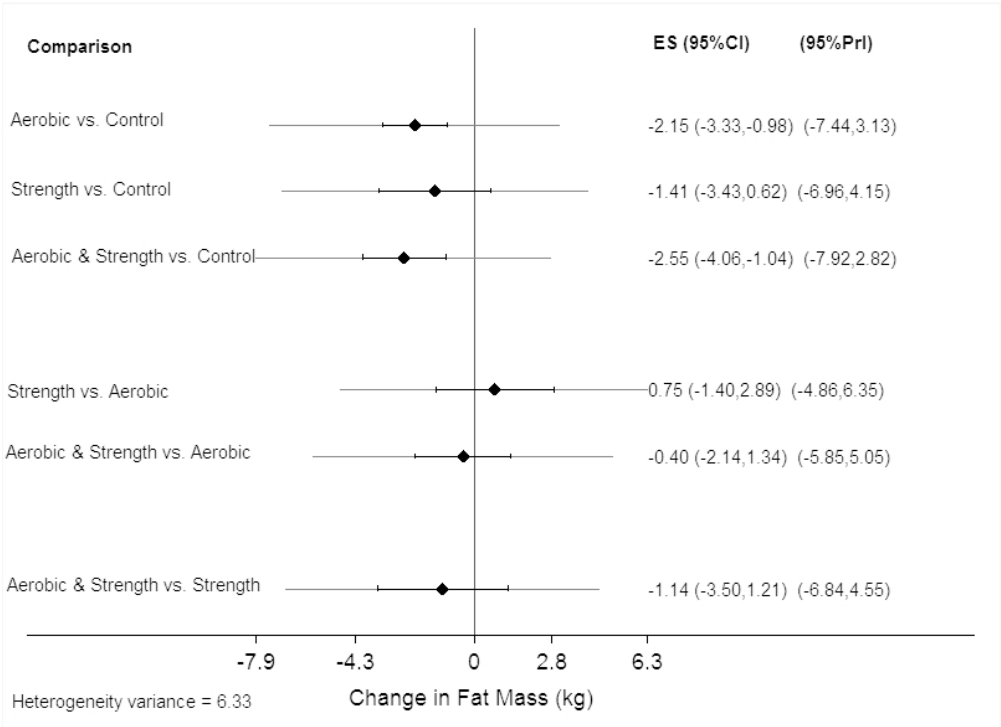
Interval plot for changes in BMI in kg.m2. Interval plot for changes in in BMI kg.m2 based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 35/1533 (aerobic vs. control), 8/331 (strength versus control), 11/426 (combined aerobic and strength versus control), 7/232 (strength versus aerobic), 4/175 (combined aerobic and strength versus aerobic), 2/121 (combined aerobic and strength versus strength).

108x78mm (300 x 300 DPI)



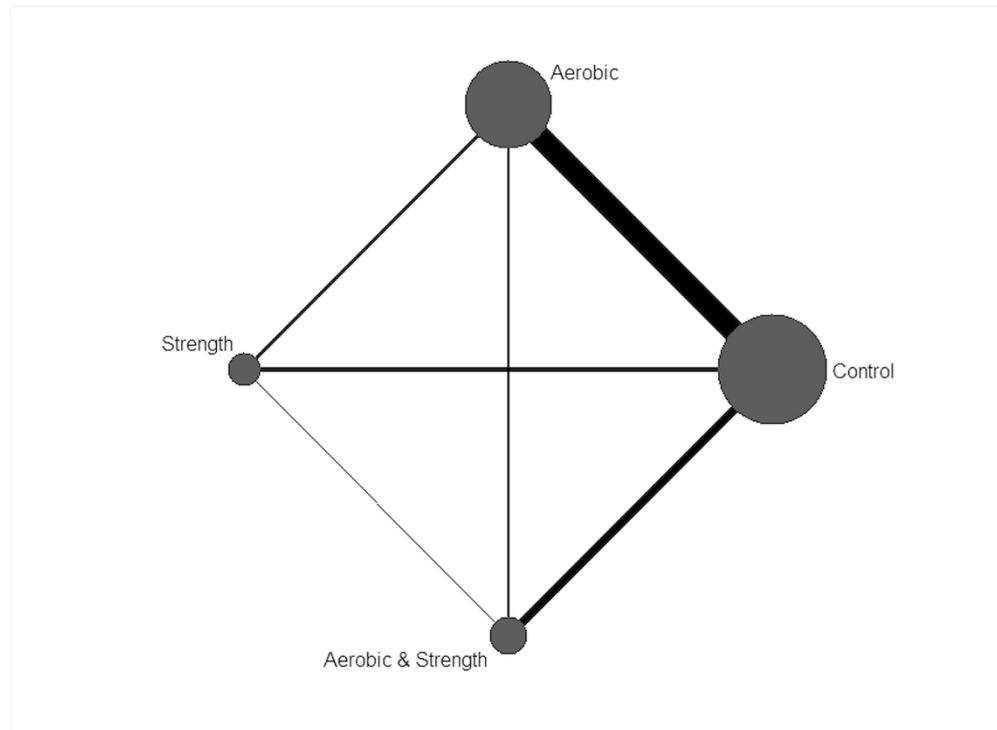
Network plot for fat mass (kg). Network plot for study comparisons included in the fat mass network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

173x126mm (300 x 300 DPI)



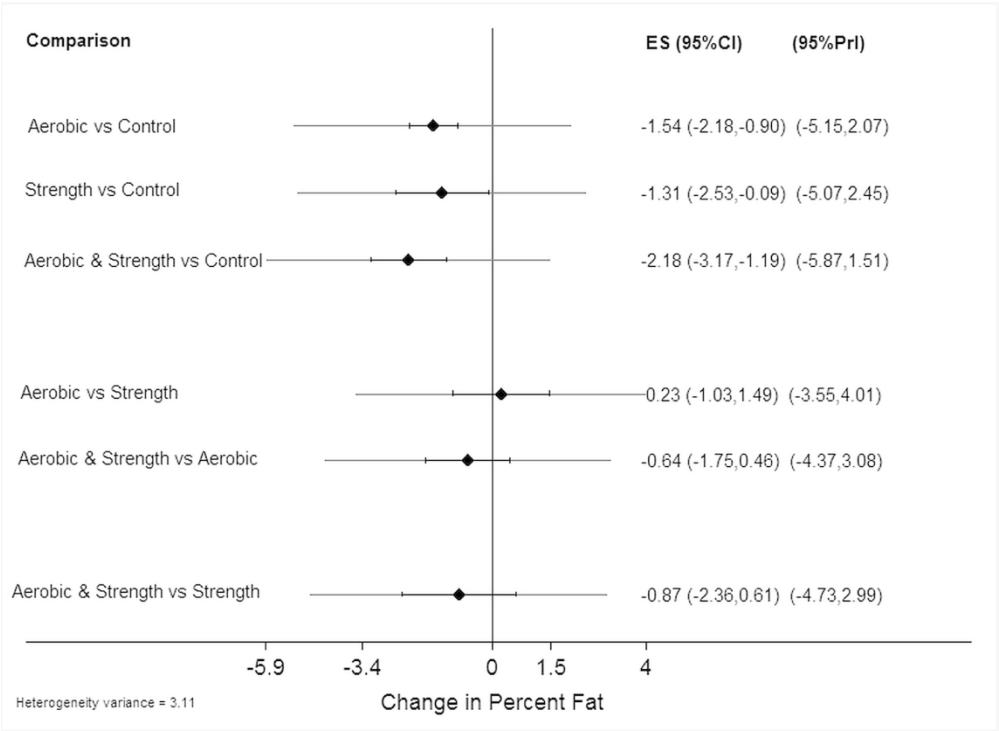
Interval plot for changes in fat mass (kg). Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 19/945 (aerobic vs. control), 7/271 (strength versus control), 10/376 (combined aerobic and strength versus control), 4/167 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

68x49mm (300 x 300 DPI)



Network plot for percent body fat. Network plot for study comparisons included in the percent body fat network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

173x126mm (300 x 300 DPI)



Interval plot for changes in percent body fat. Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 32/1602 (aerobic vs. control), 8/327 (strength versus control), 12/480 (combined aerobic and strength versus control), 6/201 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

173x126mm (300 x 300 DPI)

Supplementary file 1. PubMed search.

(exercise OR physical activity OR physical fitness OR strength training OR weight training) AND (children OR adolescen\* OR boys OR girls) AND (overweight OR obes\*) AND random\* AND ( "1973/01/01"[125] : "2018/08/22"[125] ) AND Humans[Mesh] AND (infant[MeSH] OR child[MeSH] OR adolescent[MeSH])

For peer review only



Supplementary file 2. Planned covariates to examine.

Characteristics	Variable
Study	Publication year, impact factor of journal, country study conducted, type of control group, bias (sequence generation, allocation concealment, blinding of participants & personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting), type of analysis, funding
Participant	Age, gender, race/ethnicity, maturational stage
Exercise	Type (aerobic, strength, both), length, frequency, intensity, duration, total minutes, total minutes (adjusted for compliance), mode, compliance, exercise supervision, setting, number of sets, number of repetitions, rest between sets, number of exercises, type of resistance, equipment used, fidelity (design, training, delivery, receipt, enactment)
Outcome	Baseline values for primary outcomes (BMI in kg·m <sup>2</sup> , fat mass, percent fat), method used to assess adiposity, i.e., instrumentation

Supplementary file 3. Reference list of excluded studies, including the reasons for exclusion.

1. Notation of Additional Studies. *J Teach Phys Educ*. 1986;6(1):78-89. inappropriate study design
2. Fitness Can and Should Be Fun. *Journal of Sport Psychology*. 1987;9(2):87-88. inappropriate study design
3. Obesity and Cardiovascular Disease Risk Factors in Black and White Girls: The NHLB Growth and Health Study. *American journal of public health*. 1992;82(12):1613-1620. inappropriate study design
4. Health Related Fitness and Blood Pressure in Boys and Girls Ages 10 to 17 Years. *Pediatric exercise science*. 1992;4(2):128-135. inappropriate study design
5. Caltrac Validity for Estimating Caloric Expenditure With Children. *Pediatric exercise science*. 1992;4(2):166-179. inappropriate study design
6. Research Digest. *Pediatric exercise science*. 1992;4(1):5-9. inappropriate study design
7. Program schedule. *American journal of public health*. 1994;84(8):P-7. inappropriate outcomes
8. Two-Year Follow-Up on the Impact of Physical Fitness and Body Fatness on Children's Heart Growth and Rising Blood Pressure: The Muscatine Study. *Pediatric exercise science*. 1995;7(4):364-378. inappropriate study design
9. Children's Ratings of Effort During Cycle Ergometry: An Examination of the Validity of Two Effort Rating Scales. *Pediatric exercise science*. 1995;7(4):407-421. inappropriate outcomes
10. Program Schedule. *American journal of public health*. 1995;85(8):P-9-P-143. inappropriate outcomes
11. Bone Mineral and Muscle Strength Characteristics in Children With Turner Syndrome. *Pediatric exercise science*. 1995;7(1):80-93. inappropriate study design
12. Implementation of treatment protocols in the Diabetes Control and Complications Trial. *Diabetes care*. 1995;18(3):361-376. <http://onlinelibrary.wiley.com/doi/10.2332/CN-00118332/frame.html>. inappropriate intervention
13. Is There a Scientific Rationale Supporting the Value of Exercise for the Present and Future Cardiovascular Health of Children? The Pro Argument. *Pediatric exercise science*. 1996;8(4):294-302. inappropriate study design
14. Exercise Regulation During Cycle Ergometry Using the Children's Effort Rating Table (CERT) and Rating of Perceived Exertion (RPE) Scales. *Pediatric exercise science*. 1996;8(4):337-350. inappropriate outcomes
15. Program Schedule. *American journal of public health*. 1996;86(8):P-9-P-176. inappropriate study design
16. Physical Activity, Fitness, and Adiposity of Prepubertal Girls. *Pediatric exercise science*. 1996;8(3):259-267. inappropriate study design
17. Validity and Reliability of the 1/2-Mile Run-Walk as an Indicator of Aerobic Fitness in Children With Mental Retardation. *Pediatric exercise science*. 1996;8(2):130-142. inappropriate outcomes

18. Response to Resistance Training in Pediatric Wheelchair Users. *Pediatric exercise science*. 1996;8(1):6-14. inappropriate study design

19. Conference Proceedings. *Canadian Journal of Applied Physiology*. 1997;22:1P-66P. other

20. Of interest from the journals. *Australian Journal of Nutrition & Dietetics*. 1998;55(4):178-193. other

21. PART IV: PHYSIOLOGY. *Journal of sports sciences*. 1998;16(1):31-68. other

22. PART V: PSYCHOLOGY. *Journal of sports sciences*. 1998;16(1):68-110. other

23. 3rd Baltic bone and cartilage conference. *Acta Orthopaedica Scandinavica*. 1999;70:1. other

24. Of interest from the journals. *Australian Journal of Nutrition & Dietetics*. 2000;57(4):247-247. other

25. Body Attitude, Gender, and Self-Concept: A 30-Year Perspective. *Journal of Psychology*. 2001;135(4):413. inappropriate population

26. Carbohydrate advantage-going the distance in weight management Proceedings of the Kellogg's Nutrition Symposium 2000 Sydney. 8 August 2000. *Australian Journal of Nutrition & Dietetics*. 2001;58(1):S2-S32. other

27. Of interest from the journals. *Nutrition & Dietetics*. 2002;59(4):270-272. other

28. Policy Statements Adopted by the Governing Council of the American Public Health Association, October 24, 2001. *American journal of public health*. 2002;92(3):451-483. other

29. Of interest from the journals. *Nutrition & Dietetics*. 2003;60(3):218. other

30. PART III: KINANTHROPOMETRY. *Journal of sports sciences*. 2003;21(4):293. other

31. Position of the American Dietetic Association, Society for Nutrition Education, and American School Food Service Association: Nutrition Services: An Essential Component of Comprehensive School Health Programs. *Journal of Nutrition Education & Behavior*. 2003;35(2):57. other

32. Using skinfold calipers while teaching body fatness-related concepts: cognitive and affective outcomes. *Journal of science and medicine in sport / Sports Medicine Australia*. 2003. inappropriate outcomes

33. Thursday 12th August 2004. *International Journal of Psychology*. 2004;39(5/6):346-472. inappropriate study design

34. Other Publications. *Pediatric exercise science*. 2004;16(3):296-297. other

35. Abstracts for the International Society for Aging and Physical Activity's 6th World Congress on Aging and Physical Activity: From Research to Action for an Aging Society London, Ontario, Canada, August 3-7, 2004. *Journal of Aging & Physical Activity*. 2004;12(3):246-460. inappropriate study design

36. FREE COMMUNICATIONS. *Journal of sport & exercise psychology*. 2004;26:S25-S206. other

37. Use of air displacement plethysmography in the determination of percentage of fat mass in african american children. *Pediatric research*. 2004. inappropriate study design

38. ABSTRACTS. *Canadian Journal of Applied Physiology*. 2005;30:3-S88. inappropriate study design

39. DataBase Citations Chart. *Am J Health Promot*. 2005;19(6):450-452. other

40. Research Digest. *Pediatric exercise science*. 2005;17(2):201. inappropriate outcomes
41. The following abstracts were presented at the biennial meeting of the North American Society for Pediatric Exercise Medicine, held in St. Andrews, New Brunswick, August 13-16, 2004. *Pediatric exercise science*. 2005;17(1):72. inappropriate study design
42. Efficacy of an internet-based behavioral weight loss program for overweight adolescent African-American girls. *Eating and weight disorders : EWD*. 2005. inappropriate intervention
43. Position of the American Dietetic Association: individual-, family-, school-, and community-based interventions for pediatric overweight. *Journal of the American Dietetic Association*. 2006;106(6):925-945. inappropriate study design
44. Abstracts. *Am J Health Promot*. 2006;21(2):141-144. inappropriate study design
45. Determinants of Physical Activity in an Inclusive Setting. *Adapted Physical Activity Quarterly*. 2006;23(4):390-409. inappropriate study design
46. Abstracts of the 85th Scientific Meeting of the Society for the Study of Human Biology held at University of Westminster, London, 11 May 2006. *Annals of human biology*. 2006;33(5/6):651-661. inappropriate study design
47. Real Men Do Not Read Labels: The Effects of Masculinity and Involvement on College Students' Food Decisions. *Journal of American College Health*. 2006;55(2):91-98. inappropriate study design
48. Weightlifting may help overweight teens reduce risk of diabetes. *O&P Business News*. 2006;15(17):57-57. inappropriate study design
49. Smaller bowls and spoons may curb consumption. *O&P Business News*. 2006;15(17):57-58. inappropriate outcomes
50. Secular Changes in Anaerobic Test Performance in Australasian Children and Adolescents. *Pediatric exercise science*. 2006;18(3):314-328. inappropriate study design
51. Secular Changes in Shuttle-Run Performance: A 23-Year Retrospective Comparison of 9- to 11-Year-Old Children. *Pediatric exercise science*. 2006;18(3):364-373. inappropriate study design
52. Poster Session Abstracts. *Psychophysiology*. 2006;43:S20-S110. inappropriate study design
53. RETRIEVAL AND REVIEW. *J Teach Phys Educ*. 2006;25(3):329-340. other
54. Abstracts of the Canadian Society for Clinical Nutrition's 5th Annual Scientific Meeting with guest societies the Canadian Society for Nutritional Sciences and the Canadian Society for Exercise Physiology / Résumés de la 5e assemblée annuelle de la Société Canadienne de Nutrition Clinique avec les sociétés invitées La Société Canadienne de Sciences de la Nutrition et La Société Canadienne de Physiologie de l'Exercice. *Applied Physiology, Nutrition & Metabolism*. 2006;31(3):331-365. inappropriate study design
55. Speaker Abstracts. *Isokinetics & Exercise Science*. 2006;14(2):111-152. inappropriate study design
56. APAC ACTION: New Executive Director. *Palaestra*. 2006;22(3):8-9. other
57. ECAS 2006 Abstracts and Program. European Cardiac Arrhythmia Society 2nd Annual Congress, April 2-4, 2006, Palais des Congrès, Parc Chanot Marseille,

- France. *Pacing & Clinical Electrophysiology*. 2006;29:S1-S103. inappropriate study design
58. Abstracts – Oral Presentations. *Nutrition & Dietetics*. 2006;63:A1-A24. inappropriate study design
59. Abstracts – Poster Presentations. *Nutrition & Dietetics*. 2006;63:A25-A56. inappropriate study design
60. DIGEST. *Adapted Physical Activity Quarterly*. 2006;23(1):98-101. other
61. Effective dietary interventions for overweight and obese children. *Australian nursing journal (July 1993)*. 2007;14(11):31-34. inappropriate intervention
62. Proceedings of the 2(nd) International Symposia on Lifestyle-related Disease Perspective for Primary Prevention and Treatment in Animal Models and Humans, 21--22 October 2006, Nishinomiya, Japan. *Clinical & Experimental Pharmacology & Physiology*. 2007;34:S1-S97. other
63. Abstracts of the 86th Scientific Meeting of the Society for the Study of Human Biology held at University of Oxford, 31 May 2007. *Annals of human biology*. 2007;34(6):684-696. inappropriate study design
64. THE DIGEST. *Journal of sport & exercise psychology*. 2007;29(5):673-680. inappropriate study design
65. 2007 CSEP Annual Scientific Conference / 2007 Conférence Scientifique Annuel de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2007;32:S1-S98. other
66. Abstracts. *Nutrition & Dietetics*. 2007;64:S77-S97. inappropriate study design
67. Annual conference of the british association of sport and exercise sciences. *Journal of sports sciences*. 2007;25(3):235-369. inappropriate study design
68. Stress reactivity and adiposity of youth. *Obesity*. 2007. inappropriate outcomes
69. Contents / Sommaire. *Applied Physiology, Nutrition & Metabolism*. 2008;33(6):C-1-C-9. other
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72. Abstracts of the Canadian Society for Clinical Nutrition's 7th Annual Scientific Meeting: The Road to Excellence in Canadian Nutrition / Résumés de la 7e rencontre scientifique annuelle intitulée « The Road to Excellence in Canadian Nutrition » de la Société canadienne de nutrition clinique. *Applied Physiology, Nutrition & Metabolism*. 2008;33(3):603-640. inappropriate study design
73. Oral program. *Nutrition & Dietetics*. 2008;65:A1-A24. inappropriate study design
74. Posters. *Nutrition & Dietetics*. 2008;65:A25-A48. inappropriate study design
75. APPM MEETING ABSTRACTS. *Pain Medicine*. 2008;9(1):88-141. inappropriate study design
76. Promoting physical activity in middle school girls: Trial of Activity for Adolescent Girls. *American journal of preventive medicine*. 2008. inappropriate population
77. Effects of a classroom-based weight-control intervention on cardiovascular disease in elementary-school obese children. *Acta paediatrica Taiwanica = Taiwan er ke yi xue hui za zhi*. 2008. inappropriate intervention
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81. Illness and Medical Bills Linked to Nearly Two-Thirds of All Bankruptcies. *O&P Business News*. 2009;19(18):62-63. other
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87. Socio-economic differentiation of the growth and the dietary intake of Polish boys aged 7-16 years. *Annals of human biology*. 2009;36(2):199-210. inappropriate study design
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94. The effect of a physical activity intervention on bias in self-reported activity. *Annals of epidemiology*. 2009. inappropriate study design
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98. Türkiye'de Medulla Spinalis Yaralanması Rehabilitasyonunun Tarihçesi. / The Short History of Spinal Cord Injury Rehabilitation in Turkey. *Turkish Journal of Physical Medicine & Rehabilitation / Türkiye Fiziksel Tıp ve Rehabilitasyon Dergisi*. 2010;56:59-63. other
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  106. Oral presentations (In alphabetical order by first author). *Psychology & health*. 2010;25:15-100. inappropriate study design
  107. Symposia (In alphabetical order by convenor). *Psychology & health*. 2010;25:101-131. inappropriate study design
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  109. Dr. Karola Messner Foundation. *Scandinavian journal of medicine & science in sports*. 2010;20(4):706-707. other
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  119. Abstracts. *Drug & Alcohol Review*. 2011;30:2-92. inappropriate study design
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  123. B. Interactive poster presentations. *Psychology & health*. 2011;26:73-253. inappropriate study design
  124. D. Symposium. *Psychology & health*. 2011;26:281-338. inappropriate study design
  125. Poster Session Abstracts. *Psychophysiology*. 2011;48(S1):S21-S119. inappropriate study design
  126. Poster und Freie Mitteilungen. *Schweizerische Zeitschrift für Sportmedizin & Sporttraumatologie*. 2011;2011(3):137-140. inappropriate study design
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135. The 'Healthy Dads, Healthy Kids' randomized controlled trial: efficacy of a healthy lifestyle program for overweight fathers and their children. *EvidenceUpdates*. 2011. inappropriate intervention
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137. Pilot evaluation of the HELENA (Healthy Lifestyle in Europe by Nutrition in Adolescence) Food-O-Meter, a computer-tailored nutrition advice for adolescents: a study in six European cities. *Public health nutrition*. 2011. inappropriate intervention
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142. Abstracts of XVIIth FINA World Sports Medicine Congress. *Journal of Sports Science & Medicine*. 2012;11(4):775-791. inappropriate study design
143. Beverage patterns among Canadian children and relationship to overweight and obesity. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):900-906. inappropriate study design
144. Discussion of 'Overweight and obese boys reduce food intake in response to a glucose drink but fail to increase intake in response to exercise of short duration'. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):1014-1015. inappropriate study design
145. Reply to the discussion of 'Overweight and obese boys reduce food intake in response to a glucose drink but fail to increase intake in response to exercise of short duration'. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):1016-1017. inappropriate study design
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147. Conference Day 1 - Wednesday 5 September 2012. *Nutrition & Dietetics*. 2012;69:2-20. inappropriate study design
148. Conference Day 2 - Thursday 6 September 2012. *Nutrition & Dietetics*. 2012;69:20-47. inappropriate study design
149. Conference Day 3 - Friday 7 September 2012. *Nutrition & Dietetics*. 2012;69:47-

70. inappropriate study design
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151. Poster Session Abstracts. *Psychophysiology*. 2012;49(S1):S24-S121. inappropriate study design
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156. Posters. *Knee Surgery, Sports Traumatology, Arthroscopy*. 2012;20:101-370. inappropriate study design
157. Effect of betaine supplementation on cycling sprint performance. *Journal of the International Society of Sports Nutrition*. 2012;9(1):12-18. inappropriate intervention
158. Impact of a nurse-directed, coordinated school health program to enhance physical activity behaviors and reduce body mass index among minority children: A parallel-group, randomized control trial. *EvidenceUpdates*. 2012. inappropriate intervention
159. Physical activity advertisements that feature daily well-being improve autonomy and body image in overweight women but not men. *Journal of obesity*. 2012. inappropriate population
160. Pilot intervention to increase physical activity among sedentary urban middle school girls: a two-group pretest-posttest quasi-experimental design. *The Journal of school nursing : the official publication of the National Association of School Nurses*. 2012. inappropriate study design
161. Shifts in BMI category and associated cardiometabolic risk: prospective results from HEALTHY study. *Pediatrics*. 2012. inappropriate intervention
162. Identification of facilitators and barriers to participation in weight gain prevention research by African American girls. *Contemporary clinical trials*. 2012. inappropriate study design
163. A cross-sectional and longitudinal study of travel by walking before and after school among eighth-grade girls. *The Journal of adolescent health : official publication of the Society for Adolescent Medicine*. 2012. inappropriate study design
164. The Effectiveness of School-Based Nutritional Education Program among Obese Adolescents: A Randomized Controlled Study. *International journal of pediatrics*. 2012. inappropriate intervention
165. Abstracts. *Drug & Alcohol Review*. 2013;32:2-74. inappropriate study design
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- Meeting - Extreme Human Physiology: From Pathology to Performance / Compte rendu du congrès annuel de la Société canadienne de physiologie de l'exercice - « Extreme Human Physiology: From Pathology to Performance ». *Applied Physiology, Nutrition & Metabolism*. 2013;38(10):1003-1091. inappropriate study design
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  168. A Comparison of Body Image Perceptions for Female Competitive Dancers, Fitness Cohort, and Non-Dancers in a College Population. *Sport Journal*. 2013;1-1. inappropriate population
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  170. Abstracts of the 2013 CSEP General Meeting / Résumés de la 2012 Congrès annuelle de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2013;38(4):433-476. inappropriate study design
  171. AAPM 2013 Annual Meeting Abstracts. *Pain Medicine*. 2013;14(4):557-612. inappropriate study design
  172. Full Issue PDF, Volume 84, Supplement 1. *Research Quarterly for Exercise & Sport*. 2013;84:A-i-A-98. inappropriate study design
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  174. A randomised placebo-exercise controlled trial of Kung Fu training for improvements in body composition in overweight/obese adolescents: the "Martial Fitness" study. *Journal of sports science & medicine*. 2013. inappropriate comparison group
  175. Effect of Hibiscus sabdariffa Calices on Dyslipidemia in Obese Adolescents: A Triple-masked Randomized Controlled Trial. *Materia socio-medica*. 2013. inappropriate intervention
  176. Prevalence of glucose intolerance among children and adolescents in urban South India (ORANGE-2). *Diabetes technology & therapeutics*. 2013. inappropriate study design
  177. BASES Conference 2014. *Journal of sports sciences*. 2014;32:s4-s100. inappropriate study design
  178. Effect of Mental Training on the Performance of College Age Distance Runners. *Sport Journal*. 2014:1-1. inappropriate population
  179. Orals. *Acta Physiologica*. 2014;212:21-46. inappropriate study design
  180. Poster Session Abstracts. *Psychophysiology*. 2014;51:S14-S79. inappropriate study design
  181. Abstracts from the ICBM 2014 Meeting. *International journal of behavioral medicine*. 2014;21:1-216. inappropriate study design
  182. Posters. *Knee Surgery, Sports Traumatology, Arthroscopy*. 2014;22:110-406. inappropriate study design

183. Posters in alphabetical order by first author. *Nutrition & Dietetics*. 2014;71:33-67. inappropriate study design
184. Canadian Nutrition Society: Scientific Abstracts from the 5th Annual Scientific Meeting / Société canadienne de nutrition : Résumés scientifiques de la 5e réunion scientifique annuelle. *Applied Physiology, Nutrition & Metabolism*. 2014;39(5):605-642. inappropriate study design
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187. Full Issue PDF, Volume 85, Supplement 1. *Research Quarterly for Exercise & Sport*. 2014;85:A-i-A-168. inappropriate study design
188. Short-term Effects of a Physical Activity Intervention on Obesity and Cardiovascular Fitness of 12-14-year-old Boy Students. *International journal of preventive medicine*. 2014. inappropriate population
189. Paternal Lifestyle-Related Parenting Practices Mediate Changes in Children's Dietary and Physical Activity Behaviors: Findings From the Healthy Dads, Healthy Kids Community Randomized Controlled Trial. *Journal of physical activity & health*. 2014. inappropriate intervention
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197. Concurrent session papers (in program order). *Nutrition & Dietetics*. 2015;72:3-33. inappropriate study design
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201. Drivers of overweight mothers' food choice behaviors depend on child gender. *Appetite*. 2015. other
202. Feasibility and Preliminary Efficacy of the M.A.D.E (Mothers And Daughters Exercising) 4 Life Program: A Pilot Randomized Controlled Trial. *Journal of physical activity & health*. 2015. inappropriate population
203. Health markers in obese adolescents improved by a 12-week recreational soccer program: a randomised controlled trial. *Journal of sports sciences*. 2015. inappropriate population
204. The effectiveness of a high-intensity games intervention on improving indices of health in young children. *Journal of sports sciences*. 2015. inappropriate population
205. Impact of Baltimore healthy eating zones: an environmental intervention to improve diet among african american youth. *Health Educ Behav*. 2015. inappropriate outcomes
206. 2016 North American Society for Pediatric Exercise Medicine (NASPEM) Biennial Meeting, Knoxville, Tennessee. *Pediatric exercise science*. 2016;28:2-55. inappropriate study design
207. Development. *International Journal of Psychology*. 2016;51:356-406. inappropriate study design
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209. Health Psychology. *International Journal of Psychology*. 2016;51:658-712. inappropriate study design
210. Personality. *International Journal of Psychology*. 2016;51:892-915. inappropriate study design
211. Sport and Exercise Psychology. *International Journal of Psychology*. 2016;51:1107-1116. inappropriate study design
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Supplementary file 4. Study characteristics.

Study	Year	Country	N	Age (yrs)	Sex
				( $\bar{X} \pm SD$ ) or Range	
Ackel-D'Elia et al.*	2014	Brazil	AE = 24	AE, AE+ST = 16.5 $\pm$ 1.5	MF
			AE+ST = 24		
Alberga et al.	2013	Canada	AE+ST = 12	AE+ST = 10.0 $\pm$ 1.0	MF
			CON = 7	CON = 10.0 $\pm$ 2.0	
Alves et al.	2008	Brazil	AE = 39	AE = 8.0 $\pm$ 1.8	MF
			CON = 39	CON = 7.9 $\pm$ 1.5	
Andre & Beguier	2015	France	AE = 8	AE, CON 14.4 $\pm$ 1.5	MF
			CON = 8		
Ben Ounis et al.	2010	Tunisia	AE = 16	AE = 13.4 $\pm$ 0.4	MF
			CON = 16	CON = 13.2 $\pm$ 0.6	
Berntsen et al.	2010	Norway	ST = 32	ST, CON = 12.1	MF
			CON = 16		
Cao et al.	2012	China	AE = 20	AE = NA	M
			CON = 20	CON = NA	
Chang et al.	2008	China	AE+ST = 25	AE+ST = 12.6 $\pm$ 0.8	MF
			CON = 24	CON = 12.2 $\pm$ 0.1	

Chen et al.	2015	China	AE = 15	AE = $14.1 \pm 3.1$	NA
			ST = 15	ST = $13.9 \pm 2.2$	
			AE+ST = 15	AE+ST = $14.2 \pm 3.8$	
			CON = 15	CON = $14.4 \pm 3.2$	
Chen et al.	2016	Taiwan	AE = 25	AE = $12.6 \pm 0.7$	MF
			CON = 25	CON = $12.8 \pm 0.8$	
Cheng et al.	2012	China	AE+ST = 30	AE+ST, CON = 13.0 to 14.0	M
			CON = 30		
Davis et al.	2012	US	AE (LD) = 71	AE (LD) = $9.3 \pm 0.9$	MF
			AE (HD) = 73	AE (HD) = $9.4 \pm 1.2$	
			CON = 78	CON = $9.4 \pm 1.1$	
Elloumi et al.	2011	Tunisia	AE = 7	AE = $13.1 \pm 1.0$	M
			CON = 8	CON = $13.2 \pm 0.2$	
Farpour-Lambert et al.	2009	Switzerland	AE+ST = 22	AE+ST = $9.1 \pm 1.4$	MF
			CON = 22	CON = $8.8 \pm 1.6$	
Fazelifar et al.	2013	Iran	AE+ST = 12	AE+ST, CON = 11-13	M
			CON = 12		
Fiorilli et al.	2017	Italy	AE = 12	AE, ST(MI), ST(HI) = 12-15	MF
			ST(MI) = 15		

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			ST(HI) = 14		
Ghorbanian et al.	2013	Iran	AE = 15	AE = 17.4 ± 1.1	M
			CON = 15	CON = 16.9 ± 1.2	
Gutin et al.	1997	US	AE = 17	AE = 9.6 ± 0.8	MF
			CON = 18	CON = 9.5 ± 1.3	
Hagstromer et al.	2009	Sweden	AE+ST = 16	AE+ST = 13.7 ± 2.0	MF
			CON = 15	CON = 13.6 ± 2.2	
Hay et al.	2016	Canada	AE(MI) = 32	AE(MI) = 15.1 ± 1.8	MF
			AE(HI) = 38	AE(HI) = 15.3 ± 1.7	
			CON = 33	CON = 15.2 ± 1.7	
Karacabey	2009	Turkey	AE = 20	AE = 11.8 ± 0.5	M
			CON = 20	CON = 11.2 ± 0.2	
Kelly et al.	2004	US	AE = 10	AE = 11.0 ± 2.0	MF
			CON = 10	CON = 11.0 ± 2.3	
Kelly et al.	2015	US	ST = 13	ST = 15.2 ± 0.9	MF
			CON = 13	CON = 15.5 ± 0.9	
Kim et al.	2007	SK	AE = 14	AE = 17 ± 0.4	M
			CON = 12	CON = 17.0 ± 0.4	
Kim et al.	2008	SK	AE+ST = 8	AE+ST, CON = NA	M



				CON = 9		
	Lau et al.	2015	China	AE(LI) = 21	AE(LI) = $9.9 \pm 0.9$	MF
				AE(HI) = 15	AE(HI) = $11.0 \pm 0.6$	
				CON = 12	CON = $10.6 \pm 0.6$	
	Lee et al.	2012	US	AE = 16	AE = $15.2 \pm 0.9$	M
				ST = 16	ST = $14.6 \pm 1.5$	
				CON = 13	CON = $14.8 \pm 1.4$	
	Lee et al.	2013	US	AE = 16	AE = $14.6 \pm 1.9$	F
				ST = 16	ST = $14.8 \pm 1.9$	
				CON = 12	CON = $15.0 \pm 2.2$	
	Li et al.	2014	China	AE = 20	AE = $15.4 \pm 2.6$	M
				CON = 20	CON = $14.6 \pm 3.5$	
	Maddison et al.	2011	NZ	AE = 160	AE, CON = $11.6 \pm 1.1$	MF
				CON = 162		
	McNarry et al.	2015	UK	AE = 15	AE, CON = $9.3 \pm 0.9$	MF
				CON = 11		
	Meyer et al.	2006	Germany	AE = 33	AE = $13.7 \pm 2.1$	MF
				CON = 34	CON = $14.1 \pm 2.4$	
	Monteiro et al.	2015	Brazil	AE = 11	AE = $11.0 \pm 1.0$	MF

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				AE+ST = 14	AE+ST = 11.0 ± 1.3	
Murphy et al.	2009	US		AE = 23	AE = 10.3 ± 1.9	MF
				CON = 12	CON = 10.0 ± 1.3	
Nobre et al.	2017	Brazil		AE = 40	AE = 9.8 ± 5.7	M
				CON = 19	CON = 9.9 ± 4.8	
Owens et al.	1999	US		AE = 35	AE = 9.5 ± 1.2	MF
				CON = 39	CON = 9.4 ± 1.3	
Park et al.	2012	SK		AE+ST = 15	AE+ST = 12.1 ± 0.4	MF
				CON = 14	CON = 12.2 ± 0.4	
Racil et al.	2013	Tunisia		AE(MI) = 11	AE(MI) = 16.3 ± 0.5	F
				AE(HI) = 11	AE(HI) = 15.6 ± 0.7	
				CON = 12	CON = 15.9 ± 1.2	
Racil et al.	2016	Tunisia		AE = 23	AE = 16.6 ± 0.9	F
				AE+ST = 26	AE+ST = 16.5 ± 1.2	
				CON = 19	CON = 16.9 ± 1.0	
Rooney et al.	2005	US		AE = 26	AE = 8.9 ± 2.2	MF
				CON = 33	CON = 8.6 ± 2.1	
Saygin & Ozturk	2011	Turkey		AE = 20	AE, CON = 10.0 to 12.0	F

				CON = 19		
	Schranz et al.	2014	Australia	ST = 26	ST = 14.9 $\pm$ 1.4	M
				CON = 23	CON = 15.1 $\pm$ 1.6	
	Seo et al.	2012	SK	AE = 10	AE = 14.7 $\pm$ 1.5	M
				CON = 10	CON = 14.6 $\pm$ 3.0	
	Shaibi et al.	2006	US	ST = 11	ST = 15.1 $\pm$ 1.7	M
				CON = 11	CON = 15.6 $\pm$ 1.7	
	Sigal et al.	2014	Canada	AE = 75	AE = 15.5 $\pm$ 1.4	MF
				ST = 78	ST = 15.9 $\pm$ 1.5	
				AE+ST = 75	AE+ST = 15.5 $\pm$ 1.3	
				CON = 76	CON = 15.6 $\pm$ 1.3	
	Silva et al.	2012	Brazil	AE = 9	AE, CON = 13 to 17 yrs	MF
				CON = 5		
	Song et al.	2012	SK	AE = 12	AE = 12.7 $\pm$ 0.7	M
				CON = 10	CON = 12.6 $\pm$ 0.6	
	Staiano et al.	2017	US	AE = 20	AE = 15.3 $\pm$ 1.2	F
				CON = 18	CON = 16.1 $\pm$ 1.4	
	Sun et al.	2011	China	AE = 25	AE, CON 13.6 $\pm$ 0.7	MF
				CON = 17		

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Tan et al.	2010	China	AE = 30	AE = 9.4 ± 0.5	MF
			CON = 30	CON = 9.5 ± 0.5	
Vasconcellos et al.	2016	Brazil	AE = 10	AE = 14.1 ± 1.3	MF
			CON = 10	CON = 14.8 ± 1.5	
Watts et al.	2004	Australia	AE+ST = 19	AE+ST, CON = 14.3 ± 1.5	MF
			CON = 19		
Watts et al.	2004	Australia	AE = 14	AE, CON = 8.9 ± 1.6	MF
			CON = 14		
Weintraub et al.	2008	US	AE = 9	AE = 9.5 ± 0.6	MF
			CON = 12	CON = 10.3 ± 0.8	
Wong et al.	2008	Singapore	AE+ST = 12	AE+ST = 13.8 ± 1.1	M
			CON = 12	CON = 14.3 ± 1.5	
Youssef et al.	2015	Lebanon	AE = 14	AE = 16.1 ± 1.1	F
			CON = 9	CON = 16.3 ± 1.5	
Zehsaz et al.	2017	Iran	AE = 16	AE = 10.8 ± 0.9	M
			CON = 16	CON = 10.3 ± 0.9	

Notes: US, United States; SK, South Korea; NZ, New Zealand; UK, United Kingdom; N, number of participants; yrs, years; AE, aerobic exercise, LPA, leisure physical activity; ST, strength training; CON, control;  $\bar{X} \pm SD$ , mean ± standard deviation; LI, lower intensity; MI, moderate-intensity; HI, high-intensity; M, males; F, females; NA, not available; LD, low-dose; HD, high-dose. \*, study also included a leisure intervention but was excluded because it didn't meet our eligibility criteria.

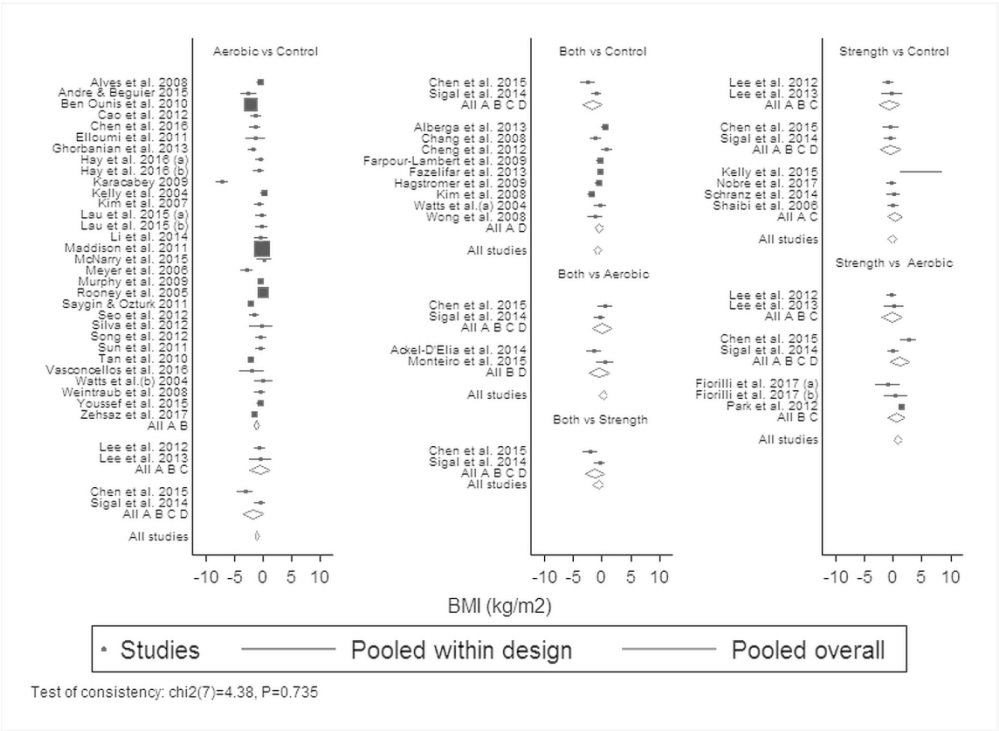


## Supplementary file 5. Study-level risk of bias assessment results.

Study	Random sequence generation	Allocation concealment	Blinding (participants & personnel)	Blinding (outcome assessors)	Incomplete outcome data	Selective reporting	Physically inactive
Ackel-D'Elia et al.*	low	unclear	high	unclear	unclear	low	unclear
Alberga et al.	low	low	high	unclear	high	unclear	unclear
Alves et al.	low	unclear	high	unclear	low	unclear	unclear
Andre & Beguier	low	unclear	high	unclear	unclear	unclear	unclear
Ben Ounis et al.	low	unclear	high	unclear	unclear	unclear	low
Berntsen et al.	low	unclear	high	unclear	low	unclear	unclear
Cao et al.	low	unclear	high	unclear	unclear	unclear	unclear
Chang et al.	high	unclear	high	unclear	unclear	unclear	unclear
Chen et al.	low	unclear	high	unclear	unclear	unclear	unclear
Chen et al.	low	unclear	high	unclear	high	unclear	unclear
Cheng et al.	low	unclear	high	unclear	unclear	unclear	unclear
Davis et al.	low	low	high	high	low	low	low
Elloumi et al.	low	unclear	high	unclear	unclear	unclear	high
Farpour-Lambert et al.	low	low	high	low	low	low	low
Fazelifar et al.	low	unclear	high	unclear	low	unclear	low
Fiorilli et al.	low	unclear	high	unclear	low	unclear	low
Ghorbanian et al.	low	unclear	high	unclear	unclear	unclear	low
Gutin et al.	low	unclear	high	unclear	low	unclear	unclear
Hagstromer et al.	low	unclear	high	unclear	high	low	high
Hay et al.	low	low	high	low	low	low	unclear

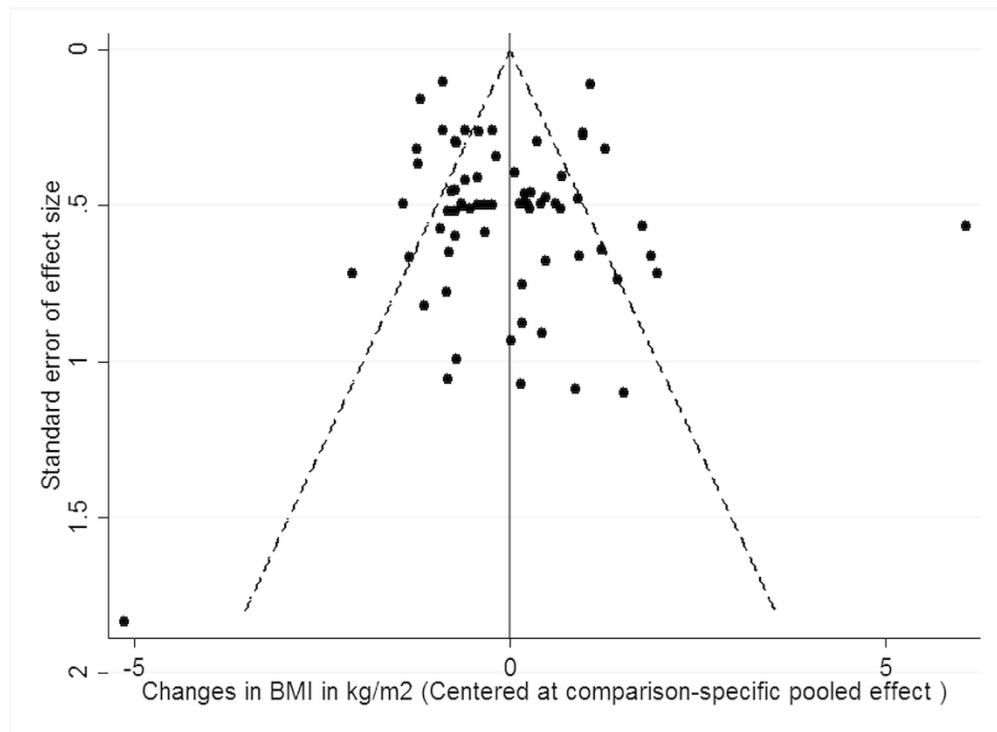
1	Karacabey	low	unclear	high	unclear	unclear	unclear	low
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3	Kelly et al.	low	unclear	high	unclear	unclear	low	unclear
4								
5	Kelly et al.	low	low	high	unclear	low	unclear	unclear
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8	Kim et al.	low	unclear	high	unclear	unclear	unclear	low
9								
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11	Kim et al.	low	unclear	high	unclear	high	unclear	unclear
12								
13								
14	Lau et al.	low	unclear	high	unclear	unclear	unclear	unclear
15								
16	Lee et al.	low	low	high	unclear	low	unclear	low
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19	Lee et al.	low	low	high	unclear	low	unclear	low
20								
21								
22	Li et al.	low	unclear	high	unclear	low	unclear	unclear
23								
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25	Maddison et al.	low	low	high	high	low	low	high
26								
27	McNarry et al.	low	low	high	unclear	unclear	high	unclear
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30	Meyer et al.	low	unclear	high	unclear	high	low	low
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33	Monteiro et al.	low	unclear	high	unclear	unclear	low	unclear
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36	Murphy et al.	low	unclear	high	unclear	unclear	low	unclear
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39	Nobre et al.	low	unclear	high	unclear	unclear	unclear	unclear
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41	Owens et al.	low	unclear	high	unclear	low	unclear	unclear
42								
43								
44	Park et al.	low	unclear	high	unclear	low	low	unclear
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47	Racil et al.	low	unclear	high	unclear	unclear	unclear	low
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50	Racil et al.	low	unclear	high	unclear	unclear	unclear	low
51								
52	Rooney et al.	low	unclear	high	unclear	low	low	unclear
53								
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55	Saygin & Ozturk	low	unclear	high	unclear	unclear	unclear	unclear
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Schranz et al.	low	unclear	high	high	low	low	unclear
Seo et al.	low	unclear	high	unclear	high	unclear	unclear
Shaibi et al.	low	unclear	high	unclear	high	low	unclear
Sigal et al.	low	low	high	unclear	low	unclear	low
Silva et al.	low	unclear	high	unclear	high	unclear	unclear
Song et al.	low	unclear	high	low	high	unclear	low
Staiano et al.	low	low	high	low	low	low	unclear
Sun et al.	low	unclear	high	unclear	low	unclear	unclear
Tan et al.	high	high	high	unclear	low	unclear	unclear
Vasconcellos et al.	low	low	high	low	high	low	low
Watts et al.	low	unclear	high	unclear	unclear	unclear	unclear
Watts et al.	low	unclear	high	unclear	unclear	unclear	unclear
Weintraub et al.	low	unclear	high	high	low	low	unclear
Wong et al.	low	unclear	high	unclear	low	unclear	unclear
Youssef et al.	low	low	high	unclear	unclear	unclear	low
Zehsaz et al.	low	unclear	high	unclear	unclear	unclear	unclear



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Supplementary file 8. Simple meta-regression results for changes in BMI (kg.m²).

Variable	Aerobic			Strength			Both		
	$\beta_1$			$\beta_1$			$\beta_1$		
	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI
<i>Study characteristics</i>									
- Year	0.02±0.56	0.32(.75)	-0.9,0.1	-	-0.06(.95)	-0.3,0.2	-0.02 ± .10	-0.17(.87)	-0.2,0.18
				0.007±0.13					
- Impact factor	0.07±0.09	0.85(.39)	-0.1,0.2	-0.18±0.14	-1.30(.19)	-0.5,0.1	0.001±0.09	0.02(.99)	-1.7,1.7
- Country (other vs USA)	<b>-1.06±0.51</b>	<b>-2.1(.04)*</b>	<b>-2.1,-0.05</b>	-0.36±0.79	0.46(.64)	-1.9,1.2	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.81±0.46	-1.8(.08)	-1.7,0.09	-0.07±0.78	-.08(.93)	-1.6,1.5	-0.69±0.73	-0.95(.34)	-2.1,0.7
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	0.44±1.1	0.42(.68)	-1.6,2.5	ID	ID	ID	ID	ID	ID
-- Unclear	-0.32±0.69	-0.48(.63)	-2.9,2.3	-0.30±1.3	-0.22(.82)	-2.9,2.3	-0.41± 1.2	-0.34(.74)	-2.8,2,0
- Incomplete data (ref = low)									
-- High	-0.93±0.63	-1.5(.14)	-2.2,0.3	0.01±1.3	0.01(.99)	-2.6, 2.6	0.004±0.88	0(1.0)	-1.7,1.7

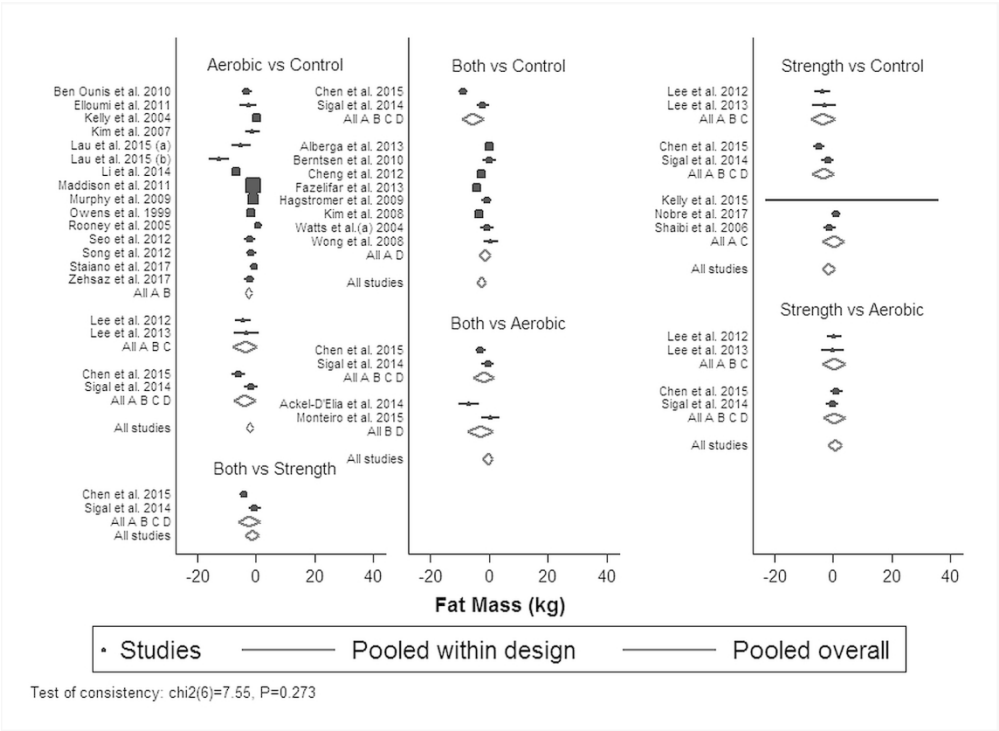
-- Unclear	-0.84±0.44	-1.9(.06)	-1.7,0.03	0.28±0.95	0.29(0.77)	-1.6,2.1	-0.39±0.77	-0.51(.61)	-1.9,1.1
- Selective reporting	-0.58±0.44	-1.3(0.18)	-1.4,0.3	-0.70±0.83	-0.85(0.4)	-2.3,0.9	-0.02±0.73	-0.02(.98)	-1.5,1.4
(unclear vs. low)									
- Inactive (ref = low)									
-- High	1.0±0.93	1.1(0.28)	-0.8,2.8	ID	ID	ID	0.35±1.3	0.27(.78)	-2.2,2.9
-- Unclear	0.81±0.43	1.9(.06)	-0.04,1.7	<b>1.83±0.77</b>	<b>2.4(.02)*</b>	<b>0.3,3.3</b>	0.02±0.73	0.02(.98)	-1.4,1.5
- Funding (yes vs no)	<b>1.06±0.40</b>	<b>2.6(.008)*</b>	<b>0.3,1.8</b>	0.56±0.89	0.63(.53)	-1.2,2.3	-0.09±0.72	-0.13(.90)	-1.5,1.3
- Matching	-0.76±0.64	1.2(.23)	-0.5,2.0	0.39±0.98	0.40(.69)	-1.5,2.3	-0.26±0.80	-0.32(.75)	-1.8,1.3
- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Control type (other vs none)	0.41±0.53	0.76(.44)	-0.6,1.4	-0.82±1.13	-0.72(.47)	-3.5,1.4	-0.81±0.75	-1.07(.28)	-2.3,0.7
- Analysis type (abp vs itt)	-0.51±0.43	-1.2(.22)	-1.3,0.3	0.34±0.78	0.43(.66)	-1.2,1.9	-0.27±0.77	-0.35(.73)	-1.8,0.8
- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (enactment)	-0.22±0.64	-0.35(.73)	-1.5,1.0	-0.10±0.73	-0.13(.90)	1.5,1.3	0.92±0.79	1.2(.24)	-0.6,2.5
(yes vs no)									
<i>Participant characteristics</i>									
- Age (years)	-0.04±0.08	-0.51(.61)	-0.2, 0.1	-0.06±0.23	-0.26(.79)	-0.5,0.4	-0.20±0.17	-1.2(.23)	-0.5,0.1

- Gender (females vs males)	-0.51±0.98	0.52(.60)	-1.4,2.4	-0.55±1.6	-0.34(.74)	-3.8,2.7	-0.45±0.48	-0.92(.35)	-1.4,0.5
- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Maturational stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
<i>Exercise characteristics</i>									
- Length (weeks)	-0.02±0.03	0.77(0.44)	-0.04,0.09	-0.03±0.07	-0.39(.70)	-0.2,0.1	-0.03±0.04	-0.77(.44)	-0.1, 0.05
- Frequency (days/week)	-0.18±0.17	1.06(.29)	-0.1,0.5	-0.67±0.63	-1.06(.29)	-1.9,0.6	-0.31±0.37	-0.84(.40)	-1.0,0.4
- Intensity (high vs moderate)	-0.88±0.45	-1.9(.05)	-1.8,0.01	ID	ID	ID	ID	ID	ID
- Duration (min/session)	-0.01±0.01	-1.8(.07)	-0.03,0.001	-0.01±0.02	-0.53(.59)	-0.05,0.03	-0.01±0.02	-0.67(0.50)	-0.06,0.03
- Compliance (%)	-0.02±0.01	-2.1(.03)*	-0.04,-.002*	-0.008±0.03	-0.25(.80)	-0.08,0.06	0.03±0.06	0.46(.64)	-0.08,0.1
- Minutes per week (total) <sup>a</sup>	-0.01±.002	-2.6(.01)*	-0.009,-.001	NA	NA	NA	NA	NA	NA
- Minutes per week (adjusted total) <sup>a</sup>	-0.01±.0004	13.3(<0.001)*	-0.007,-0.005	NA	NA	NA	NA	NA	NA
- Sets <sup>b</sup>	NA	NA	NA	-0.03±0.05	-0.55(.58)	-0.1,0.07	NA	NA	NA
- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA

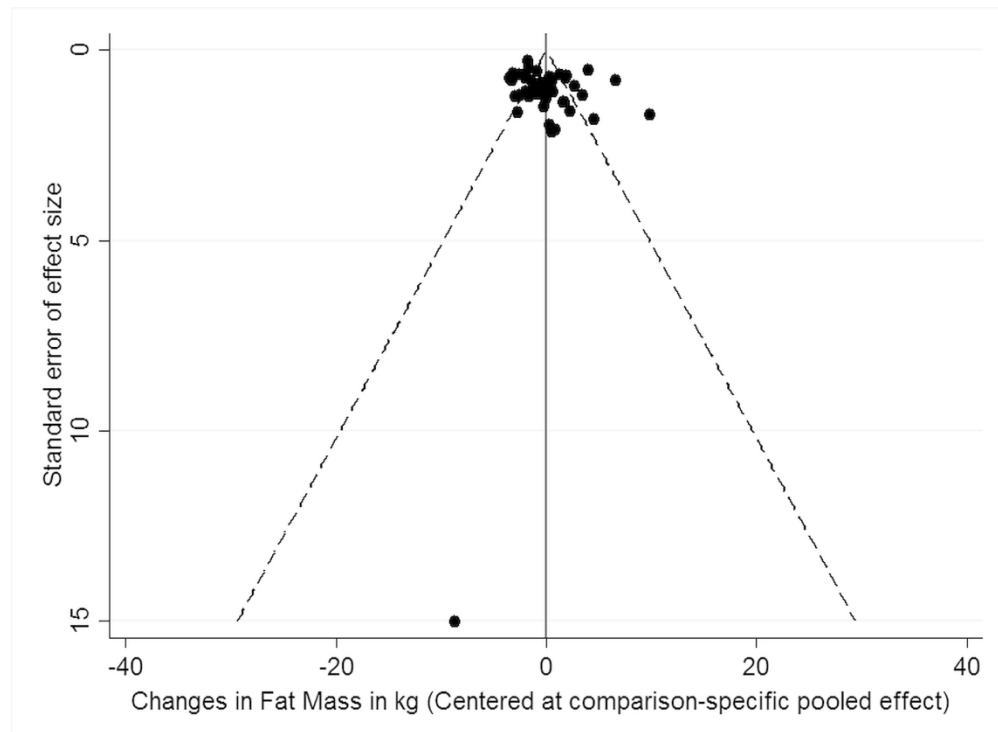


- Number of exercises <sup>b</sup>	NA	NA	NA	-0.21±0.80	-0.27(.79)	-1.8,1.3	NA	NA	NA
- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Type of strength program <sup>b</sup> (c vs t)	NA	NA	NA	0.01±0.75	0.01(.99)	-2.2,2.2	NA	NA	NA
- Type of strength equipment <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Supervision (no vs yes)	0.94±0.67	1.4(.16)	-0.4,2.3	<b>5.1±2.2</b>	<b>2.4(.02)*</b>	<b>0.9,9.4</b>	ID	ID	ID
- Location (home versus facility)	-0.77±0.44	1.7(.08)	-0.1,1.6	<b>5.1±2.0</b>	<b>2.6(.01)*</b>	<b>1.2,9.0</b>	ID	ID	ID
<i>Outcome characteristics</i>									
- Baseline BMI (kg.m <sup>2</sup> )	-0.08±0.05	-1.7(.10)	-0.2,0.01	-0.09±0.0	-0.99(.32)	-0.3,.08	-0.07±0.10	-0.67(.50)	-0.3,0.1
- Assessment method	NA	NA	NA	NA	NA	NA	NA	NA	NA

Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; BMI, body mass index; c vs t, circuit versus traditional; **boldface** items indicate statistically significant findings; \*, statistically significant (two-tailed  $p \leq 0.05$ ).



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Supplementary file 11. Simple meta-regression results for changes in fat mass (kg).

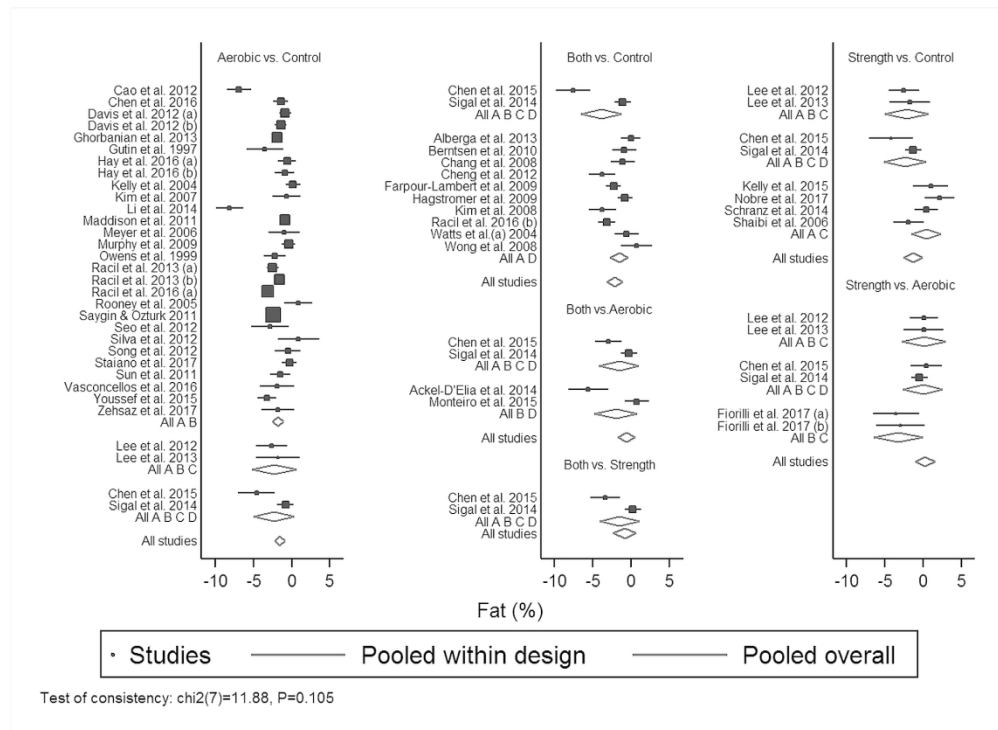
Variable	Aerobic			Strength			Both		
	$\beta_1$ ( $\bar{X} \pm SE$ )	z(p)	95% CI	$\beta_1$ ( $\bar{X} \pm SE$ )	z(p)	95% CI	$\beta_1$ ( $\bar{X} \pm SE$ )	z(p)	95% CI
<i>Study characteristics</i>									
- Year	-0.23±0.1	-1.9(.06)	-0.5,0.01	0.09±0.30	0.31(.76)	-0.5,0.7	<b>0.48±0.22</b>	<b>-2.1(.03)*</b>	<b>-0.9,-0.4</b>
- Impact factor	0.16±0.27	0.58(.56)	-0.4,0.7	-0.12±0.35	-0.35(.73)	-0.8,0.6	0.25±0.28	0.91(.36)	-0.3,0.8
- Country (other vs usa)	-1.7±1.2	-1.4(.17)	-4.1,0.7	0.54±2.1	0.26(.79)	-3.5,4.6	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.66±1.4	-0.46(.64)	-3.5,2.1	1.3±2.2	0.60(.55)	-2.9,5.5	-1.8±2.0	-0.92(.35)	-5.7,2.1
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	ID	ID	ID	ID	ID	ID	ID	ID	ID
-- Unclear	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Incomplete data (ref = low)									
-- High	0.37±2.2	0.17(.87)	-4.0,4.7	1.0±3.3	0.31(.76)	-5.4,7.4	0.22±2.1	0.11(.91)	-3.9,4.3
-- Unclear	-0.69±1.3	-0.52(.61)	-3.3,1.9	1.3±2.4	.056(.58)	-3.3,6.0	-2.8±1.9	-1.5(.13)	-6.5,0.9
- Selective reporting (unclear vs. low)	<b>-3.2±1.2</b>	<b>-2.6(.009)*</b>	<b>-5.7,-0.8</b>	-0.68±2.8	-0.24(.81)	-6.2,4.9	-0.40±1.9	-0.21(.83)	-4.1,3.3
- Inactive (ref = low)									
-- High	0.93±2.4	0.39(.69)	-3.7,5.6	ID	ID	ID	2.4±3.4	0.72(.47)	-4.2,9.1
-- Unclear	0.15±1.5	0.10(.92)	-2.7,3.0	2.1±2.2	0.94(.35)	-2.3,6.5	0.62±2.1	0.30(.77)	-3.5,4.7
- Funding (yes vs no)	2.5±1.5	1.7(.09)	-0.4,5.5	1.7±2.4	0.69(.49)	-3.0,6.4	<b>3.6±1.6</b>	<b>2.3(.02)*</b>	<b>0.5,6.8</b>
- Matching	2.3±1.4	1.67(.09)	-0.4,4.9	-0.20±2.7	-0.08(.94)	-5.4,5.0	-0.47±2.0	-0.23(.82)	-4.4,3.5
- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID



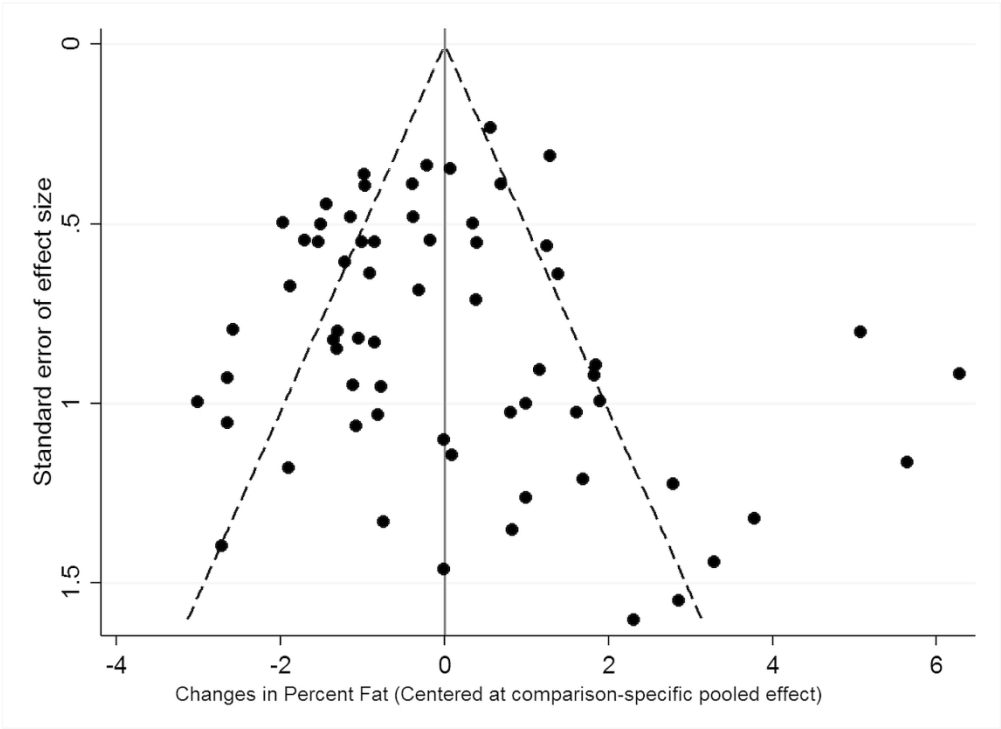
- Control type (other vs none)	2.6±1.9	1.4(.16)	-1.0,6.3	0.45±2.8	0.16(.87)	-5.0,5.9	1.4±1.8	0.79(.43)	-2.2,5.0
- Analysis type (abp vs itt)	0.63±1.3	0.47(.64)	-2.0,3.2	1.9±2.1	0.91(.36)	-2.3,6.2	-1.3±1.9	-0.69(.49)	-5.0,2.4
- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (enactment) (yes vs no)	-1.2±1.0	-1.2(.25)	-3.2,0.8	-1.2±1.7	-0.74(.46)	-4.5,2.0	ID	ID	ID
<i>Participant characteristics</i>									
- Age (years)	-0.02±0.26	-0.10(.92)	-0.5,0.5	-0.62±0.54	-1.1(.25)	-1.7,0.4	-0.67±0.44	-1.5(.13)	-1.5,0.2
- Gender (females vs males)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Maturation stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
<i>Exercise characteristics</i>									
- Length (weeks)	<b>0.26±0.11</b>	<b>2.3(.02)*</b>	<b>0.04,0.48</b>	0.07±0.22	0.33(.74)	-0.4,0.5	0.13±0.15	0.83(.41)	-0.2,0.4
- Frequency (days/week)	0.54±0.44	1.2(.22)	-0.3,1.4	-1.7±1.5	-1.2(.24)	-4.6,1.1	-1.6±0.96	-1.7(.09)	-3.5,0.2
- Intensity (high vs moderate)	<b>-4.9±1.7</b>	<b>-2.9(.003)*</b>	<b>-8.2,1.6</b>	ID	ID	ID	ID	ID	ID
- Duration (min/session)	0.02±0.03	0.86(.39)	-0.03,0.09	-0.02±0.06	-0.39(.69)	-0.1,.1	0.09±0.06	1.6(.11)	-0.02,0.2
- Compliance (%)	<b>-0.07±0.02</b>	<b>-3.9(&lt;0.001)*</b>	<b>-0.1,-0.03</b>	-0.26±0.37	-0.72(.47)	-1.0,0.4	0.002±.03	0.06(.95)	-0.07,.07
- Minutes per week (total) <sup>a</sup>	0.007±0.01	0.69(.49)	-0.01,0.03	NA	NA	NA	NA	NA	NA
- Minutes per week (adjusted total) <sup>a</sup>	<b>-0.006±.003</b>	<b>-2.1(.03)*</b>	<b>-0.01,-0.0006</b>	NA	NA	NA	NA	NA	NA
- Sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Number of exercises <sup>b</sup>	NA	NA	NA	0.10±1.2	0.08(.93)	-2.3,2.5	NA	NA	NA
- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA

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2										
3	- Type of strength program <sup>b</sup> (c vs t)	NA	NA	NA	-0.85±1.3	-0.65(.52)	-3.4,1.7	NA	NA	NA
4	- Type of strength equipment <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
5										
6	- Supervision (no vs yes)	2.3±1.7	1.3(.18)	-1.1,5.6	8.1±15.3	0.53(.59)	-21.8,38.1	ID	ID	ID
7										
8	- Location	2.2±1.6	1.4(.17)	-0.9,5.3	8.3±15.2	054(.59)	-21.6,38.1	ID	ID	ID
9										
10	<i>Outcome characteristics</i>									
11	- Baseline fat mass (kg)	-0.09±0.05	-1.8(.07)	-0.2,0.007	-0.10±0.08	-1.3(.18)	-0.3,05	-0.01±0.08	-.17(.86)	-0.2,0.1
12										
13	- Assessment method (ref = DEXA)									
14										
15	-- MRI	-2.5±2.1	-1.2(.22)	-6.7,1.6	-1.9±3.2	-0.59(.56)	-8.1,4.3	-1.3±2.6	-0.51(.61)	-6.4,3.8
16										
17	-- BI	-2.2±1.7	-1.3(.20)	-5.6,1.2	ID	ID	ID	-2.7±2.7	-0.98(.33)	-8.1,2.7
18										
19	-- Skinfolts	-3.1±1.7	-1.8(.07)	-6.4,0.3	2.1±3.7	0.55(.58)	-5.3,9.4	0.65±2.8	0.23(.82)	-4.8,6.1

20 Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct  
21 analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; c vs t, circuit versus  
22 traditional; DEXA, dual-energy x-ray absorptiometry; MRI, magnet resonance imaging; BI, bioelectrical impedance; **boldface** items indicate statistically  
23 significant findings; \*, statistically significant (two-tailed p ≤ 0.05).  
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173x126mm (300 x 300 DPI)



173x126mm (300 x 300 DPI)



## Supplementary file 14. Simple meta-regression results for changes in percent body fat.

Variable	Aerobic			Strength			Both		
	$\beta_1$			$\beta_1$			$\beta_1$		
	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI
<i>Study characteristics</i>									
- Year	-0.003±0.07	-0.04(.97)	-0.1,0.1	0.03±0.20	0.16(.87)	-0.38,0.44	-0.26±0.15	-1.8(.08)	-0.6, 0.03
- Impact factor	0.04±0.05	0.86(.39)	-0.05,0.1	-0.07±0.22	-0.34(.73)	-0.5,0.4	0.12±0.14	0.83(.41)	-0.2,0.4
- Country (other vs usa)	-0.68±0.72	-0.94(.35)	-2.1,0.74	-0.34±1.3	-0.27(.79)	-2.8,2.2	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.43±0.70	-0.62(.54)	-1.8,0.9	-0.24±1.3	-0.19(.85)	-2.7,2.2	-1.3±1.2	-1.1(.27)	-2.7,2.2
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	-0.23±1.4	-0.17(.87)	-2.9,2.5	ID	ID	ID	ID	ID	ID
-- Unclear	-0.97±0.96	-1.0(.31)	-2.8,0.91	-2.0±2.1	-0.96(.34)	-6.1,2.1	0.06±1.9	0.03(.98)	-3.8,3.9
- Incomplete data (ref = low)									
-- High	0.21±0.96	0.22(.83)	-1.7,2.1	-0.31±2.1	-0.14(.88)	-4.5,3.9	-0.35±1.4	-0.25(.80)	-3.1,2.4
-- Unclear	-0.66±0.71	-0.93(.35)	-2.0,0.7	1.6±1.5	1.07(.28)	-1.4,4.6	-0.35(1.4)	-0.25(.80)	-3.1,2.4
- Selective reporting (unclear vs. low)	<b>-1.6±0.66</b>	<b>-2.4(.01)*</b>	<b>-2.9,-0.30</b>	-1.0±1.5	-0.66(.51)	-4.0,2.0	-0.19±1.1	-0.17(.86)	-2.4,2.0
- Inactive (ref = low)									
-- High	0.82±1.9	0.44(.66)	-2.8,4.5	ID	ID	ID	1.6±2.1	0.75(.45)	-2.5,5.6
-- Unclear	-0.04±0.67	-0.07(.95)	-1.4,1.3	<b>2.7±1.3</b>	<b>2.2(.03)*</b>	<b>0.25,5.2</b>	0.05±1.2	0.75(.45)	-2.5,5.6
- Funding (yes vs no)	<b>2.1±0.70</b>	<b>3.0(0.003)*</b>	<b>0.7,3.5</b>	<b>4.1±1.3</b>	<b>3.07(.002)*</b>	<b>1.5,6.8</b>	<b>4.4±1.2</b>	<b>3.6(&lt;0.001)*</b>	<b>2.0,6.8</b>

1										
2	- Matching	1.1±0.77	1.4(.16)	-0.4,2.6	-0.21±1.7	-0.12(.90)	-3.6,3.2	0.41±1.2	0.34(.73)	-1.9,2.7
3										
4	- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID
5										
6	- Control type (other vs none)	-0.03±0.82	-0.03(.97)	-1.6,1.6	-1.2±1.7	-0.72(.47)	-4.6,2.1	0.78±1.1	0.71(.48)	-1.4,2.9
7										
8	- Analysis type (abp vs itt)	0.22±0.70	0.32(.75)	-1.1,1.6	0.09±1.3	0.07(.94)	-2.4,2.6	-1.1±1.1	-1.02(.31)	-3.3,1.1
9										
10	- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
11										
12	- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
13										
14	- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
15										
16	- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
17										
18	- Fidelity (enactment) (yes vs no)	-0.59±0.43	-1.4(.17)	-1.4,0.26	-1.5±0.84	-1.7(.08)	-3.1,0.17	-0.78±0.87	-0.89(.37)	-2.5,0.93
19										
20	<i>Participant characteristics</i>									
21										
22	- Age (years)	-0.12±0.11	-1.05(.29)	-0.34,0.10	-0.64±0.35	-1.83(.07)	-1.3,0.05	-0.31±0.2	-1.5(.12)	-0.7,0.08
23										
24	- Gender (females vs males)	0.51±0.98	0.52(.60)	-1.4,2.4	-0.55±1.6	-0.34(.74)	-3.8,2.7	ID	ID	ID
25										
26	- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
27										
28	- Maturation stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
29										
30	<i>Exercise characteristics</i>									
31										
32	- Length (weeks)	<b>0.13±0.06</b>	<b>2.2(.03)*</b>	<b>0.01,0.25</b>	0.03±0.11	0.29(0.77)	-0.19,0.26	0.07±0.07	1.0(.31)	-0.06,0.20
33										
34	- Frequency (days/week)	0.20±0.28	0.73(.47)	-0.3,0.7	-1.4,0.96	-1.5(.14)	-3.3,0.5	-0.40±0.58	-0.70(.49)	-1.5,0.7
35										
36	- Intensity (high vs moderate)	0.33±0.81	0.41(.68)	-1.3,1.9	ID	ID	ID	-1.3±2.0	-0.62(.53)	-5.3,2.7
37										
38	- Duration (min/session)	-0.006±0.01	-0.47(.64)	-0.03,0.02	-0.06±0.04	-1.6(.12)	-0.14,0.02	0.03±0.02	1.06(.29)	-0.02,0.07
39										
40	- Compliance (%)	-0.03±0.02	-1.7(.10)	-0.07,0.006	-0.05±0.05	-0.92(.36)	-0.16,0.06	0.03±0.04	0.91(.36)	-0.04,0.1
41										
42	- Minutes per week (total) <sup>a</sup>	-0.002±0.004	-0.48(.63)	-0.01,0.006	NA	NA	NA	NA	NA	NA
43										
44	- Minutes per week (adjusted total) <sup>a</sup>	-0.005±0.004	-1.1(.26)	-0.01,0.003	NA	NA	NA	NA	NA	NA
45										
46										
47										

- Sets <sup>b</sup>	NA	NA	NA	0.13±0.09	1.3(.18)	-0.06,0.31	NA	NA	NA
- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Number of exercises <sup>b</sup>	NA	NA	NA	0.03±0.97	0.03(.97)	-1.9,1.9	NA	NA	NA
- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Type of strength program <sup>b</sup> (c vs t)	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Type of strength equipment <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Supervision (no vs yes)	1.5±1.2	1.3(.18)	-0.7,3.8	2.5±2.3	1.1(.27)	-1.9,7.0	ID	ID	ID
- Location	1.5±1.1	1.4(.17)	-0.67,3.7	2.6±2.2	1.2(.24)	-1.7,6.9	ID	ID	ID
<i>Outcome characteristics</i>									
- Baseline percent fat	0.06±0.05	1.3(.21)	-0.03,0.16	0.03±0.08	.39(.69)	-0.13,0.19	0.12±0.07	1.7(.08)	-0.02,0.27
- Assessment method (ref = DEXA)	NA	NA	NA	NA	NA	NA	NA	NA	NA
-- MRI	-0.38±1.2	-0.31(.76)	-2.8,2.1	-1.5±1.5	-0.99(.32)	-4.4,1.4	0.42±1.7	0.24(.81)	-3.0,3.8
-- BI	-1.2±0.73	-1.7(.09)	-2.7,0.2	ID	ID	ID	-0.22±1.5	-0.15(.88)	-3.1,2.6
-- Skinfolds	0.65±1.1	0.61(.54)	-1.4,2.7	-1.1±1.7	-0.67(.51)	-4.4,2.2	1.2±1.9	0.62(.53)	-2.5,4.9
-- Plethysmography	1.3±316.2	0.00(1.0)	-618,621	ID	ID	ID	-3.6±316	-0.01(.99)	-623,616

Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; BMI, body mass index; c vs t, circuit versus traditional; DEXA, dual-energy x-ray absorptiometry; MRI, magnet resonance imaging; BI, bioelectrical impedance; **boldface** items indicate statistically significant findings; \*, statistically significant (two-tailed  $p \leq 0.05$ ).

Supplementary file 15. Changes in secondary outcomes.

Variable	Aerobic				Strength				Both			
	ES/P	$\beta_1$			ES/P	$\beta_1$			ES/P	$\beta_1$		
	(#)	$(\bar{X} \pm SE)$	z(p)	95% CI	(#)	$(\bar{X} \pm SE)$	z(p)	95% CI	(#)	$(\bar{X} \pm SE)$	z(p)	95% CI
Body weight (kg)	35/1478	<b>-1.9±0.34</b>	<b>-5.4(&lt;0.001)*</b>	<b>-2.5,-1.2</b>	8/331	0.28±0.71	0.39(.70)	-1.1,1.7	13/510	<b>-1.4± 0.50</b>	<b>-2.8(0.004)*</b>	<b>-2.4,-0.4</b>
Fat-free mass (kg)	16/177	0.07±0.40	0.18(.86)	-0.72,0.86	7/305	0.82±0.62	1.3(.19)	-0.40,2.0	11/431	<b>1.3±0.46</b>	<b>2.8(0.006)*</b>	<b>0.4,2.2</b>
WC (cm)	19/973	<b>-1.9±0.62</b>	<b>-3.1(.002)*</b>	<b>-3.1,-0.7</b>	5/195	-0.34±1.1	-0.32(.75)	-2.5,1.8	4/223	-2.2±1.3	-1.7(.08)	-4.6,0.3
VO <sub>2max</sub> (ml·kg <sup>-1</sup> ·min <sup>-1</sup> )	22/1167	<b>3.1±0.50</b>	<b>6.1(&lt;0.001)*</b>	<b>2.1,4.1</b>	6/248	1.2±0.84	1.4(.15)	-0.45,2.9	8/366	<b>3.0±0.82</b>	<b>3.6(&lt;0.001)*</b>	<b>1.4,4.6</b>
SBP (mmHg)	12/489	<b>-4.4±1.5</b>	<b>-2.9(.004)*</b>	<b>-7.5,-1.4</b>	3/151	-2.9±2.6	-1.1(.26)	-8.1,2.2	5/255	-2.3±2.3	-0.97(.33)	-6.9,2.3
DBP (mmHg)	11/421	<b>-2.5±1.1</b>	<b>-2.2(.03)*</b>	<b>-4.6,-0.3</b>	3/151	-1.5±1.8	-0.84(.40)	-5.0,2.0	5/255	-2.3±1.6	-1.4(.16)	-5.5,0.9
TC (mg/dl)	14/463	<b>-5.3±2.5</b>	<b>-2.1(.03)*</b>	<b>-10.2, -0.4</b>	2/125	0.07±5.5	0.01(.99)	-10.8,10.9	7/326	-3.5±3.6	-0.96(.34)	-10.5,3.6
HDL (mg/dl)	17/602	<b>3.3±0.89</b>	<b>3.7(&lt;0.001)*</b>	<b>1.6,5.1</b>	2/125	0.82±2.2	0.38(.71)	-3.5,5.1	7/326	0.95±1.4	0.67(.50)	-1.8,3.7
LDL (mg/dl)	16/570	<b>-6.2±2.3</b>	<b>-2.7(.006)*</b>	<b>-10.7,1.8</b>	2/125	-1.2±5.4	-0.23(.82)	-11.8,9.3	7/326	-4.8±3.3	-1.4(.15)	-11.4,1.7
TG (mg/dl)	16/560	<b>-14.8±3.4</b>	<b>-4.3(&lt;0.001)*</b>	<b>-21.4,-8.1</b>	2/125	-8.4±9.4	-0.90(.37)	-26.9,10	7/326	<b>-11.1±4.9</b>	<b>-2.2(.02)*</b>	<b>-20.8,1.4</b>
Fasting glucose (mg/dl)	19/753	-1.9±1.0	-1.9(.06)	-3.9,.08	5/195	0.06±1.8	0.03(.97)	-3.4,3.6	7/346	<b>-4.8±1.7</b>	<b>-2.82(.005)*</b>	<b>-8.2,-1.5</b>
Fasting insulin (uU/ml )	17/725	<b>-2.9±0.6</b>	<b>-4.6(&lt;0.001)*</b>	<b>-4.3,-1.7</b>	4/167	<b>-3.2±1.4</b>	<b>-2.2(.03)*</b>	<b>-6.0,-0.3</b>	5/240	<b>-3.6±1.1</b>	<b>-3.2(.002)*</b>	<b>-5.8,-1.4</b>

Notes: #ES/P, number of effect sizes and number of participants (exercise plus control); ID, insufficient data available to conduct meta-analysis; \*, **boldface** items statistically significant; \*, statistically significant (two-tailed p ≤ 0.05).



Supplementary file 16. Original published protocol for study. See below.

For peer review only

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# BMJ Open Exercise and adiposity in overweight and obese children and adolescents: protocol for a systematic review and network meta-analysis of randomised trials

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## ABSTRACT

**Introduction** Overweight and obesity is a worldwide public health problem among children and adolescents. However, the magnitude of effect, as well as hierarchy of exercise interventions (aerobic, strength training or both), on selected measures of adiposity is not well established despite numerous trials on this issue. The primary purposes of this study are to use the network meta-analytical approach to determine the effects and hierarchy of exercise interventions on selected measures of adiposity in overweight and obese children and adolescents.

**Methods and analysis** Randomised exercise intervention trials >4 weeks, available in any language up to 31 August 2017 and which include direct and/or indirect evidence, will be included. Studies will be located by searching seven electronic databases, cross-referencing and expert review. Dual selection and abstraction of data will occur. The primary outcomes will be changes in body mass index (in kg/m<sup>2</sup>), fat mass and percent body fat. Risk of bias will be assessed using the Cochrane Risk of Bias assessment instrument while confidence in the cumulative evidence will be assessed using the Grading of Recommendations Assessment, Development and Evaluation instrument for network meta-analysis. Network meta-analysis will be performed using multivariate random-effects meta-regression models. The surface under the cumulative ranking curve will be used to provide a hierarchy of exercise treatments (aerobic, strength or both).

**Ethics and dissemination** This study does not require ethics approval. Findings will be presented at a professional conference and published in a peer-reviewed journal.

**PROSPERO registration number** CRD42017073103.

## INTRODUCTION

### Rationale

Overweight and obesity in children and adolescents is a major public health problem worldwide. Between 1980 and 2013, the worldwide prevalence of overweight and obesity in children and adolescents increased by 6.9%, from 16.9% to 23.8%, in boys and by 6.4%, from 16.2% to 22.6%, in girls from

Strengths and limitations of this study

- To the best of the investigative team's knowledge, this is the first systematic review to use the network meta-analytical approach to determine the effects as well as hierarchy of exercise interventions (aerobic, strength training or both) on body mass index in kg/m<sup>2</sup>, fat mass and percent body fat in overweight and obese children and adolescents.
- The results of this systematic review with network meta-analysis should be useful to practitioners and policy-makers for making informed decisions about exercise in the treatment of overweight and obesity in children and adolescents.
- The results of this systematic review with network meta-analysis should be useful to researchers with respect to the conduct and reporting of future research on this topic.
- Common to most meta-analyses, the results may yield significant heterogeneity which cannot be explained.
- Like any aggregate data meta-analysis, the possibility of ecological fallacy exists, that is, that group averages are not reflective of an individual's values.

developed countries.<sup>1</sup> For developing countries, increases of 4.8%, from 8.1% to 12.9% for boys and 5%, from 8.4% to 13.4% in girls, were reported.<sup>1</sup> The negative outcomes associated with obesity in children and adolescents are both immediate and long term.<sup>2</sup> For immediacy, a population-based study of children and adolescents 5–17 years of age found that approximately 70% of obese youth had a minimum of one cardiovascular disease risk factor (high cholesterol, high blood pressure, etc).<sup>3</sup> Obese children and adolescents are also more likely to be diagnosed with prediabetes,<sup>4</sup> as well as being at an increased risk for bone and joint difficulties, sleep apnoea,



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and social and psychological issues such as stigmatisation, poor self-esteem and poorer health-related quality of life.<sup>5 6</sup> Long-term, childhood and adolescent overweight and obesity has been demonstrated to track into adulthood,<sup>7–11</sup> thus placing overweight and/or obese adults at a greater risk for cardiovascular disease, type 2 diabetes, stroke, several types of cancer and osteoarthritis.<sup>2</sup>

One promising intervention in the treatment of overweight and obesity is exercise. However, previous randomised trials that were limited to or included overweight and obese children and adolescents have led to conflicting results,<sup>12–58</sup> with some reporting statistically significant reductions in adiposity (body mass index (BMI)) as a primary outcome<sup>12 13 16 17 22 27 28 31 41 51–56 59–63</sup> and others reporting no change.<sup>14 15 18–21 23–26 29 30 32–40 42–50 57 58 62 64 65</sup> When limited to overweight and obese male and female children and adolescents,<sup>12 14 17–20 22–26 28 31 33 36 38–41 45–57</sup> only 18 (45.0%) have reported statistically significant reductions in BMI.<sup>12 17 22 28 31 41 50–58</sup> While this may lead one to the general conclusion that exercise does little to reduce BMI in overweight and obese children and adolescents, this would be short-sighted since it relies on the vote-counting approach,<sup>66</sup> an approach that has been shown to be less valid than the meta-analytical approach.<sup>66 67</sup>

Previous systematic reviews with meta-analyses that have focused on the effects of exercise as an independent intervention on BMI as a primary outcome in male and female children and adolescents have reported conflicting findings with five reporting a significant improvement in BMI<sup>68–72</sup> and five others reporting no statistically significant improvement.<sup>73–77</sup> However, 9 of the 10 suffer from one or more of the following limitations: (1) inclusion of a small number of studies with exercise as the only intervention,<sup>71 73–75</sup> (2) inclusion of non-randomised trials,<sup>68 74</sup> (3) inclusion of children and adolescents who were not overweight or obese.<sup>70 72 74 76 77</sup> Relevant to this study, all 10 suffer from reliance on pairwise versus network meta-analyses, the latter of which incorporates both direct and indirect evidence. In addition, there was an absence of an established hierarchy for determining which types of exercise (aerobic, strength training or both) might be best for improving BMI based on both direct and indirect evidence.<sup>68–77</sup> To partially address this issue as well as demonstrate feasibility, the investigative team has recently used the network meta-analytical approach to examine the effects of exercise (aerobic, strength training or both) on BMI z-score in overweight and obese children and adolescents.<sup>78 79</sup> Statistically significant reductions in BMI z-score were found for aerobic exercise and combined aerobic and strength exercise, but not strength training alone (mean, 95% CI, aerobic, –0.10, –0.15 to –0.05; aerobic and strength, –0.11, –0.19 to –0.03; strength, 0.04, –0.07 to 0.15).<sup>79</sup> Combined aerobic and strength training was ranked best, followed by aerobic exercise and then strength training.<sup>79</sup> Consistency in evidence and risk of bias did not differ between direct and indirect studies.<sup>79</sup> It was concluded that combined aerobic exercise

and strength training as well as aerobic exercise alone are associated with reductions in BMI z-score.<sup>79</sup> The lack of effect on BMI z-score in the strength training studies may have been the result of increases in lean muscle mass. However, since BMI in kg/m<sup>2</sup> continues to be the most frequently assessed and reported measure of adiposity in both the clinical and public health setting, such an examination using the network meta-analytical approach is needed. In addition, since all types of BMI measures as well as body weight do not capture changes in body composition (fat mass, percent body fat, etc), the inclusion of such outcomes, as previously suggested,<sup>79</sup> is also necessary.

## Objectives

The primary objectives of the current study are to conduct a systematic review with network meta-analysis of randomised trials to (1) determine the effects of exercise (aerobic, strength training or both) on adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents, and (2) establish a hierarchy of exercise interventions (aerobic, strength training or both) for treating adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents.

## METHODS

### Overview

This study will follow the guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension statement for network meta-analyses of healthcare interventions.<sup>80</sup>

### Eligibility criteria

The inclusion criteria for this proposed network meta-analysis will be as follows: (1) direct evidence from randomised trials that compare two or more exercise interventions (aerobic, strength training, both) or indirect evidence from randomised controlled trials that compare an exercise intervention group to a comparative control group (non-intervention, attention control, usual care, wait-list control, placebo), (2) exercise-only intervention (aerobic, strength training or both), (3) studies lasting ≥4 weeks, (4) male and/or female children and adolescents 2–18 years of age, (5) participants overweight or obese, as defined by the authors, (6) studies published in any language up to 31 August 2017, (7) data available for BMI in kg/m<sup>2</sup>, fat mass or percent body fat.

Studies will be limited to randomised trials because it is the only way to control for confounders that are not known or measured as well as the observation that non-randomised controlled trials tend to overestimate the effects of healthcare interventions.<sup>81 82</sup> Indirect evidence studies will be limited to randomised controlled trials with at least one exercise arm that participates in either aerobic, strength training, or a combination of aerobic and strength training exercise. Direct evidence





studies will be limited to randomised trials that include at least two of the following exercise arms: (1) aerobic, (2) strength training, (3) aerobic and strength training exercise.

For the purposes of this study, exercise, aerobic exercise and strength training will be defined according to the 2008 Physical Activity Guidelines for Americans,<sup>83</sup> that is, movement which is 'planned, structured, and repetitive and purposive in the sense that the improvement or maintenance of one or more components of physical fitness is the objective',<sup>83 84</sup> aerobic exercise as 'exercise that primarily uses the aerobic energy-producing systems, can improve the capacity and efficiency of these systems, and is effective for improving cardiorespiratory endurance',<sup>83</sup> and strength training as 'exercise training primarily designed to increase skeletal muscle strength, power, endurance, and mass'.<sup>83</sup> Four weeks was chosen as the lower cut point for intervention length based on previous research demonstrating improvements in adiposity over this period of time in 11-year-olds.<sup>21</sup>

Participants will be limited to overweight and obese children and adolescents, as defined by the original study authors, because it has been shown that this population is at an increased risk for premature morbidity and mortality throughout their lifetime.<sup>85</sup>

While some research has suggested that studies yielding statistically significant and positive results are more likely to be published in English-language versus non-English-language journals,<sup>86</sup> other research has shown this to not be the case.<sup>87</sup> Given the former, studies from both English-language and non-English-language articles will be included with the latter translated into English by the second author using the freely available web-based Babelfish and Bing translators. For those studies that cannot be translated using Babelfish and/or Bing, professional translation services will be used.

BMI in kg/m<sup>2</sup> was included as one of the three primary adiposity outcomes because it is the most commonly used and understood variable by practitioners as well as others and can be easily measured from body weight and height. However, because BMI is an indirect measure of adiposity, fat mass and percent body fat will be included because they are more direct measures of adiposity. The inclusion of fat mass and percent body fat may be especially relevant for studies that include strength training given that decreases in adiposity as measured by BMI may be offset by increases in muscle mass, a secondary outcome that will be included.

Information sources

The following seven electronic databases will be searched: (1) PubMed, (2) Web of Science, (3) Cochrane Central Register of Controlled Trials, (4) Cumulative Index to Nursing and Allied Health Literature, (5) Sport Discus, (6) Translating Research into Practice and (7) ProQuest Dissertations and Theses. In addition to electronic database searches, cross-referencing will be conducted by examining the reference lists of previous review articles as

well as each included study for potential articles that meet the inclusion criteria. On completion of initial searches, the third author will examine the reference list for thoroughness and completeness. Suggested studies will then be retrieved to see if they meet all inclusion criteria.

Search strategy

Search strategies specific to each database will be developed by the investigative team. Major keywords, or forms of keywords to include will be 'random', 'children', 'adolescents', 'overweight', 'obese', 'exercise', 'physical fitness', 'body composition', 'fat mass', 'body fat', 'body composition', 'body mass index', 'adiposity'. A copy of a preliminary search strategy using PubMed, including limits, can be found in the online supplementary file. This search strategy will be adapted for other database searches. All database searches and article retrieval will be conducted by the second author with oversight from the first author.

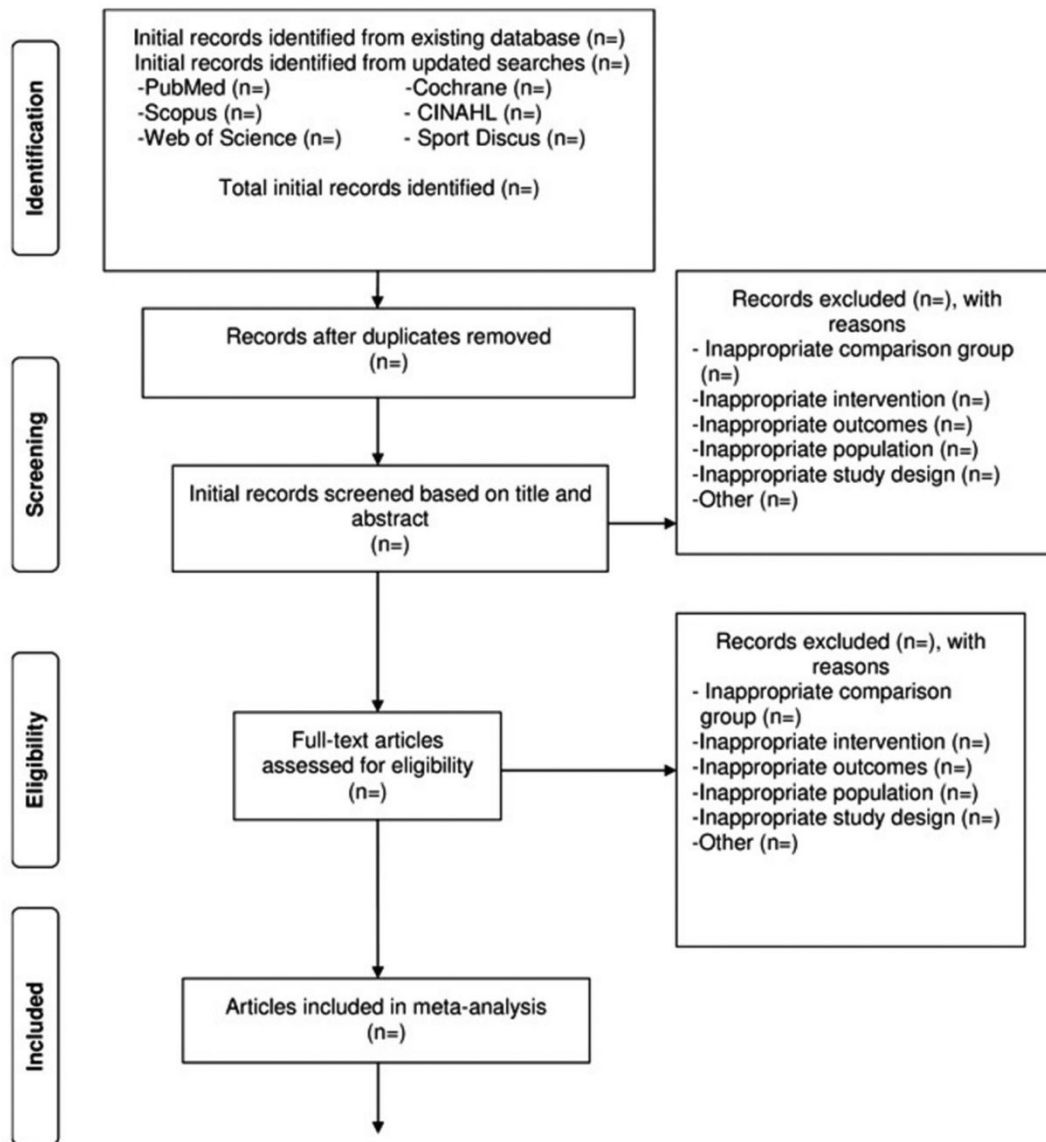
Study records

Study selection

All studies to be screened will be imported into EndNote (V.X8; Thomson-Reuters; 2016, New York, USA) and duplicates removed electronically and then manually by the second author. A copy of the database will then be provided to the first author for duplicate screening. To minimise selection bias, the first and second authors will select all studies, independent of each other. They will then review their selections for accuracy and consistency. The full report for each article will be retrieved for all titles and abstracts that appear to meet the inclusion criteria as well as those where uncertainty exists. Multiple reports for the same study will be addressed by including the most recently published article and drawing from prior reports, assuming the same methods and sample sizes are reported. Based on previous research suggesting neither a clinically nor statistically significant effect on results, blinding to journal titles, study authors or institutions of the authors will not be employed during the screening and data abstraction processes.<sup>88</sup> Reasons for excluded studies will be recorded using the following categories: (1) inappropriate population, (2) inappropriate intervention, (3) inappropriate comparison(s), (4) inappropriate outcome(s), (5) inappropriate study design, (6) other. On the conclusion of screening, the first and second authors will meet and review their selections. Cohen's  $\kappa$  statistic will be used to measure interselection agreement.<sup>89</sup> Any discrepancies will be resolved by consensus. If consensus cannot be reached, the third author will serve as an arbitrator. After selecting the final number of studies to include, the overall precision of the searches will be computed by dividing the number of included studies by the total number of studies screened after removing duplicates.<sup>90</sup> The number needed-to-read (NNR) will then be calculated as the reciprocal of the precision.<sup>90</sup> A flow diagram that describes the search procedure will be included as well as supplementary file



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**Figure 1** Proposed flow diagram to depict the search process.

a reference list of all excluded studies, including the reason(s) for exclusion. **Figure 1** illustrates the proposed structure for the flow diagram.

#### Data abstraction

For this project, Microsoft Excel (V.2016; Microsoft Corporation, Redmond, Washington, USA) will be used to develop comprehensive electronic codebooks that will define the coding process for each of the variables coded. The codebook will be created by the first two authors with feedback from the third author. Consequently, the abstraction of data from the studies in this proposed project should require little subjective judgement on the part of the coder. The major groups of variables to code will include (1) study characteristics (author, journal, year of publication, etc), (2) participant characteristics (age, gender, height, body weight, etc) and (3) data for

primary and secondary outcomes (sample sizes, baseline and postexercise means and SD, etc). **Table 1** contains a preliminary list of variables that will be coded. Based on previous research by the investigative team,<sup>79</sup> a codebook capable of including at least 242 items from each study is expected. To avoid data abstraction bias, the first two authors will independently code (dual-coding) all studies to ensure accuracy and consistency. Inter-rater agreement will be assessed using Cohen's  $\kappa$ .<sup>89</sup> Any disagreement in the items coded will be discussed until mutual agreement is reached. If agreement cannot be reached, the third author will serve as an arbitrator.

#### Outcomes and prioritisation

The primary outcomes in this study will be changes in BMI in  $\text{kg}/\text{m}^2$ , fat mass, and percent body fat in overweight and obese children and adolescents. Secondary



**Table 1** Covariates to examine using simple meta-regression

Characteristics	Variable
Study	Publication year, impact factor of journal, country study conducted, type of control group, bias (sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting), type of analysis
Participant	Age, gender, race/ethnicity, maturational stage
Exercise	Type (aerobic, strength, both), length, frequency, intensity, duration, total minutes, total minutes (adjusted for compliance), mode, compliance, exercise supervision, setting, number of sets, number of repetitions, rest between sets, number of exercises, type of resistance, equipment used, fidelity (design, training, delivery, receipt, enactment)
Outcome	Baseline values for primary outcomes (BMI in kg/m <sup>2</sup> , fat mass, percent fat), method used to assess adiposity, that is, instrumentation, body weight, lean body mass, waist circumference, waist-to-hip ratio, diet, energy intake, energy expenditure, physical activity level, non-exercise activity, maximum oxygen consumption (relative and absolute), muscular strength, resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin

BMI, body mass index.

outcomes will include body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, maximum oxygen consumption (relative and absolute), muscular strength, resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high-density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin.

**Risk of bias assessment in individual studies**

Risk of bias for included studies will be assessed using the Cochrane Risk of Bias Instrument.<sup>91</sup> Assessment is based on judgements of low, high or unclear risk of bias across six defined domains: (1) sequence generation, (2) allocation sequence concealment, (3) blinding of participants and personnel, (4) blinding of outcome assessors, (5) incomplete outcome data and (6) selective outcome reporting. A seventh domain, whether participants were exercising regularly, as defined by the original study authors, will also be assessed using the same approach as for the other six domains. As previously recommended, study-level results will be reported for each domain according to risk of bias (low, high or unclear) while the percentage of low, high or unclear results across each domain will also be reported.<sup>91</sup> This risk of bias approach has been recommended over the use of study quality rating scales given the lack of empirical evidence to support the latter.<sup>82 92 93</sup> Assessment for risk of bias will be limited to the primary outcomes of interest, that is, changes in BMI in kg/m<sup>2</sup>, fat mass and percent body fat. All studies will be classified as high risk of bias with respect to the category ‘blinding of participants and personnel’ given that it’s virtually impossible to blind participants to group assignment in exercise intervention protocols. Based on previous research, no study will be excluded based on risk of bias results.<sup>94</sup>

**Data synthesis**

**Calculation of effect sizes**

The primary outcomes for this study will be changes in BMI in kg/m<sup>2</sup>, fat mass (kg), and percent body fat using the original metric. Changes for indirect comparisons will be calculated by subtracting the change outcome difference in the exercise group minus the change outcome difference in the control group. Variances will be computed using the pooled SDs of change scores in the exercise and control groups. If change score SDs are not available, they will be calculated from 95% CIs for either change outcome or treatment effect differences as well as pre-SD and post-SD values, the latter according to procedures developed by Follmann *et al.*<sup>95</sup> For direct comparisons, that is, randomised trials with no control group, the same general procedures will be followed except that the control group data will be replaced with one of the exercise interventions as follows: (1) aerobic minus strength training, (2) aerobic and strength training combined minus aerobic training, (3) aerobic and strength training combined minus strength training. Ninety-five percent CI and *z*-α values will be calculated for each outcome from each study. For those studies that include both direct and indirect comparisons, only direct comparison data will be included since a primary purpose of the current meta-analysis is determining which exercise interventions(s) might work best for improving adiposity in children and adolescents. For studies in which adiposity outcomes are assessed at multiple intervention time points, for example, 0 weeks, 8 weeks and 16 weeks, only data from the initial and last assessment will be used. If follow-up data are available, results from such studies will also be analysed separately to determine the sustainability of changes in adiposity. If any cross-over trials are included, treatment effects will be calculated by using all assessments from the intervention and control periods and analysing them similar to a parallel group



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trial.<sup>96</sup> While the possibility of a unit-of-analysis error exists as well as studies being underweighted versus overweighted, this method is believed to be better than alternative approaches, for example, limiting data from the first assessment point or trying to impute SDs, especially given the primary and secondary outcomes included and expected distribution of findings.<sup>96</sup>

Secondary outcomes (body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, maximum oxygen consumption (relative and absolute), resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high-density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin) will be handled using the same approach as for primary outcomes. However, given the different metrics expected and the inability to convert between them, changes in physical activity levels and muscular strength will be calculated using the standardised mean difference effect size, adjusted for small sample sizes.<sup>97</sup>

#### Pooled estimates for changes in outcomes

*Network (geometry) plots* for each outcome will be used to provide a visual representation of the evidence base with nodes (circles) weighted by the number of participants randomised to each treatment and edges (lines) weighted by the number of studies evaluating each pair of treatments.<sup>98 99</sup> *Contribution plots* for each outcome will be used to determine the most dominant comparisons for each network estimate as well as for the entire network.<sup>98</sup> The weights applied will be a function of the variance of the direct treatment effect and the network structure, the result being a percent contribution of each direct comparison to each network estimate.<sup>98</sup>

Network meta-analysis will be performed using *multivariate random-effects meta-regression models* that can be performed within a frequentist setting, allows for the inclusion of potential covariates, and correctly accounts for the correlations from multiarm trials.<sup>100 101</sup> A two-tailed  $\alpha$  value  $\leq 0.05$  and non-overlapping 95% CI will be considered to represent statistically significant changes. Separate network meta-analysis models will be used to examine for changes in each primary and secondary outcome. Potential *covariates* will be examined by (1) conducting simple meta-regression for statistically significant associations between covariates and changes in primary outcomes (BMI in  $\text{kg}/\text{m}^2$ , fat mass, percent fat), (2) examining for multicollinearity between covariates ( $r > 0.80$ ) and (3) building a multiple meta-regression model. A list of potential covariates to examine using simple meta-regression is shown in [table 1](#). While we will include all methods used to assess adiposity, we will also conduct sensitivity analyses to see if results differ according to method of assessment, for example, fat mass assessed using whole body MRI versus bioelectrical impedance. Secondary outcomes (energy intake and expenditure,

physical activity level, muscular strength) will be handled using the same approach. *Transitivity*, that is, similarity in the distribution of potential effect modifiers across the different pairwise comparisons for each outcome<sup>102</sup> will include those listed in [table 1](#). *Inconsistency*, that is differences in effect estimates between direct and indirect results for the same comparison,<sup>103</sup> will be checked by assessing differences in treatment effects between direct and indirect effect estimates as well as differences between trials with different designs, for example, two-arm versus multiarm trials.<sup>101 103 104</sup> However, the probability of inconsistency is considered small given recent research demonstrating that inconsistency was detected in only 2%–14% of tested loops, depending on the effect measure and heterogeneity estimation method.<sup>105 106</sup> Finally, *prediction intervals* will be used to enhance interpretation of results with respect to the magnitude of heterogeneity as well as provide an estimate of expected results in a future study.<sup>107–109</sup> For network meta-analysis, degrees of freedom (*df*) will be set to the number of studies—the number of comparisons–1.<sup>109</sup>

#### Meta-biases

*Small-study effects* (publication bias, etc) will be assessed using comparison-adjusted funnel plots.<sup>98</sup> In the absence of small-study effects, the comparison-adjusted funnel plot should be symmetrical around the zero line.

#### Confidence in cumulative evidence

*Quality analysis* of specific pairwise effect estimates in the network meta-analysis will be evaluated using a recently developed modification of the Grading of Recommendations Assessment, Development and Evaluation for network meta-analysis across five domains: (1) study limitations, (2) indirectness, (3) inconsistency, (4) imprecision and (5) small-study effects.<sup>110</sup> Assessment will be conducted using the same procedures as for study selection and data abstraction.

To establish a hierarchy of exercise interventions for selected outcomes in the current meta-analysis, *ranking analysis*, that is, the ability to rank all interventions for a single outcome under study, for example changes in BMI in  $\text{kg}/\text{m}^2$ , will be used based on probabilities. However, because the ranking of treatments based exclusively on the probability of each treatment being the best should be avoided given that it does not account for the uncertainty in the relative treatment effects and the possibility for assigning higher ranks for treatments in which little evidence is available, separate *rankograms* and *cumulative ranking probability plots* will be used to present ranking probabilities along with their uncertainty for changes in primary and secondary outcomes.<sup>98 111</sup> The surface under the cumulative ranking curve (SUCRA), a transformation of the mean rank, will be used to establish a hierarchy of exercise interventions (aerobic, strength, both) while accounting for the location and variance of all treatment effects.<sup>98 111</sup> Larger SUCRA values indicate better ranks for the treatment.<sup>98 111</sup> Interpretation of all rankings will





be approached from the perspective of absolute and relative treatment effects.<sup>99</sup>

Software used for statistical analysis

All data will be analysed using Stata (V.14.1; Stata/SE for Windows, Stata Corporation, College Station, Texas, USA), Microsoft Excel (V.2016; Microsoft Corporation, Redmond, Washington, USA), and two add-ins for Excel, SSC-Stat (V.2.18; SSC-Stat, V.3.0.; Statistical Services Center; 2007; University of Reading, UK) and EZAnalyze (V.3.0; TA Poynton; 2007).

Amendments to protocol

None to date. If this protocol is amended, the date of each amendment, a description of the change, as well as a rationale for the change, will be provided.

**Contributors** GAK is the guarantor. GAK, KSK and RRP drafted the manuscript. All authors contributed to the development of the data sources to search for relevant literature, including search strategy, selection criteria, data extraction criteria and risk of bias assessment strategy. GAK provided statistical expertise while RRP provided content expertise on exercise and adiposity in overweight and obese children and adolescents. All authors read, provided feedback and approved the final manuscript.

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**PRISMA Network Meta-Analysis (NMA) Checklist**  
**Exercise and Adiposity in Overweight and Obese Children and Adolescents: A Systematic**  
**Review with Network Meta-Analysis of Randomised Trials**

Section/Topic	Item #	Checklist Item	Reported on Line # or page #
<b>TITLE</b>			
Title	1	Identify the report as a systematic review <i>incorporating a network meta-analysis (or related form of meta-analysis)</i> .	<b>1 and 2</b>
<b>ABSTRACT</b>			
Structured summary	2	Provide a structured summary including, as applicable: <b>Background:</b> main objectives <b>Methods:</b> data sources; study eligibility criteria, participants, and interventions; study appraisal; and <i>synthesis methods, such as network meta-analysis</i> . <b>Results:</b> number of studies and participants identified; summary estimates with corresponding confidence/credible intervals; <i>treatment rankings may also be discussed. Authors may choose to summarize pairwise comparisons against a chosen treatment included in their analyses for brevity.</i> <b>Discussion/Conclusions:</b> limitations; conclusions and implications of findings. <b>Other:</b> primary source of funding; systematic review registration number with registry name.	<b>21-47</b>
<b>INTRODUCTION</b>			
Rationale	3	Describe the rationale for the review in the context of what is already known, <i>including mention of why a network meta-analysis has been conducted</i> .	<b>61-132</b>
Objectives	4	Provide an explicit statement of questions being addressed, with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	<b>132-142</b>
<b>METHODS</b>			
Protocol and registration	5	Indicate whether a review protocol exists and if and where it can be accessed (e.g., Web address); and, if available, provide registration information, including registration number.	<b>145-149</b>
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale. <i>Clearly describe eligible treatments included in the treatment network, and note whether any have been clustered or merged into the same node (with justification).</i>	<b>150-196</b>
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last	<b>197-205</b>

		searched.	
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	206-213, <i>Supplementary file 1</i>
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	214-238
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	239-243, 248-253
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	243-248, 254-268
<b>Geometry of the network</b>	<b>S1</b>	Describe methods used to explore the geometry of the treatment network under study and potential biases related to it. This should include how the evidence base has been graphically summarized for presentation, and what characteristics were compiled and used to describe the evidence base to readers.	309-312
Risk of bias within individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	269-289
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means). <i>Also describe the use of additional summary measures assessed, such as treatment rankings and surface under the cumulative ranking curve (SUCRA) values, as well as modified approaches used to present summary findings from meta-analyses.</i>	291-307, 343-357
Planned methods of analysis	14	Describe the methods of handling data and combining results of studies for each network meta-analysis. This should include, but not be limited to: <ul style="list-style-type: none"> <li>• <i>Handling of multi-arm trials;</i></li> <li>• <i>Selection of variance structure;</i></li> <li>• <i>Selection of prior distributions in Bayesian analyses; and</i></li> <li>• <i>Assessment of model fit.</i></li> </ul>	313-336
<b>Assessment of Inconsistency</b>	<b>S2</b>	Describe the statistical methods used to evaluate the agreement of direct and indirect evidence in the treatment network(s) studied. Describe efforts taken to address its presence when found.	331-336
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	328-331
Additional analyses	16	Describe methods of additional analyses if done, indicating which were pre-specified. This may include, but not be limited to, the following: <ul style="list-style-type: none"> <li>• Sensitivity or subgroup analyses;</li> <li>• Meta-regression analyses;</li> </ul>	337-342, <i>Supplementary file 2</i>



- *Alternative formulations of the treatment network; and*
- *Use of alternative prior distributions for Bayesian analyses (if applicable).*

## RESULTS†

Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	375-385, <i>Figure 1, Supplementary file 3</i>
<b>Presentation of network structure</b>	<b>S3</b>	Provide a network graph of the included studies to enable visualization of the geometry of the treatment network.	<i>Figures 3,5,7</i>
<b>Summary of network geometry</b>	<b>S4</b>	Provide a brief overview of characteristics of the treatment network. This may include commentary on the abundance of trials and randomized patients for the different interventions and pairwise comparisons in the network, gaps of evidence in the treatment network, and potential biases reflected by the network structure.	<i>501-508, 539-546, 577-584</i>
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	<i>374-448, 457-471, 477-488, Tables 1 and 2, Supplementary file 4</i>
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment.	<i>Supplementary file 5</i>
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: 1) simple summary data for each intervention group, and 2) effect estimates and confidence intervals. <i>Modified approaches may be needed to deal with information from larger networks.</i>	<i>Supplementary files 6, 9, and 12</i>
Synthesis of results	21	Present results of each meta-analysis done, including confidence/credible intervals. <i>In larger networks, authors may focus on comparisons versus a particular comparator (e.g. placebo or standard care), with full findings presented in an appendix. League tables and forest plots may be considered to summarize pairwise comparisons.</i> If additional summary measures were explored (such as treatment rankings), these should also be presented.	<i>Pages 24-35, Figures 4, 6, 8, Table 3, Supplementary file 15</i>
<b>Exploration for inconsistency</b>	<b>S5</b>	Describe results from investigations of inconsistency. This may include such information as measures of model fit to compare consistency and inconsistency models, <i>P</i> values from statistical tests, or summary of inconsistency estimates from different parts of the treatment network.	<i>Pages 25-35, Supplementary files 6, 9, and 12</i>
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies for the evidence base being studied.	<i>Pages 25-35, Figure 2,</i>

			<i>Supplementary files 7, 10, 13</i>
Results of additional analyses	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression analyses, <i>alternative network geometries studied, alternative choice of prior distributions for Bayesian analyses</i> , and so forth).	<i>Pages 25-35, Supplementary files 8, 11, and 14</i>
<b>DISCUSSION</b>			
Summary of evidence	24	Summarize the main findings, including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy-makers).	<i>Lines 731-909</i>
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review level (e.g., incomplete retrieval of identified research, reporting bias). <i>Comment on the validity of the assumptions, such as transitivity and consistency. Comment on any concerns regarding network geometry (e.g., avoidance of certain comparisons).</i>	<i>Lines 910-927</i>
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	<i>Lines 928-931</i>
<b>FUNDING</b>			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review. This should also include information regarding whether funding has been received from manufacturers of treatments in the network and/or whether some of the authors are content experts with professional conflicts of interest that could affect use of treatments in the network.	<i>Lines 941-947</i>

PICOS = population, intervention, comparators, outcomes, study design.  
\* Text in italics indicates wording specific to reporting of network meta-analyses that has been added to guidance from the PRISMA statement.  
† Authors may wish to plan for use of appendices to present all relevant information in full detail for items in this section.

# BMJ Open

## Exercise and Adiposity in Overweight and Obese Children and Adolescents: A Systematic Review with Network Meta-Analysis of Randomised Trials

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Exercise and Adiposity in Overweight and Obese Children and Adolescents: A  
Systematic Review with Network Meta-Analysis of Randomised Trials

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Abstract = 300 words

Text = 10,506 words

Tables = 3

Figures = 8

Supplementary files = 17



## ABSTRACT

**Objectives:** Determine both the effects and hierarchy of effectiveness for exercise interventions (aerobic, strength training or both) on selected measures of adiposity (BMI in kg·m<sup>2</sup>, fat mass, and percent body fat) in overweight and obese children and adolescents.

**Design:** Network meta-analysis of randomised exercise intervention trials.

**Setting:** Any setting where a randomised trial could be conducted.

**Participants:** Overweight and obese male and/or female children and adolescents 2 to 18 years of age.

**Interventions:** Randomised exercise intervention trials  $\geq 4$  weeks, published between January 1, 1973 to August 22, 2018, and which included direct and/or indirect evidence for aerobic, strength training, or combined aerobic and strength training.

**Primary outcomes:** Changes in BMI in kg/m<sup>2</sup>, fat mass and percent body fat.

**Results:** Fifty-seven studies representing 127 groups (73 exercise, 54 control) and 2,792 participants (1,667 exercise, 1,125 control) met the criteria for inclusion. Length of training ( $\bar{X} \pm SD$ ) averaged  $14.1 \pm 6.2$  weeks, frequency,  $3.3 \pm 1.1$  days per week, and duration  $42.0 \pm 21.0$  minutes per session. Significant and clinically important reductions in BMI, fat mass, and percent body fat were observed in aerobic vs. control comparisons (BMI, mean, 95% CI, -1.0, -1.4 to -0.6; fat mass, -2.1, -3.3 to -1.0 kg; percent fat, -1.5, -2.2 to -0.9%) and combined aerobic and strength vs. control comparisons (BMI, -0.7, -1.4 to -0.1; fat mass, -2.5, -4.1 to -1.0 kg; percent fat, -2.2, -3.2 to -1.2%). A significant reduction in percent fat was also found for strength vs. control comparisons (-1.3, -2.5 to -0.1%). Combined aerobic and strength training was ranked

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first for improving both fat mass (kg) and percent body fat while aerobic exercise was ranked first for improving BMI.

**Conclusions:** Aerobic and combined aerobic and strength training are associated with improvements in adiposity outcomes in overweight and obese children and adolescents.

**Trial registration number:** PROSPERO # CRD42017073103

**Strengths and limitations of this study**

- **Major Strengths**

- To the best of the authors' knowledge, this is the first network meta-analysis to examine the effects of exercise on adiposity outcomes in overweight and obese children and adolescents.
- This study included methods to determine the clinical relevance of the reported outcomes.

- **Potential Limitations**

- Since this was an aggregate data meta-analysis, the potential for ecological fallacy exists.
- Meta-regression results should be considered exploratory and thus, do not support causal inferences.

**Keywords:** exercise, overweight, obesity, children, adolescents, network meta-analysis

## BACKGROUND

Overweight and obesity among children and adolescents is a major public health problem worldwide. Between 1980 and 2013, the worldwide prevalence of overweight and obesity in children and adolescents increased by 6.9%, from 16.9% to 23.8%, in boys and by 6.4%, from 16.2% to 22.6%, in girls from developed countries.[1] For developing countries, increases of 4.8%, from 8.1% to 12.9% for boys and 5%, from 8.4% to 13.4% in girls, were reported.[1] In terms of absolute values, 41 million children under the age of 5 and more than 340 million children and adolescents aged 5-19 were considered to be overweight or obese in 2016.[2]

The deleterious consequences associated with obesity in children and adolescents are both immediate and long-term.[3] For example, a study of children and adolescents 5 to 17 years of age found that approximately 70% of obese youth had at least one cardiovascular disease risk factor (high cholesterol, high blood pressure, etc.).[4] Obese children and adolescents are also at an increased risk for prediabetes,[5] as well as more prone to bone and joint problems, sleep apnea, and social and psychological issues that include stigmatization, low self-esteem, and low health-related quality-of-life. [6, 7] Long-term, childhood and adolescent overweight and obesity has been shown to track into adulthood,[8-12] thus placing overweight and/or obese adults at a greater risk for cardiovascular disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.[3]

One approach to treating overweight and obesity is exercise. However, previous randomised trials limited to overweight and obese male and female children and adolescents have reached conflicting results with respect to exercise-induced changes

in adiposity.[13-69] For body mass index (BMI in  $\text{kg}\cdot\text{m}^2$ ), fat mass, and percent body fat, statistically significant decreases were reported for 45.2%, 50.0%, and 40.0% of findings, respectively, as a result of exercise (aerobic, strength training, or both).[13-69] When limited to studies that included aerobic exercise as an intervention,[13, 15-17, 19, 21, 22, 24, 25, 29, 30, 32-34, 36, 38-46, 48, 50-53, 55, 57-64, 66, 67, 69] statistically significant decreases in BMI in  $\text{kg}\cdot\text{m}^2$ , fat mass, and percent body fat, were reported for 43.2%, 66.7%, and 75.0% of findings. For strength training interventions,[14, 21, 28, 35, 39, 40, 47, 53, 54, 56, 57] statistically significant decreases were reported for 9.1% (BMI in  $\text{kg}\cdot\text{m}^2$ ), 25.0% (fat mass) and 63.6% (percent fat) of findings. Finally, when restricted to combined aerobic and strength training,[13, 18-21, 23, 26, 27, 31, 37, 45, 49, 51, 57, 64, 67, 69] statistically significant decreases were reported for 78.6% (BMI in  $\text{kg}\cdot\text{m}^2$ ), 44.4% (fat mass) and 69.2% (percent fat) of results. While this may lead one to question the benefits of exercise for improving adiposity in overweight and obese children and adolescents, this would be shortsighted since it relies on the vote-counting approach, [70] an approach that has been shown to be less valid than the meta-analytic approach. [70, 71] To address these discrepancies in findings, several previous systematic reviews with aggregate data meta-analyses limited to randomised trials focused on the effects of exercise (aerobic, strength, or both) as an independent intervention on one or more measures of adiposity as primary outcomes (BMI in  $\text{kg}\cdot\text{m}^2$ , fat mass, percent fat) in overweight and obese children and adolescents have been conducted.[72-76] Across all intervention types, two [74, 76] of four [72, 74-76] reported statistically significant reductions in BMI in  $\text{kg}\cdot\text{m}^2$ , one of one reported a statistically significant reduction in fat mass,[75] and one [72] of two [72, 76] a statistically significant reduction in percent fat.



Another meta-analysis focused on combined aerobic and resistance training reported statistically significant reductions in BMI in  $\text{kg}\cdot\text{m}^2$ , fat mass, and percent fat.[73] A lack of meta-analytic data was available on the effects of aerobic and resistance training alone on BMI in  $\text{kg}\cdot\text{m}^2$  as well as fat mass and percent fat.[72-76] In addition, randomised trials without a control group, i.e., direct evidence studies that assessed the effects of exercise on adiposity outcomes, were absent.[72-76] Furthermore, there was an absence of an established hierarchy for determining which types of exercise (aerobic, strength training, or both) might be best for improving adiposity outcomes based on both direct and indirect evidence.[72-76] Network meta-analysis is an approach that includes both direct and indirect evidence as well as allowing for the ranking of treatments. To demonstrate the feasibility of this approach, the authors recently used the network meta-analytic approach to examine the effects of exercise (aerobic, strength training, or both) on BMI z-score in overweight and obese children and adolescents.[77, 78] Statistically significant reductions in BMI z-score were found for aerobic exercise and combined aerobic and strength exercise, but not strength training alone (mean, 95% CI: aerobic, -0.10, -0.15 to -0.05; aerobic and strength, -0.11, -0.19 to -0.03; strength, 0.04, -0.07 to 0.15).[78] Combined aerobic and strength training was ranked best, followed by aerobic exercise and then strength training.[78] It was concluded that combined aerobic exercise and strength training as well as aerobic exercise alone are associated with reductions in BMI z-score.[78] While these results are encouraging, BMI in  $\text{kg}/\text{m}^2$  continues to be the most frequently assessed and reported measure of adiposity across all ages in both the clinical and public health setting. Thus, an examination of such using the network meta-analytic approach is needed. In addition, since all types of BMI

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measures as well as body weight do not capture changes in body composition (fat mass, percent body fat, etc.), the inclusion of such outcomes, as previously suggested, [78] is also necessary. Thus, given (1) the prevalence of overweight and obesity in children and adolescents, (2) the negative consequences associated with such, (3) the conflicting findings of previous randomised trials addressing the effects of exercise on adiposity outcomes in overweight and obese children and adolescents, and (4) the strengths of network meta-analysis, the two primary objectives of the current study were to conduct a systematic review with network meta-analysis of randomised trials to (1) determine the effects of exercise (aerobic, strength training, or both) on adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents, and (2) establish a hierarchy of exercise interventions (aerobic, strength training, or both) for treating adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents.

**METHODS**

**Overview**

This study followed the guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) extension statement for network meta-analyses of health care interventions.[79] The protocol for this network meta-analysis is registered in PROSPERO (trial registration number CRD42017073103) and has been published in BMJ Open.[80] We provide a brief description of the Methods used and include a description of any deviations from the original protocol, [80] including reasons. Detailed information regarding the Methods can be found in the originally published protocol.[80]

## **Patient and Public Involvement**

**No patient involved.**

## **Eligibility criteria**

The inclusion criteria for this proposed network meta-analysis were as follows: (1) direct evidence from randomised trials that compared two or more exercise interventions (aerobic, strength training, both) or indirect evidence from randomised controlled trials that compared an exercise intervention group to a comparative control group (non-intervention, attention control, usual care, wait-list control, placebo, etc.), (2) exercise-only intervention (aerobic, strength training, or both), (3) studies lasting  $\geq 4$  weeks, (4) male and/or female children and adolescents 2 to 18 years of age, (5) participants overweight or obese, as defined by the authors, (6) studies published in any language up through August 22, 2018, (7) data available for BMI in  $\text{kg/m}^2$ , fat mass or percent body fat. The August 22, 2018 end date for searching was extended from the originally proposed end data of August 30, 2017 listed in the original protocol in order to stay as current as possible and while allowing for the time it takes to complete all stages of a network meta-analysis.[80]

## **Information sources**

The following seven electronic databases were searched: (1) PubMed, (2) Web of Science, (3) Cochrane Central Register of Controlled Trials (CENTRAL), (4) Cumulative Index to Nursing and Allied Health Literature (CINAHL), (5) Sport Discus, (6) Translating Research into Practice (TRIP) and (7) ProQuest Dissertations and Theses. In addition to electronic database searches, cross-referencing was conducted by examining the reference lists of previous review articles as well as each included study for potential

articles that met the inclusion criteria. Upon completion of initial searches, the third author examined the reference list for thoroughness and completeness.

**Search strategy**

Search strategies specific to each database were developed by the investigative team. The searches covered the periods from January 1, 1973 to August 22, 2018. A copy of one of the databases searched (PubMed) is shown in Supplementary file 1. All database searches and article retrieval were conducted by the second author with oversight from the first author.

**Study records**

**Study selection**

To minimize selection bias, the first and second authors selected all studies independent of each other. They then reviewed their selections for agreement. Reasons for excluded studies were recorded using the following categories: (1) inappropriate population, (2) inappropriate intervention, (3) inappropriate comparison(s), (4) inappropriate outcome(s), (5) inappropriate study design, and (6) other. Upon completion of screening, the first and second authors met and reviewed all selections. Cohen's kappa statistic ( $\kappa$ ) was used to measure inter-selection agreement.[81] Any discrepancies were resolved by discussion. If agreement could not be reached, the third author served as an arbitrator. Upon selecting the final number of studies to include, the overall precision of the searches was computed by dividing the number of included studies by the total number of studies screened after removing duplicates.[82] The number needed-to-read (NNR) was then calculated as the reciprocal of the precision. [82]

**Data abstraction**



For this project, Microsoft Excel (version 2016; Redmond, WA: Microsoft Corporation; 2016) was used to develop comprehensive electronic codebooks that could hold up to 1,475 items from each study. The major categories of variables coded included (1) study characteristics (author, journal, year of publication, etc.), (2) participant characteristics (age, gender, height, body weight, etc.), (3) intervention characteristics (type, length, frequency, intensity, duration, compliance, etc.), and (4) data for primary and secondary outcomes (sample sizes, baseline and post-exercise means and standard deviations, etc.). To avoid data abstraction bias, the first two authors independently coded (dual-coding) all studies. The first two authors then met to review their decisions. Any disagreement in the items coded were discussed until mutual agreement was achieved. If agreement could not be reached, the third author provided a recommendation. Using Cohen's kappa statistic ( $\kappa$ ), [81] inter-rater agreement prior to correcting discrepant items was 0.95.

### **Outcomes and prioritization**

The a priori primary outcomes in this study were changes in BMI in  $\text{kg/m}^2$ , fat mass, and percent body fat in overweight and obese children and adolescents. Secondary a priori outcomes included body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, maximum oxygen consumption ( $\text{VO}_{2\text{max}}$  in  $\text{ml}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$ ), muscular strength, resting systolic and diastolic blood pressure, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated hemoglobin, fasting and non-fasting glucose and insulin. Missing data for primary outcomes were

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requested via electronic mail. Post hoc, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, muscular strength, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, glycosylated hemoglobin and non-fasting glucose and insulin were not examined because of a lack of data across the three treatments.

**Risk of bias assessment in individual studies**

Risk of bias for included studies was assessed using the Cochrane Risk of Bias Instrument.[83] Judgments of low, high or unclear risk of bias were made across seven domains. Assessment for risk of bias was limited to the primary outcomes of interest (changes in BMI in kg·m<sup>2</sup>, fat mass, and percent body fat). All studies were classified as high risk of bias with respect to the category “blinding of participants and personnel” given that it’s virtually impossible to blind participants to group assignment in exercise intervention protocols. No trial was excluded based on risk of bias results.[84] The first two authors independently assessed risk of bias (dual-coding) for all studies. Any disagreements in the items coded were discussed until mutual agreement was reached. If mutual agreement could not be achieved, the third author served as an arbitrator. Using Cohen’s kappa statistic ( $\kappa$ ),[81] inter-rater agreement prior to resolving disagreements was 0.72.

**Data Synthesis**

**Calculation of effect sizes**

Changes in outcomes for randomised controlled trials were calculated by subtracting the change outcome differences between the exercise and control groups. Variances were computed using the pooled standard deviations of change scores in the exercise

and control groups. If change score standard deviations were not available, they were calculated from 95% confidence intervals (CI) for either change outcome or treatment effect differences as well as pre and post standard deviation values, the latter according to procedures developed by Follmann et al.[85] For direct comparisons, i.e., randomised trials with no control arm, the same procedures were used as for randomised controlled trials by taking the differences and variances between the two treatment groups. For studies in which adiposity outcomes were assessed at multiple intervention time points, only data from the initial and last assessment were used. A post-hoc decision was made to not analyze follow-up data because of the lack of available endpoints. Cross-over trials were handled by using all assessments from the intervention and control periods and analyzing them similar to a parallel group trial.[86] Pooled estimates for changes in outcomes

Network (geometry) plots were used to provide a visual representation of the evidence base with nodes (circles) weighted by the number of participants randomised to each treatment and edges (lines) weighted by the number of studies evaluating each pair of treatments.[87, 88]

Transitivity, i.e., similarity in the distribution of potential effect modifiers across the different pairwise comparisons for each outcome,[89] was examined using chi-square tests for categorical variables and one-way-ANOVA tests for continuous variables. If statistically significant differences were found, follow-up tests were conducted, when necessary, using the Bonferroni approach for continuous data and 2 x 2 chi-square tests for categorical data. A two-tailed alpha value  $\leq 0.05$  was considered to be statistically significant. Variables analysed between treatment contrasts included risk of

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bias variables (sequence generation, allocation concealment, blinding of outcome assessors, incomplete outcome data, selective reporting, physical activity), type of control group, age, gender, training program characteristics (length, frequency, intensity, duration, compliance, exercise supervision status), baseline values for the outcome of interest, and method for assessing the outcome of interest.

Network meta-analysis was performed using random-effects, multivariate, restricted maximum likelihood models performed within a frequentist setting and which allowed for the inclusion of potential covariates while accounting for the correlations from multi-arm trials.[90, 91] A two-tailed alpha value  $\leq 0.05$  and non-overlapping 95% CI were considered to represent statistically significant changes. In addition, 95% prediction intervals were generated in order to examine the interval in which the outcome of interest in a future study would lie.[92] Global inconsistency across each network was examined using the Wald test,[93] with an alpha value  $\leq 0.05$  considered to represent statistically significant inconsistency. Small-study-effects (publication bias, etc.) across all comparisons were conducted using funnel plots and Egger’s regression-intercept test.[94, 95] An alpha value  $\leq 0.05$  was considered to represent statistically significant small-study effects.

Potential covariates were examined by conducting simple meta-regression for statistically significant associations between covariates and changes in the primary outcomes (BMI in kg/m<sup>2</sup>, fat mass, percent fat). A list of covariates examined using simple meta-regression is shown in Supplementary file 2. A post hoc decision was made to not conduct any type of multiple meta-regression because of missing data for different variables from different studies.



292 To establish a hierarchy of exercise interventions for all outcomes in the current meta-  
293 analysis, the surface under the cumulative ranking curve (SUCRA), a transformation of  
294 the mean rank, was used and while accounting for the location and variance of all  
295 treatment effects.[87, 96] Larger SUCRA values indicate better ranks for the  
296 treatment.[87, 96] Interpretation of all rankings was approached from the perspective of  
297 both absolute and relative treatment effects.[88]

#### 298 Confidence in cumulative evidence

299 The a priori plan was to examine for the strength of evidence for network meta-  
300 analyses using the approach described by Salanti et al.[97] However, since that time,  
301 an alternative approach has been suggested,[98] with no clear consensus and  
302 continuing controversy on the best approach for network meta-analysis, including the  
303 validity and reliability of these assessment tools. Therefore, a post hoc decision was  
304 made to use a qualitative approach versus a formal assessment instrument to examine  
305 for the strength of the evidence.

#### 306 Software used for statistical analysis

307 All data were analysed using Stata (V.14.1; Stata/SE for Windows, version 14.0.  
308 College Station, TX: Stata Corporation LP; 2015), Microsoft Excel (version 2016;  
309 Redmond, WA: Microsoft Corporation; 2016), and two add-ins for Excel, SSC-Stat  
310 (V.2.18; SSC-Stat, version 3.0. University of Reading, United Kingdom: Statistical  
311 Services Center; 2007), and EZ-Analyze (V.3.0; EZ Analyze, version 3.0. TA Poynton;  
312 2007).

## 313 RESULTS

### 314 Study Characteristics

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Of the 6,478 citations screened after removing duplicates both electronically and manually, 57 studies representing 127 groups (73 exercise, 54 control) and 2,792 participants (1,667 exercise, 1,125 control) met the criteria for inclusion.[13-37, 39, 40, 42-69, 99, 100] The number needed to screen was 0.88% while the NNR was 114. Reasons for exclusion, in order of prevalence, included inappropriate study design (48.4%), inappropriate population (20.5%), inappropriate intervention (13.6%), other, for example, editorials (9.6%), inappropriate outcome (6.9%), inappropriate comparison (1.0%), and unable to retrieve data (0.03%). A flow diagram that depicts the search process is shown in Figure 1 while a list of the 6,421 excluded studies, including the reasons for exclusion, can be found in Supplementary File 3. A total of 4 different requests for data were made to authors, 2 (50%) of which provided such.

General study characteristics are shown in Supplementary file 4. The included studies were published in 45 different journals since 1997 ( $\bar{X} \pm SD = 2011 \pm 4$ , Median = 2012). Fifty-two studies (91.2%) were published in the English language,[13, 14, 16-18, 20, 22, 24-37, 39, 40, 42-69, 99] while the remaining 5 (8.8%) were published in either Chinese [19, 21, 23, 100] or Spanish.[15] The location in which studies were conducted included 20 different countries, 12 in the United States,[24, 30, 34, 35, 39, 40, 46, 48, 52, 56, 60, 66] 8 in China,[19-23, 61, 62, 99, 100] 6 in Brazil,[13, 15, 45, 47, 58, 63] 5 in South Korea,[36, 37, 49, 55, 59] 4 in Tunisia,[17, 25, 50, 51] 3 each in Australia,[54, 64, 65] Canada,[14, 32, 57] and Iran,[27, 29, 69] 2 in Turkey,[33, 53] and 1 each in either France,[16] Germany,[44] Italy,[28] Lebanon,[68] New Zealand,[42] Norway,[18] Singapore,[67] Sweden,[31] Switzerland,[26] Taiwan,[22] or the United Kingdom [43]. Of the 57 included studies, 45 (78.9%) were two-arm randomised controlled trials limited to

1 exercise and 1 control group that met all eligibility criteria,[14-20, 22, 23, 25-27, 29-31, 33-37, 42-44, 46-49, 52-56, 58-69, 100] seven (12.3%) were three-arm randomised controlled trials that included 2 exercise arms,[24, 32, 39, 40, 50, 51, 99] and two (3.5%) were four-arm randomised controlled trials that included three exercise arms.[21, 57] The remaining three studies (5.3%) were randomised trials that compared two or more different exercise interventions directly but did not include an eligible control group.[13, 28, 45] Ten of 57 studies (17.5%) included matching procedures according to either race/ethnicity,[60] age, sex and BMI,[34] age and sex,[45] BMI,[45] sex and BMI, [13] race/ethnicity and sex,[24, 42, 48] sex [49] or sex and degree of overweight.[57] Two studies (3.5%) used a crossover design.[64, 65] With respect to the statistical analysis of data, 39 studies (68.4%) used the per protocol approach,[13, 14, 16, 17, 19-23, 25, 27-31, 33-37, 44, 46-48, 50-53, 55, 56, 58, 59, 63-65, 67-69, 99] 11 (19.3%) used intention-to-treat or reported that all subjects completed the study,[18, 24, 42, 43, 45, 49, 54, 61, 62, 66, 100] while 7 (12.3%) used both per protocol and intention-to-treat analyses.[15, 26, 32, 39, 40, 57, 60] Only 18 studies (31.6%) reported sample size estimates for their primary outcome(s) of interest.[15, 18, 22, 24, 26, 32, 35, 39, 42, 45, 48, 49, 54, 57, 59, 63, 65, 66] In relation to funding, 42 studies (73.7%) reported receiving financial support for their research,[13, 14, 17, 18, 20, 22, 24-26, 30-32, 34-37, 39, 40, 42, 44-52, 54-57, 59-61, 63-68, 99] 16 from government sources,[17, 18, 22, 24, 25, 30, 31, 47, 50, 51, 54, 55, 60, 61, 66, 68] 4 from private sources,[45, 52, 64, 65] 8 from universities,[14, 20, 37, 44, 49, 59, 67, 99] 8 from both government and private sources,[32, 34, 39, 40, 42, 46, 48, 63-68] 3 from government and university sources,[13, 26, 35] 2 from government, university and private sources,[56, 57] and 1

from university and private sources.[36] None of the studies reported any information on the cost-effectiveness of their interventions. Overweight and obesity was most commonly defined using age and sex-specific BMI cutpoints. However, variability existed in the criteria used to determine overweight and obesity (Supplementary file 4).

**Participant Characteristics**

Baseline characteristics of the participants are shown in Supplementary file 4 and Table 1. More than half the studies (57.1%) included both males and females,[13-18, 20, 22, 24, 26, 28, 30-32, 34, 42-46, 48, 49, 52, 57, 58, 61-65, 68, 99] followed by those limited to males (32.1%),[19, 23, 25, 27, 29, 33, 35-37, 39, 47, 54-56, 59, 67, 69, 100] and females (10.7%).[40, 50, 51, 53, 60, 68] Participants included those across all five stages of puberty.[13, 14, 16, 17, 24-26, 32, 34, 35, 39, 40, 43, 50, 56, 57, 63, 64, 68, 69] For those studies that reported race/ethnicity,[16-20, 23, 24, 30, 32, 35, 39, 40, 42, 48, 52, 56, 57, 59-62, 65, 66, 100] and as reported by the authors, participants included Whites, Blacks/African Americans, Asians, Hispanics/Latinos, Native Hawaiian/Pacific Islander, Maori, Aboriginal, Arabic, Chinese, Koreans, French, Norwegian, Tunisian and native Canadian. Some studies included one or more participants with hyperlipidemia,[17, 26, 52] hypertension,[26, 56] metabolic syndrome,[17, 34, 46, 56] and/or asthma.[46, 52] For those studies in which data were available, none reported that any of the participants smoked cigarettes [19, 27, 39, 40, 44, 64, 65, 67-69, 100] or consumed alcohol.[13, 100] For the 31 studies (54.4%) that reported data by group,[15, 20, 22, 24, 26, 28, 32, 34, 35, 37, 39, 40, 42, 44, 45, 48-51, 54-58, 60-63, 66, 68, 100] dropouts ranged from 0% to 60.9% in the exercise groups ( $\bar{X} \pm SD$ ,  $15.2 \pm 14.5$ , Median = 12.5) and 0% to 61.5% in the control groups ( $\bar{X} \pm SD$ ,  $14.9 \pm 14.9$ , Median = 13.8).



Reasons for dropouts in the exercise group were varied, consisting of such things as lack of time, personal reasons, dissatisfaction with program and logistics. For the control groups, reasons included such things as unhappiness with group assignment and logistics. Of the 11 studies (19.3%) that reported data on adverse events,[24, 32, 42, 47, 51, 57, 60, 62, 64-66] only one reported a serious adverse event (one foot fracture). [24]

Table 1. Baseline physical characteristics of participants.\*

Variable	Exercise				Control			
	S/G/P (#)	$\bar{X} \pm SD$	Mdn	Range	S/G/P (#)	$\bar{X} \pm SD$	Mdn	Range
Age (years)	51/65/1666	$13.1 \pm 2.6$	14	8-17	49/49/1117	$12.7 \pm 2.6$	13	8-17
Height (cm)	44/55/1342	$157.7 \pm 11.3$	163	130-176	42/42/910	$156.5 \pm 12.2$	161	127-175
Body Weight (kg)	52/65/1371	$76.3 \pm 17.2$	79	35-107	49/49/906	$75.4 \pm 17.3$	75	34-103
BMI (kg/m <sup>2</sup> )	52/66/1451	$29.4 \pm 3.9$	29	21-38	48/48/929	$29.3 \pm 3.7$	29	21-37
Fat mass (kg)	31/40/867	$33.4 \pm 11.5$	31	15-60	29/29/567	$31.2 \pm 10.2$	30	15-56
Body fat (%)	46/59/1364	$38.1 \pm 6.8$	38	27-52	42/42/840	$37.0 \pm 6.6$	37	23-51
Fat-free mass (kg)	33/42/764	$46.6 \pm 9.8$	48	25-64	29/29/435	$45.8 \pm 11.1$	47	25-64
WC (cm)	23/34/757	$95.1 \pm 9.2$	94	76-115	21/21/445	$95.5 \pm 8.8$	95	80-111
VO <sub>2max</sub> (ml·kg <sup>-1</sup> ·min <sup>-1</sup> )	28/38/980	$30.7 \pm 4.9$	31	20-41	26/26/524	$30.5 \pm 6.1$	30	20-44

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3	SBP (mmHg)	20/24/484	118.2 ±	118	98-	19/19/330	119.4 ±	118	100-
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5			8.7		139		9.1		134
6									
7	DBP (mmHg)	19/23/450	69.8 ± 6.8	68	56-81	18/18/296	69.7 ± 8.1	70	52-85
8									
9	TC (mg/dl)	21/27/454	157.8 ±	160	110-	20/20/301	163.1 ±	163	114-
10									
11			16.3		200		19.7		220
12									
13	HDL (mg/dl)	25/30/523	42.9 ± 5.2	43	34-56	23/23/371	44.0 ± 6.3	45	33-59
14									
15	LDL (mg/dl)	24/29/507	96.5 ±	98	75-	22/22/354	100.4 ±	98	81-
16									
17			11.4		124		14		142
18									
19	TG (mg/dl)	25/30/521	111.6 ±	107	53-	22/22/351	109.9 ±	102	102-
20									
21			27.2		173		27.4		187
22									
23	Fasting Glucose	25/33/684	88.5 ± 5.6	90	76-98	24/24/360	88.4 ± 5.3	88	74-97
24	(mg/dl)								
25									
26	Fasting Insulin	18/27/586	21.1 ± 9.2	21	6-46	17/17/230	21.0 ±	19	6-48
27	(uU/ml )								
28							11.0		
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30 391 Notes: \*, Descriptive data for exercise characteristics calculated based on number of groups (G); S/G/P  
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32 392 (#), number of studies/groups/participants;  $\bar{X} \pm SD$ , mean  $\pm$  standard deviation; Mdn, median; BMI, body  
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34 393 mass index; WC, waist circumference; WHR, waist-to-hip ratio;  $VO_{2max}$ , maximum oxygen consumption;  
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36 394 SBP, resting systolic blood pressure; DBP, resting diastolic blood pressure; TC, total cholesterol; HDL,  
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38 395 high-density lipoprotein cholesterol; LDL, low-density lipoprotein cholesterol; TG, triglycerides; non-HDL,  
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40 396 non-high-density lipoprotein cholesterol, calculated as total cholesterol minus high-density lipoprotein  
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42 397 cholesterol; HbA1c, glycated hemoglobin.

43 398 **Exercise Intervention Characteristics**

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46 399 Characteristics of the exercise interventions are shown in Supplementary file 4 and  
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48 400 Table 2. Forty-one studies (71.9%) included aerobic exercise,[13, 15-17, 19, 21-25, 28-  
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50 401 30, 32-34, 36, 39, 40, 42-46, 48, 50-53, 55, 57-63, 65, 66, 68, 69, 99, 100] 9 (15.8%)  
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52 402 included strength training,[21, 28, 35, 39, 40, 47, 54, 56, 57] and 17 (29.8%) included  
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55 403 combined aerobic and strength training.[13, 14, 18, 20, 21, 23, 26, 27, 31, 37, 45, 49,

57, 58, 64, 67, 69] While methods for assessing the intensity of training for both aerobic and resistance exercise varied between the 38 studies (66.7%) that reported such information,[14, 17, 19-22, 24, 26-28, 30, 32-34, 37, 39, 40, 45, 48-51, 53, 55-59, 61-65, 67-69, 99, 100] the intensities most commonly reported ranged from moderate to vigorous based on American College of Sports Medicine cutpoints.[101] Specific types of activities performed included, but were not necessarily limited to, various non-video games (soccer, dodgeball, basketball, etc.), active video games, walking, running, cycling, swimming, stairclimbing, jumping rope, dance, and resistance training, including circuit training.[13-29, 31-34, 36, 37, 39, 40, 42-52, 54-69, 99, 100]

Table 2. Exercise program characteristics.\*

Variable	S/G/P	$\bar{X} \pm SD$	Mdn	Range
Length (weeks)	57/73/1663	14.1 $\pm$ 6.2	12	6-36
Frequency (days/week)	56/72/1655	3.3 $\pm$ 1.1	3	1-7
Duration (min/session)	53/55/1251	42 $\pm$ 21	40	6-90
Compliance (%)	19/25/580	81.9 $\pm$ 18.8	87	42-100
Minutes per week**	37/46/1092	132.6 $\pm$ 73.2	125	18-360
Minutes per week (adj)**	16/18/568	133.1 $\pm$ 74.2	124	39-360

Notes: Notes: \*, Descriptive data for exercise characteristics calculated based on number of groups (G); S/G/P (#), number of studies/groups/participants;  $\bar{X} \pm SD$ , mean  $\pm$  standard deviation; Mdn, median; min, minutes; \*\*, limited to aerobic exercise; Minutes per week of exercise, calculated as frequency per week x duration per session in minutes; Minutes per week (adj) of exercise, calculated as frequency per week x duration per session in minutes x compliance, defined as the percentage of exercise sessions attended. For those studies that included resistance training and provided additional data, [13, 14, 18, 20, 21, 23, 26-28, 31, 35, 37, 39, 40, 45, 47, 49, 51, 54, 56, 57, 64, 67, 69] the number of sets ranged from 1 to 3 ( $\bar{X} \pm SD$ , 2  $\pm$  1, Median = 3), repetitions from 5 to 17 ( $\bar{X} \pm SD$ , 11  $\pm$  5, Median = 11), and exercises from 3 to 13 ( $\bar{X} \pm SD$ , 9  $\pm$  3, Median = 9).

Types of resistance included one’s own body weight, heavy balls, elastic bands, free weights and machine weights. For the 56 studies (98.2%) that provided data on exercise delivery,[13-15, 17-37, 39, 40, 42-69, 99, 100] 51 (91.1%) were supervised,[13-15, 17-34, 36, 37, 39, 40, 43-45, 47-51, 53-56, 58-69, 99, 100] 4 (7.1%) were unsupervised,[35, 42, 46, 52] and 1 (1.8%) included both [57].

**Risk of Bias Assessment**

Summary results using the Cochrane Risk of Bias Instrument [83] are shown in Figure 2 while study-level results are shown in Supplementary file 5. With the exception of blinding of participants and personnel, the number of studies rated as being at a high risk of bias ranged from only 2% to 18%, with 5 of the 6 items being less than 10%. All studies were considered to be at a high risk of bias for blinding of participants and personnel because it is virtually impossible to blind participants to group assignment in exercise intervention studies. In contrast, the vast majority of studies (97%) were considered to be at a low risk of bias for random sequence generation. Finally, with the exception of random sequence generation and blinding of participants and personnel, 42% to 75% of studies were rated as being at an unclear risk of bias for the remaining 5 items.

**Data Synthesis**

Data are reported for primary outcomes (BMI in kg·m<sup>2</sup>, fat mass and percent body) according to (1) overall findings, (2) interval plot results, (3) ranking of treatments, and (4) meta-regression results. Separate results are then reported for all secondary outcomes: body weight, fat-free mass, waist circumference, maximum oxygen consumption, systolic blood pressure, diastolic blood pressure total cholesterol, high-



density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, fasting glucose and insulin.

## Primary Outcomes

*Body mass index (overall findings).* Data from 50 studies representing 67 effect sizes were included in the BMI in kg·m<sup>2</sup> analyses.[13-17, 19-23, 25-29, 31-37, 39, 40, 42-47, 49, 52-59, 61-69, 99, 100] The network geometry plot for BMI in kg·m<sup>2</sup> is shown in Figure 3. The most common group was the control group followed by the aerobic group. The most common comparison was aerobic versus control (n = 35) followed by combined aerobic and strength versus control (n = 11), strength versus control (n = 8), strength versus aerobic (n = 7), combined aerobic and strength versus aerobic (n = 4), and combined aerobic and strength versus strength (n = 2). An examination for transitivity found no statistically significant differences for potential effect modifiers across treatment comparisons (p > 0.05 for all, results not shown).

*Body mass index (interval plot).* An interval plot for changes in BMI in kg·m<sup>2</sup> is shown in Figure 4 while a study-level network forest plot that includes each comparison-specific effect size can be found in Supplementary file 6. As can be seen in Figure 4, non-overlapping 95% confidence intervals for BMI in kg·m<sup>2</sup> were observed for the aerobic versus control (n = 35) as well as the combined aerobic and strength versus control comparisons (n = 11) (p < 0.05 for both). Changes were equivalent to relative reductions of 3.8% for the aerobic versus control comparison and 2.4% for the combined aerobic and strength training versus control comparison. However, all 95% prediction intervals were overlapping. No statistically significant differences were observed for direct comparisons. In addition, the overall test for inconsistency was not

statistically significant ( $\chi^2(7df) = 4.4$ ,  $p = 0.74$ , Supplementary file 6). No statistically significant small-study effects (publication bias, etc.) were found ( $n = 67$ ,  $p = 0.51$ , Supplementary file 7).

*Body mass index (ranking of treatments).* The ranking of treatments for BMI in  $\text{kg}\cdot\text{m}^2$  is shown in Table 3. As can be seen, aerobic exercise had the highest probability of being ranked as the best treatment. This was followed by combined aerobic and strength training and then strength training alone.

*Body mass index (meta-regression).* Meta-regression results, including sample sizes for these models, can be found in Supplementary file 8. For aerobic exercise, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in BMI as a result of (1) studies conducted in countries other than those in the United States, (2) unfunded versus funded studies, (3) greater compliance to the exercise intervention, (4) greater number of total minutes of exercise per week, and (5) greater number of total minutes per week of exercise after adjusting for compliance. For

Table 3. Ranking analyses for treatments.

Variable	Best (%)	2 <sup>nd</sup> (%)	3 <sup>rd</sup> (%)	Worst (%)	$\bar{X}$ Rank	SUCRA
BMI $\text{kg}\cdot\text{m}^2$						
- Aerobic	78.0	21.6	0.4	0.0	<b>1.2</b>	<b>0.9</b>
- Strength	0.9	8.9	55.3	34.9	3.2	0.3
- Both	21.1	69.1	9.1	0.7	1.9	0.7
- Control	0	0.4	35.3	64.4	3.6	0.1
Fat mass (kg)						
- Aerobic	27.9	52.3	19.7	0	1.9	0.7
- Strength	11.3	18.7	61.6	8.4	2.7	0.4
- Both	60.7	29.0	10.3	0	<b>1.5</b>	<b>0.8</b>

- Control	0	0	8.4	91.6	3.9	0
Body fat (%)						
- Aerobic	9.9	57.0	33.1	0	2.2	0.6
- Strength	10.2	27.6	60.3	1.9	2.5	0.5
- Both	79.7	15.4	4.7	0	<b>1.2</b>	<b>0.9</b>
- Control	0	0	1.9	98.1	4	0

Notes: SUCRA, surface under the cumulative ranking curve analysis; **Boldface** values indicate best treatment;  $\bar{X}$  Rank, mean rank.

strength training, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in BMI and (1) studies at a low versus unclear risk of bias with respect to participants being physically inactive prior to study initiation, (2) supervised versus unsupervised exercise, and (3) facility versus home-based exercise. No other statistically significant associations were observed.

*Fat mass (overall findings).* Data from 31 studies representing 46 effect sizes were included in the fat mass (kg) analyses.[13, 14, 17, 18, 21, 23, 25, 27, 31, 34-37, 39, 40, 42, 45-48, 52, 55-57, 59, 60, 64, 67, 69, 99, 100] The network geometry plot for fat mass (kg) is shown in Figure 5. As can be seen, the control group was the most common followed by the aerobic group. The most common comparison was aerobic versus control ( $n = 19$ ) followed by combined aerobic and strength versus control ( $n = 10$ ), strength versus control ( $n = 7$ ), strength versus aerobic ( $n = 7$ ), combined aerobic and strength versus aerobic ( $n = 4$ ), and combined aerobic and strength versus strength ( $n = 2$ ) comparisons. An examination for transitivity revealed a statistically significant overall difference between comparisons for frequency of training in days per week ( $F(5,40df) = 3.4$ ,  $p = 0.01$ ). Post-hoc follow-up testing revealed that frequency of training was greater in the aerobic versus control versus combined aerobic and strength versus

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control comparisons (4.0 versus 2.4 days per week,  $p = 0.008$ ). No other statistically significant between-comparison differences were observed ( $p > 0.05$  for all, results not shown).

*Fat mass (interval plot).* An interval plot for changes in fat mass in kg is shown in Figure 6 while a network forest plot that includes each comparison-specific effect size can be found in Supplementary file 9. As can be seen by the non-overlapping 95% confidence intervals in Figure 6, statistically significant reductions in fat mass in kg were found for the aerobic versus control ( $n = 19$ ) as well as the combined aerobic and strength versus control comparisons ( $n = 10$ ) ( $p < 0.05$  for both). Changes were equivalent to relative reductions of 8.3% for the aerobic versus control comparison and 8.4% for the combined aerobic and strength training versus control comparison. However, all 95% prediction intervals were overlapping. No statistically significant differences were observed for head-to-head comparisons. In addition, the overall test for inconsistency was not statistically significant ( $\chi^2$  (6df) = 7.5,  $p = 0.27$ , Supplementary file 9). No statistically significant small-study effects (publication bias, etc.) were found ( $n = 46$ ,  $p = 0.10$ , Supplementary file 10).

*Fat mass (ranking of treatments).* The ranking of treatments for fat mass in kg is shown in Table 3. As can be seen, combined aerobic and strength training exercise had the highest probability of being ranked as the best treatment followed by aerobic exercise.

*Fat mass (meta-regression).* Meta-regression results for fat mass (kg), including sample sizes for these models, are shown in Supplementary file 11. For aerobic exercise, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in BMI as a result of (1) studies at an unclear versus low risk of bias for selective reporting, (2)



shorter interventions (weeks), (3) high versus moderate intensity exercise, (4) greater compliance to the exercise protocol, and (5) greater total minutes per week of exercise, adjusted for compliance. For combined aerobic and strength training, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in fat mass and more recent year of publication as well as unfunded versus funded studies. No other statistically significant associations were observed.

*Percent body fat (overall findings).* Data from 45 studies representing 64 effect sizes were included in the percent body fat analyses.[13, 14, 18-24, 26, 28-32, 34-37, 39, 40, 42, 44-48, 50-61, 63, 64, 67-69, 100] The network plot for fat mass (kg) is shown in Figure 7. As can be seen, the control group was the most common followed by the aerobic group. The most common comparison was the aerobic versus control group ( $n = 32$ ) followed by combined aerobic and strength versus control ( $n = 12$ ), strength versus control ( $n = 8$ ), strength versus aerobic ( $n = 6$ ), combined aerobic and strength versus aerobic ( $n = 4$ ), and combined aerobic and strength versus strength ( $n = 2$ ) comparisons. An examination for transitivity revealed a statistically significant difference between comparisons with respect to the method used for the assessment of percent body fat ( $\chi^2 (25df) = 43.7$ ,  $p = 0.01$ ). Post-hoc follow-up testing revealed that the difference was between the aerobic versus control and strength versus control comparisons ( $\chi^2 (4df) = 12.7$ ,  $p = 0.01$ ) as well as aerobic versus control and combined aerobic and strength training versus aerobic comparisons ( $\chi^2 (5df) = 12.3$ ,  $p = 0.03$ ). In addition, frequency of training was associated with specific comparisons ( $F (5, 58df) = 2.9$ ,  $p = 0.02$ ). Post hoc follow-up testing showed that frequency of training was lower in the combined aerobic and strength training comparison (2.6 days per week) versus the

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aerobic and control comparison (3.8 days per week,  $p = 0.02$ ). No other statistically significant between-comparison differences were observed ( $p > 0.05$  for all).

*Percent body fat (interval plot).* An interval plot for changes in percent body fat is shown in Figure 8 while a network forest plot that includes each comparison-specific effect size can be found in Supplementary file 12. As can be seen by the non-overlapping 95% confidence intervals in Figure 8, statistically significant reductions ( $p < 0.05$ ) in percent body fat were found for the aerobic versus control ( $n = 32$ ), strength versus control ( $n = 8$ ), and combined aerobic and strength versus control comparisons ( $n = 12$ ). Changes were equivalent to relative reductions of 5.4% for the aerobic versus control comparison, 2.8% for the strength versus control comparison, and 6.0% for the combined aerobic and strength training versus control comparison. However, all 95% prediction intervals were overlapping. No statistically significant differences were observed for direct comparisons. In addition, the overall test for inconsistency was not statistically significant ( $\chi^2 (7df) = 11.9, p = 0.10$ , Supplementary file 12). No statistically significant small-study effects (publication bias, etc.) were found ( $n = 64, p = 0.65$ , Supplementary file 13).

*Percent body fat (ranking of treatment).* The ranking of treatments for percent body fat is shown in Table 3. As can be seen, combined aerobic and strength training exercise had the highest probability of being ranked as the best treatment followed by aerobic exercise alone and strength training alone.

*Percent body fat (meta-regression).* Meta-regression results for percent body fat, including sample sizes for statistically significant results, are shown in Supplementary file 14. For aerobic exercise, statistically significant associations ( $p < 0.05$ ) were found

for greater reductions in percent body fat as a result of (1) studies at an unclear versus low risk of bias for selective reporting, (2) unfunded versus funded studies, and (3) shorter interventions (weeks). For strength training, greater reductions were associated with low versus unclear risk of bias for participants being physically active prior to study initiation as well as unfunded versus funded studies. For combined aerobic and strength training, greater reductions in percent body fat were associated with unfunded versus funded studies. No other statistically significant associations were observed.

## Secondary Outcomes

The overall results for secondary outcomes are shown in Supplementary file 15.

**Body weight.** Statistically significant reductions in body weight were observed for both aerobic exercise and combined aerobic and strength training. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative reductions of 3.0% and 4.0% respectively, for aerobic and combined exercise. In addition greater reductions were observed for the combined aerobic and strength versus strength training only comparison ( $\bar{X}$ , -1.7, 95% CI, -3.3 to -0.07). The global test for inconsistency was not statistically significant ( $\chi^2$  (7df) = 10.5, p = 0.16). Statistically significant small-study effects (publication bias, etc.) were observed (n = 67, p = 0.002). For ranking of treatments, aerobic exercise was ranked as the best treatment followed by combined aerobic and strength training.

**Fat free mass.** Statistically significant increases in fat free mass (kg) were observed for combined aerobic exercise and strength training but none of the other interventions. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative increases of 2.5%. In addition, increases in fat free mass were

greater for combined aerobic and strength versus aerobic comparisons ( $\bar{X}$ , 1.2, 95% CI, 0.1 to 2.3). The global test for inconsistency was not statistically significant ( $\chi^2$  (7df) = 2.8,  $p = 0.90$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $n = 45$ ,  $p = 0.008$ ). For ranking of treatments, combined aerobic and strength training was ranked first for increasing fat free mass.

Waist circumference. Statistically significant reductions in waist circumference were found for aerobic exercise. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative reductions of 2.2%. No statistically significant differences were observed for head-to-head comparisons ( $p < 0.05$  for all). The global test for inconsistency was not statistically significant ( $\chi^2$  (6df) = 8.1,  $p = 0.23$ ). No statistically significant small-study effects (publication bias, etc.) were observed ( $n = 36$ ,  $p = 0.39$ ). For ranking of treatments, combined aerobic and strength training was ranked first followed by aerobic exercise.

*Maximum oxygen consumption.* Statistically significant increases were found for  $VO_{2max}$  in  $ml \cdot kg^{-1} \cdot min^{-1}$  as a result of either aerobic exercise or combined aerobic exercise and strength training. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative increases of 12.2% and 8.9%, respectively for aerobic exercise and combined aerobic and strength exercise. No statistically significant differences were observed for the three direct comparisons. The global test for inconsistency was also not statistically significant ( $\chi^2$  (6df) = 10.0,  $p = 0.12$ ). No statistically significant small-study effects (publication bias, etc.) were observed ( $n = 47$ ,  $p = 0.32$ ). For ranking of treatments, combined aerobic exercise was ranked first while combined aerobic and strength training was ranked second.



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3 616 *Systolic blood pressure.* Statistically significant decreases were found for resting  
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6 617 systolic blood pressure as a result of aerobic exercise. However, 95% prediction  
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8 618 intervals for all comparisons included zero. Changes were equivalent to a relative  
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10 619 reduction of 3.5%. No statistically significant differences were observed for the head-to-  
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12 620 head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2$   
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14 621 (4df) = 2.0, p = 0.74). Statistically significant small-study effects (publication bias, etc.)  
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17 622 were observed (n = 24, p = 0.01). For ranking of treatments, aerobic exercise was  
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19 623 ranked first.

21 624 *Diastolic blood pressure.* Statistically significant decreases for resting diastolic blood  
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23 625 pressure were found as a result of aerobic exercise. However, the 95% prediction  
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25 626 intervals for all comparisons included zero. Changes were equivalent to a relative  
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27 627 reduction of 3.4%. No statistically significant differences were observed for any of the  
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29 628 head-to-head comparisons. The global test for inconsistency was not statistically  
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31 629 significant ( $\chi^2$  (4df) = 0.53, p = 0.97). Statistically significant small-study effects  
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33 630 (publication bias, etc.) were observed (n = 23, p = 0.001). For ranking of treatments,  
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35 631 aerobic exercise was ranked first.

38 632 *Total cholesterol.* Statistically significant decreases in total cholesterol were found as a  
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40 633 result of aerobic exercise but none of the other interventions. However, the 95%  
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42 634 prediction intervals for all comparisons included zero. Changes were equivalent to a  
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44 635 relative reduction of 3.3%. No statistically significant differences were observed for the  
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46 636 three head-to-head comparisons. The global test for inconsistency was not statistically  
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48 637 significant ( $\chi^2$  (5df) = 1.8, p = 0.87). Furthermore, no statistically significant small-study  
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638 effects (publication bias, etc.) were observed ( $n = 28$ ,  $p = 0.70$ ). For treatment rankings,  
639 aerobic exercise was ranked as best.

640 *High-density lipoprotein cholesterol*. Statistically significant increases were found for  
641 high-density lipoprotein cholesterol as a result of aerobic exercise only. Conversely, the  
642 95% prediction intervals for all comparisons included zero. Changes were equivalent to  
643 relative increases of 7.4%. No statistically significant differences were observed for any  
644 of the direct comparisons. The global test for inconsistency was not statistically  
645 significant ( $\chi^2$  (5df) = 2.6,  $p = 0.76$ ). Statistically significant small-study effects  
646 (publication bias, etc.) were observed ( $n = 31$ ,  $p = 0.04$ ). For treatment rankings,  
647 combined aerobic exercise was ranked as the best.

648 *Low-density lipoprotein cholesterol*. Statistically significant decreases in low-density  
649 lipoprotein cholesterol were found as a result of aerobic exercise but none of the other  
650 interventions. In addition, the 95% prediction interval did not include zero. Changes  
651 were equivalent to a relative reduction of 6.0%. No statistically significant differences  
652 were observed for the three head-to-head comparisons. The global test for  
653 inconsistency was not statistically significant ( $\chi^2$  (5df) = 2.4,  $p = 0.79$ ). Statistically  
654 significant small-study effects (publication bias, etc.) were observed ( $n = 30$ ,  $p = 0.006$ ).  
655 For treatment rankings, aerobic exercise was ranked as best.

656 *Triglycerides*. Statistically significant decreases in triglycerides were found as a result of  
657 aerobic exercise as well as combined aerobic and strength exercise. In addition, the  
658 95% prediction intervals did not include zero for both treatments. Changes were  
659 equivalent to a relative reduction of 11.9% as a result of aerobic exercise and 14.4% as  
660 a result of combined aerobic and strength exercise. No statistically significant

661 differences were observed for the three head-to-head comparisons. The global test for  
662 inconsistency was not statistically significant ( $\chi^2$  (5df) = 1.4, p = 0.92). No statistically  
663 significant small-study effects (publication bias, etc.) were observed (n = 30, p = 0.44).

664 For treatment rankings, aerobic exercise was ranked best, followed by combined  
665 aerobic and strength training.

666 *Fasting Glucose.* Statistically significant decreases in fasting glucose were found as a  
667 result of combined aerobic and strength exercise. In addition, the 95% prediction  
668 interval did not include zero. Changes were equivalent to a relative reduction of 6.1%.

669 For head-to-head comparisons decreases, were greater for combined aerobic and  
670 strength versus strength only interventions ( $\bar{X}$ , -4.9, 95% CI, -9.5 to -0.2). The global test  
671 for inconsistency was not statistically significant ( $\chi^2$  (6df) = 2.2, p = 0.90). No statistically  
672 significant small-study effects (publication bias, etc.) were observed (n = 37, p = 0.35).

673 For treatment rankings, combined aerobic and strength training was ranked as best.

674 *Fasting Insulin.* Statistically significant decreases in fasting insulin were observed for  
675 aerobic exercise, strength exercise, and combined aerobic and strength exercise as a  
676 result of combined aerobic and strength exercise. In addition, the 95% prediction  
677 interval did not include zero for any of the three intervention types. Changes were  
678 equivalent to relative reductions of 21.2% (aerobic exercise), 22.6% (strength exercise)  
679 and 17.1% (combined aerobic and strength exercise). No statistically significant  
680 differences were observed for the three head-to-head comparisons. The global test for  
681 inconsistency was not statistically significant ( $\chi^2$  (7df) = 5.6, p = 0.59). However,  
682 statistically significant small-study effects (publication bias, etc.) were observed (n = 33,

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p = 0.008). For treatment rankings, combined aerobic and strength training was ranked as best, followed by strength training and aerobic exercise.

**DISCUSSION**

**Overall Findings for Primary Outcomes**

The primary purpose of the current study was to conduct a network meta-analysis of randomised trials on the effects of exercise (aerobic, strength training, or both) on adiposity outcomes (BMI in kg·m<sup>2</sup>, fat mass, percent fat) in overweight and obese children and adolescents. The overall findings suggest that exercise is associated with statistically significant reductions in all three primary outcomes. More specifically, aerobic exercise as well as combined aerobic and strength exercise were shown to decrease BMI in kg·m<sup>2</sup>, fat mass and percent fat while decreases as a result of strength training interventions were limited to percent fat only. Of the three exercise interventions, combined aerobic and strength exercise was ranked as best for reducing fat mass and percent fat while aerobic exercise was ranked best for reducing BMI in kg·m<sup>2</sup>. These findings are further strengthened by the lack of global inconsistency for all three primary outcomes as well as the lack of small study effects (publication bias, etc.) observed for all three adiposity outcomes. Alternatively, the positive findings could be questioned given the overlapping 95% prediction intervals across all three treatments. These findings suggest that in a future setting, some participants would benefit while others would not.[102]

A major question to address is the clinical importance of the observed changes in adiposity as a result of exercise. Generally, reductions in adiposity of at least 5% may be considered clinically important.[103] Using this threshold, none of the treatments that



were found to be statistically significant in the current study would meet this cutpoint for changes in BMI in  $\text{kg}\cdot\text{m}^2$ . However, the reductions in fat mass as a result of aerobic exercise (8.3%) as well as combined aerobic and strength exercise (8.4%) appear to be clinically important. In addition, the reductions observed for percent body fat as a result of aerobic exercise (5.4%) as well as combined aerobic and strength exercise (6.0%) also appear to be clinically important. Thus, clinically relevant benefits were derived when more direct measures of adiposity (fat mass and percent body fat) were used.

### 713 **Meta-regression Findings**

Simple meta-regression analyses yielded several statistically significant associations for those treatments and outcomes in which the overall findings were statistically significant. First, the statistically significant association between greater reductions in BMI in  $\text{kg}\cdot\text{m}^2$  as a result of aerobic exercise for studies conducted in countries other than the United States may reflect a tendency for other countries to submit studies that yield larger improvements in BMI in  $\text{kg}\cdot\text{m}^2$ . Alternatively, this association may be confounded by other factors. For example, differences in diet and exercise[104] habits between the US and other countries have been shown to exist, something that would appear plausible given the magnitude of the obesity problem in the US.[1] Second, greater reductions as a result of aerobic exercise for both BMI in  $\text{kg}\cdot\text{m}^2$  and percent fat were associated with unfunded versus funded studies. This same association was found for fat mass and percent body fat congruent with combined aerobic and strength training interventions as well as for percent body fat and strength training. One possible and broad explanation for these associations may be that funded studies are of higher quality than unfunded studies. Third, greater compliance, defined as the percentage of

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exercise sessions attended, was associated with greater reductions in both BMI in kg·m<sup>2</sup> as well as fat mass as a result of aerobic exercise. These associations appear plausible given that greater reductions should be expected if exercise attendance is greater.

Fourth, greater reductions in BMI in kg·m<sup>2</sup> were associated with greater total minutes of exercise per week as a result of aerobic exercise. When adjusted for compliance, total minutes of exercise per week were also associated with greater reductions in both BMI in kg·m<sup>2</sup> and fat mass as a result of aerobic exercise. These observed associations seem quite plausible. Fifth, larger reductions in both fat mass and percent fat were associated with studies that were at an unclear versus low risk of bias for selective reporting of study results. This might suggest a tendency for authors to selectively report results that are statistically significant. However, caution is warranted in the interpretation of these findings since a rating of unclear does not guarantee that selective reporting of results occurred, but rather, reflects a lack of available data to classify a study as either high or low risk. Sixth, the association between greater reductions in fat mass and percent fat as a result of shorter intervention length, i.e., weeks, as a result of aerobic exercise may represent a certain threshold in which no further benefits can be achieved. However, maintaining an exercise program is probably important as the cessation of training will most likely return adiposity levels back to their original values. Seventh, the association between greater reductions in fat mass as a result of high versus moderate-intensity aerobic exercise suggests that training regimes such as interval training may be optimal for reducing fat mass. However, this needs to be balanced with the possibility of placing the child and adolescent at an increased risk for injury as well as possible concerns about decreased compliance with high intensity

exercise programs. Eighth, the association between greater reductions in fat mass and more recent year of publication as a result of combined aerobic and strength exercise may reflect higher quality studies. In contrast, this may reflect an increased emphasis on investigators tending to report results that are large and statistically significant. Finally, the greater strength training reductions in percent fat as a result of studies that were at a low versus unclear risk of bias for participants not being physically active prior to study participation reflects the belief that those who are least active have the most to gain from an exercise program. Again however, a rating of unclear does not guarantee that subjects were physically active prior to study participation, but rather, reflects a lack of available data to classify a study as being at either a high or low risk of bias.

## **Overall Findings for Secondary Outcomes**

Across all three treatments, statistically significant improvements were observed for secondary outcomes. For aerobic exercise, these included reductions in body weight, waist circumference, resting systolic and diastolic blood pressure, total cholesterol, low density lipoprotein cholesterol, triglycerides, and fasting insulin, as well as increases in  $VO_{2max}$  in  $ml \cdot kg^{-1} \cdot min^{-1}$  and high-density lipoprotein cholesterol. For strength training, statistically significant reductions were limited to fasting insulin while combined aerobic and strength training resulted in statistically significant improvements in body weight, fat free mass,  $VO_{2max}$  in  $ml \cdot kg^{-1} \cdot min^{-1}$ , triglycerides, fasting glucose and fasting insulin. Thus, unlike most pharmacological interventions that are intended to target one condition and often include significant side effects, exercise, especially aerobic as well as combined aerobic and strength training, can yield significant improvements in both adiposity

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774 outcomes as well as a number of other outcomes in overweight and obese children and  
775 adolescents.

776 **Implications for Research**

777 There are several implications for reporting future randomised trials on exercise and  
778 adiposity in overweight and obese children and adolescents. First, given that reductions  
779 in adiposity are dependent on the balance between energy intake and expenditure,  
780 future randomised trials should track and report data on both energy intake and  
781 expenditure so that the independent effects of exercise on adiposity can be better  
782 quantified. Second, future studies should track and report the total physical activity  
783 levels of participants during the entire day in order to ensure that physical activity  
784 compensation is not occurring.[105] Third, a clear definition and accurate reporting of  
785 adverse events is needed so that the benefits and potential harms of exercise on  
786 adiposity in overweight and obese children can be more clearly delineated. Fourth, in  
787 order to better assess the quality of the study design, information should be provided  
788 about allocation concealment, blinding of outcome assessors, incomplete outcome data  
789 and reporting, as well as the physical activity levels of participants prior to taking part in  
790 the study. Fifth, given that less than half of the studies provided data on compliance to  
791 the exercise intervention, future studies should report this information since it can have  
792 a significant impact on outcomes. Along those lines, it is suggested that researchers  
793 adhere to the Consensus on Exercise Reporting Template (CERT) when designing their  
794 study and reporting exercise program information from their clinical trials.[106]

795 In addition to reporting, there are several suggestions for the conduct of future  
796 research addressing the effects of exercise interventions on adiposity outcomes in



overweight and obese children and adolescents. First, given the small number of direct studies included, a need exists for additional randomised trials that examine the effects of different exercise interventions head-to-head, as was done in the study by Sigal et al. [57] Ideally, this would include an aerobic, strength, and combined aerobic and strength training group as well as a control group. Such an approach would provide additional and possibly more valid information regarding the effects of each intervention on adiposity outcomes. Third, given the lack of follow-up data, a need exists for future studies that include follow-up assessment several weeks and/or months after the intervention period has ended. This would allow one to track both changes in adiposity outcomes as well as continued participation in exercise. Fourth, given the potential of calorie restriction for improving adiposity outcomes and the need to identify the best treatment, a need exists for a network meta-analysis that includes the following treatment arms: exercise, calorie restriction, exercise and calorie restriction, control. This would allow one to examine both the separate and combined effects of exercise and caloric restriction on adiposity outcomes in overweight and obese children and adolescents. In addition, research that includes a transition to a diet without processed foods[107] as well as sweetened beverages[108] would also be worthy of investigating. Finally, a need exists for cost-effectiveness analyses.

### **Implications for Practice**

The results of the current network meta-analysis have important implications for practice. First, given the statistically significant and clinically important improvements in adiposity outcomes, lack of adverse events for those that reported such data, and improvements observed for a number of secondary outcomes, exercise may be more

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3 820 vital than any other type of intervention for the overall physiological health of overweight  
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5 821 and obese children and adolescents. While the current network meta-analysis was  
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7 822 unable to determine the exact dose-response effects of exercise on adiposity in  
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10 823 overweight and obese children and adolescents, it would appear reasonable to suggest  
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12 824 that aerobic or combined aerobic and strengthening exercise would be optimal. Along  
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14 825 those lines, it is suggested that adherence to the recent 2018 guidelines for exercise  
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16 826 and physical activity in children and adolescents be followed.[109] These include at  
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18 827 least 60 minutes per day of moderate to vigorous physical activity, including a minimum  
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20 828 of 3 days of vigorous intensity activity, as well as muscle-strengthening activities at least  
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22 829 three days per week.[109] More broadly, it is recommended that clinicians and other  
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24 830 healthcare practitioners adhere to the recent recommendations from the United States  
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26 831 Preventive Service Task Force regarding screening for obesity in children and  
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28 832 adolescents.[103] These recommendations include screening for obesity in children and  
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30 833 adolescents  $\geq 6$  years of age and offering or referring them to comprehensive, intensive  
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32 834 behavioral interventions to promote improvements in weight status.[103] Multi-  
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34 835 component behavioral interventions that include, but are not necessarily limited to,  
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36 836 exercising, healthy eating, and reductions in screen time may be optimal.[103] Reducing  
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38 837 adiposity in overweight and obese children and adolescents will probably require  
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40 838 intensive efforts given the obesogenic environments in which most people reside today.  
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47 **Implications for Policy**

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49 840 Evidence-based policies play a pivotal role in reducing childhood obesity.[110] The  
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51 841 results of the current network meta-analysis provide evidence to support policies aimed  
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53 842 at increasing the exercise and physical activity habits of overweight and obese children  
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and adolescents. This is especially relevant for policy given that one of the main reasons for conducting a network meta-analysis is to identify the best treatment(s) for a disease or condition. Broadly, the development of policies aimed at making exercise and physical activity safer, easier, and more appealing might be best.[110] More specifically, policies directed towards increasing active transportation and recreation as well as reducing sedentary behavior are probably important.[110] In addition, and most pertinent to the current network meta-analysis, policies aimed at increasing the number of overweight and obese children and adolescents who participate in exercise and physical activity programs that include aerobic and strength training according to current guidelines [109] is probably relevant. Finally, policies aimed at increasing exercise and physical activity for reducing childhood obesity should probably work in concert with food policies that aim to do the same.[110]

### **Strengths and Limitations**

There are several strengths to this study. First, to the best of the investigative team's knowledge, this is the largest as well as first systematic review to use the network meta-analytic approach to determine the effects as well as hierarchy of exercise interventions (aerobic, strength training, or both) on BMI in kg/m<sup>2</sup>, fat mass and percent body fat in overweight and obese children and adolescents. This work is important for determining which type of exercise treatment(s) is/are best for reducing adiposity. Second, the results of this systematic review with network meta-analysis should be useful to researchers with respect to the conduct and reporting of future research on this topic, including priority areas. Third, the findings of the current study should be useful to practitioners and policy-makers for making informed decisions regarding the use of

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exercise in the treatment of overweight and obesity in children and adolescents. For example, clinicians and other healthcare personnel can include this information along with their own clinical judgment and parent/child preferences when making evidence-based decisions regarding the use of exercise in the treatment of adiposity in overweight and obese children and adolescents.

In addition to strengths, there are also several potential limitations. First, the number of effect sizes for some treatments and comparisons, for example strength training and fat mass, were small. As a result, there may have been a lack of statistical power to detect a true effect, assuming such an effect exists. Second, the results could have been affected by the different criteria used across the studies for determining overweight and obesity. In addition, since many studies used BMI to determine overweight and obesity, one or more studies may have excluded some eligible children and adolescents given that BMI has been shown to fail to identify more than 25% of children with excess body fat percentage.[111] Third, common to any type of aggregate data meta-analysis, meta-regression results do not support causal inferences because the included studies are not randomly assigned to covariates.[112] Thus, any of the associations observed in the current network meta-analysis should be tested in original randomised controlled trials. Fourth, because a large number of statistical tests were conducted, some of the statistically significant results observed may have been nothing more than the play of chance. However, common to most aggregate data meta-analyses, no adjustments for multiple testing were made because of concerns about missing possibly important findings that could be tested in original randomised controlled trials.[113] Fifth, the results for the secondary outcomes in the current study may be a biased sample since



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3 889 studies were only included if one or more measures of adiposity, our primary outcomes,  
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6 890 were assessed. Finally, common to all aggregate data meta-analyses, there is the  
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8 891 possibility of ecological fallacy, i.e., that group averages are not reflective of an  
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10 892 individual's values for variables that were reported on the group versus individual  
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12 893 level.[114]

## 14 894 **CONCLUSIONS**

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17 895 The findings of the current network meta-analysis suggest that aerobic exercise as  
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19 896 well as combined aerobic and strength training exercise are associated with clinically  
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21 897 important reductions in selected measures of adiposity.  
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**ORIGINAL PROTOCOL FOR STUDY**

See Supplementary file 16.

**PRISMA CHECKLIST FOR NETWORK META-ANALYSIS**

See Supplementary file 17.

**CONTRIBUTORS**

GAK is the guarantor. GAK, KSK and RRP drafted the manuscript. All authors contributed to the development of the data sources to search for relevant literature, including search strategy, selection criteria, data extraction criteria and risk of bias assessment strategy. GAK provided statistical expertise while RRP provided content expertise on exercise and adiposity in overweight and obese children and adolescents. All authors read, provided feedback and approved the final manuscript.

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**COMPETING INTERESTS**

None declared.

**DATA AVAILABILITY**

Data for this aggregate data systematic review with meta-analysis is available from the corresponding author upon request. This data derives from summary data previously reported in studies published in peer-review journals.

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**FIGURE LEGENDS**

Figure 1. Flow diagram for selection of studies. Flow of information through the different phases of the systematic review and network meta-analysis.

Figure 2. Summary results for risk of bias. Grouped risk of bias results using the Cochrane Risk of Bias Instrument.

Figure 3. Network plot for BMI in kg·m<sup>2</sup>. Network plot for study comparisons included in the BMI in kg·m<sup>2</sup> network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

Figure 4. Interval plot for changes in BMI in kg·m<sup>2</sup>. Interval plot for changes in BMI kg·m<sup>2</sup> based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 35/1533 (aerobic vs. control), 8/331 (strength versus control), 11/426 (combined aerobic and strength versus control), 7/232 (strength versus aerobic), 4/175 (combined aerobic and strength versus aerobic), 2/121 (combined aerobic and strength versus strength).

Figure 5. Network plot for fat mass (kg). Network plot for study comparisons included in the fat mass network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

Figure 6. Interval plot for changes in fat mass (kg). Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 19/945 (aerobic vs. control), 7/271 (strength versus control), 10/376 (combined aerobic and strength versus control), 4/167 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

Figure 7. Network plot for percent body fat. Network plot for study comparisons included in the percent body fat network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

Figure 8. Interval plot for changes in percent body fat. Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 32/1602 (aerobic vs. control), 8/327 (strength versus control), 12/480 (combined aerobic and strength versus control), 6/201 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

**SUPPLEMENTARY FILES LIST**

**Supplementary file 1.** Results of PubMed search.

**Supplementary file 2.** Planned covariates to examine for in meta-regression analyses.

**Supplementary file 3.** Reference list of excluded studies, including the reasons for exclusion.

**Supplementary file 4.** Characteristics of included studies.

**Supplementary file 5.** Cochrane risk of bias results for each element from each study.

**Supplementary file 6.** Network forest plot for changes in BMI in kg·m<sup>2</sup> based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as blue point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow green diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow red diamonds

**Supplementary file 7.** Funnel plot of small-study effects for changes in BMI in kg·m<sup>2</sup>.

**Supplementary file 8.** Simple meta-regression results for changes in BMI (kg·m<sup>2</sup>) and potential covariates.

**Supplementary file 9.** Network forest plot for changes in fat mass (kg) based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as blue point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow green diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow red diamonds

**Supplementary file 10.** Funnel plot of small-study effects for changes in fat mass (kg).

**Supplementary file 11.** Simple meta-regression results for changes in fat mass (kg) and potential covariates.

**Supplementary file 12.** Network forest plot for changes in percent body fat based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as blue point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow green diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow red diamonds.

**Supplementary file 13.** Funnel plot of small-study effects for changes in percent body fat.

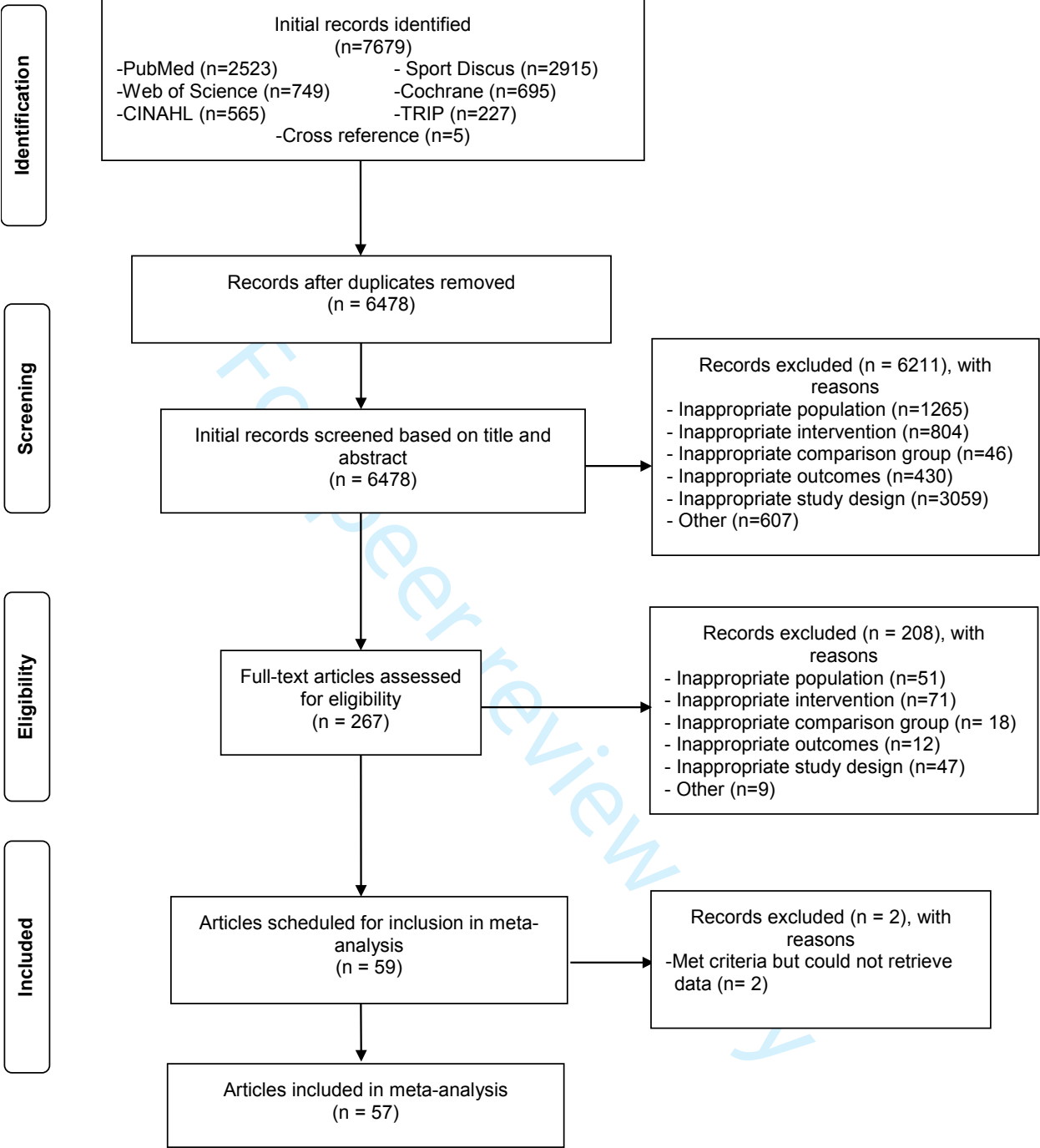
**Supplementary file 14.** Simple meta-regression results for changes in percent body fat and potential covariates.

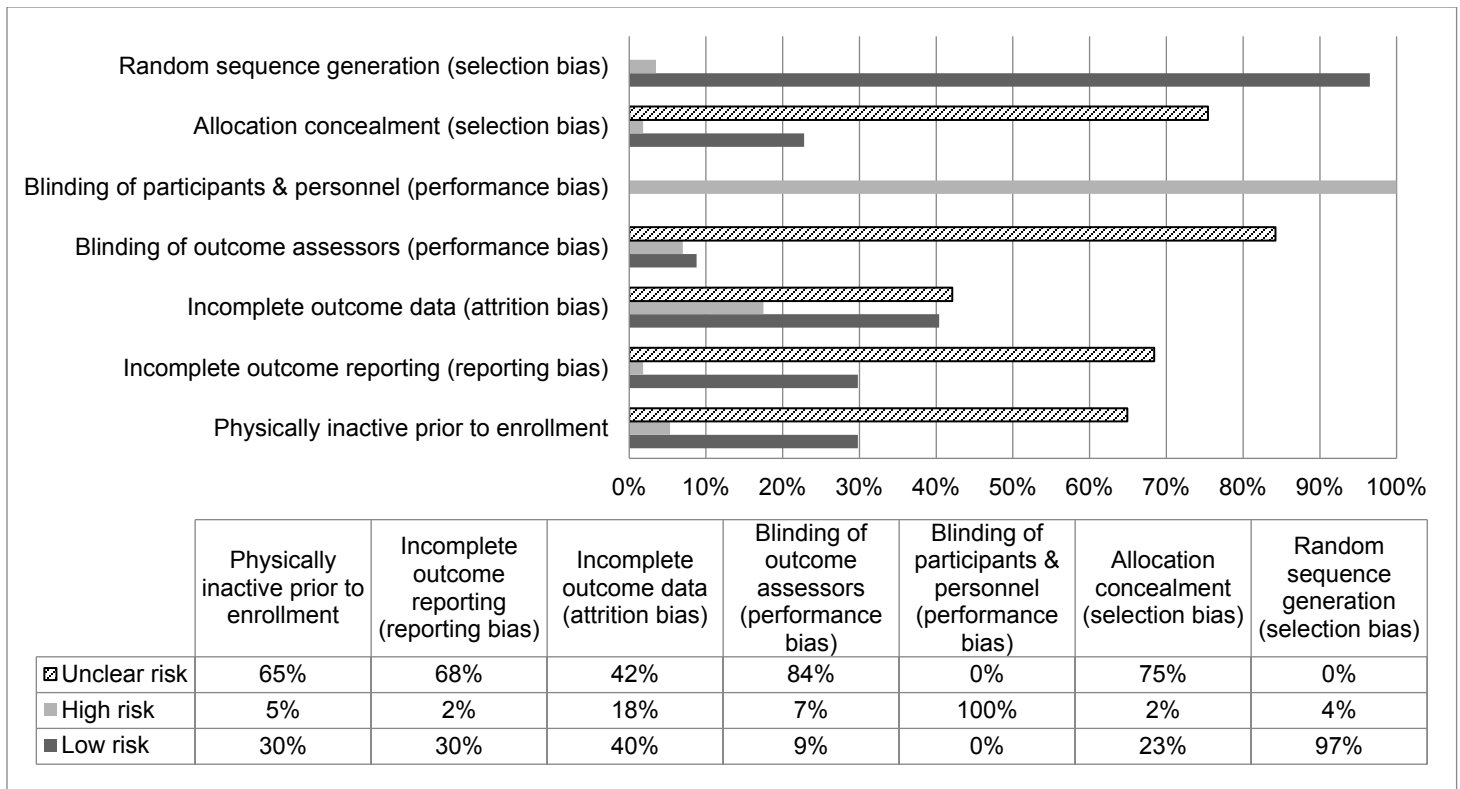
**Supplementary file 15.** Treatment-specific changes in secondary outcomes.

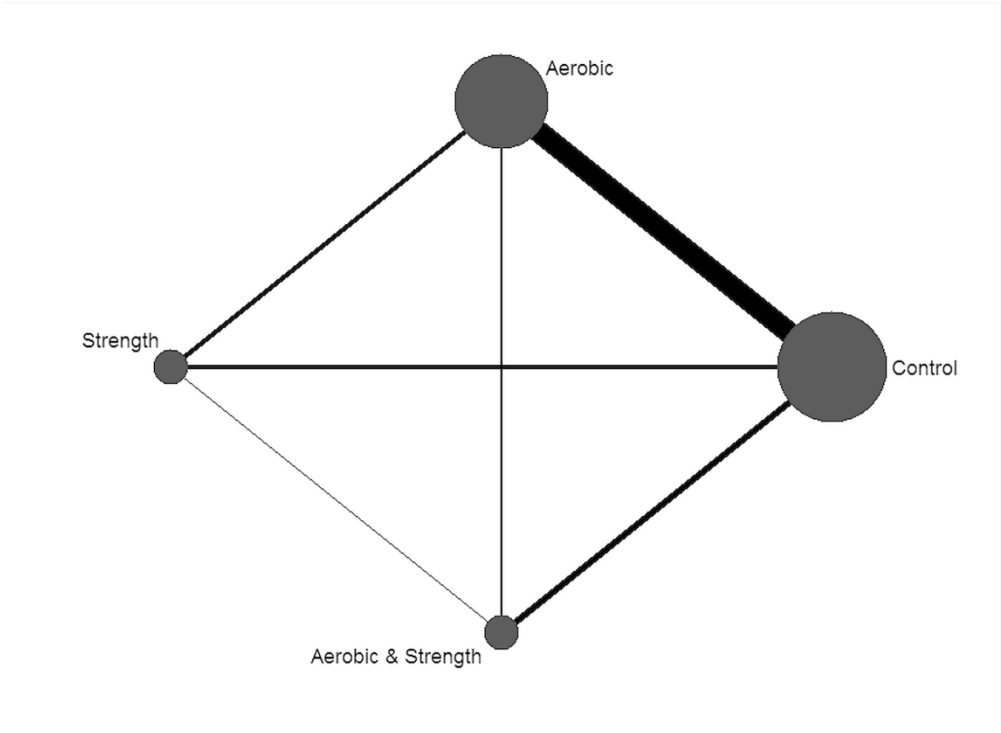
**Supplementary file 16.** Original published protocol for study.

**Supplementary file 17.** PRISMA protocol checklist for a network meta-analysis.



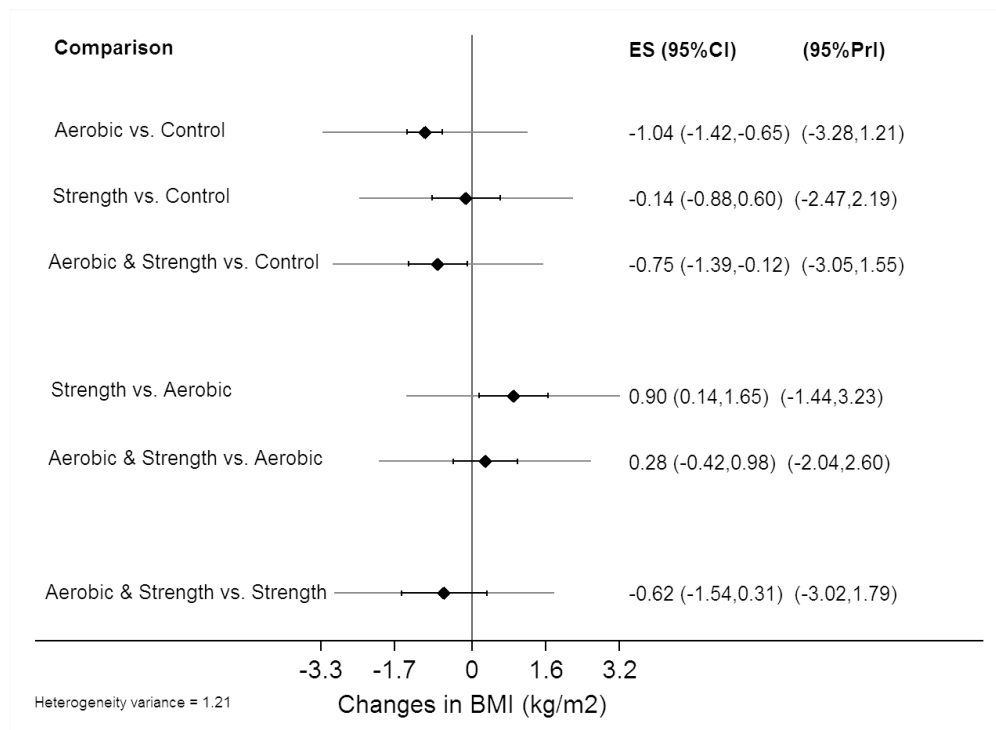






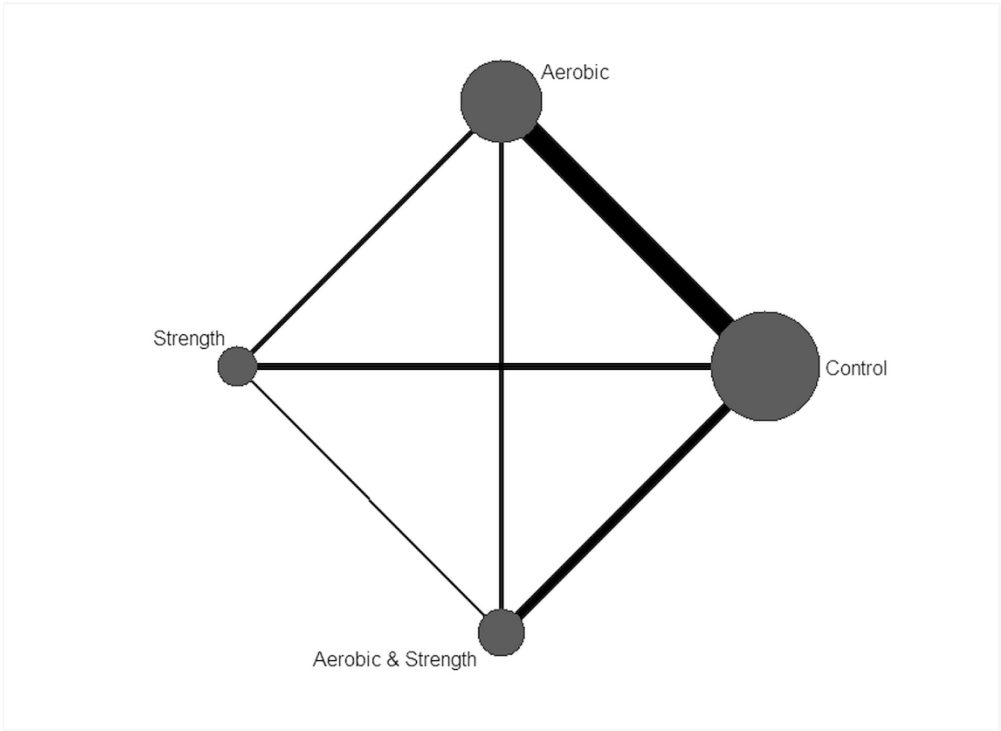
Network plot for BMI in kg.m2. Network plot for study comparisons included in the BMI in kg.m2 network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

173x126mm (300 x 300 DPI)



Interval plot for changes in BMI in kg.m2. Interval plot for changes in in BMI kg.m2 based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 35/1533 (aerobic vs. control), 8/331 (strength versus control), 11/426 (combined aerobic and strength versus control), 7/232 (strength versus aerobic), 4/175 (combined aerobic and strength versus aerobic), 2/121 (combined aerobic and strength versus strength).

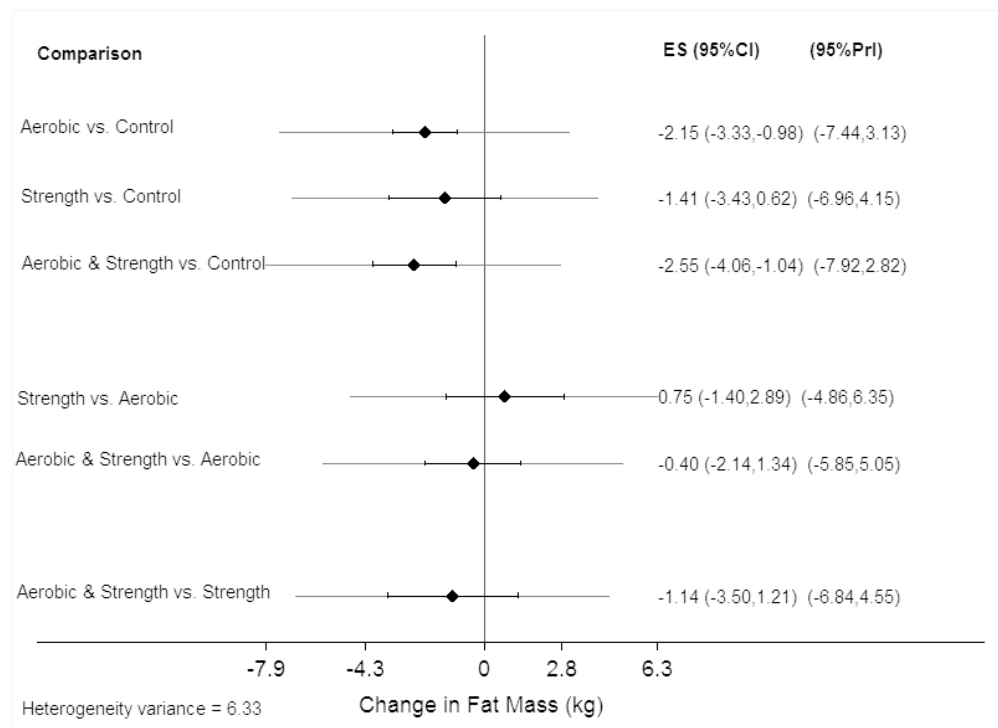
108x78mm (300 x 300 DPI)



Network plot for fat mass (kg). Network plot for study comparisons included in the fat mass network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

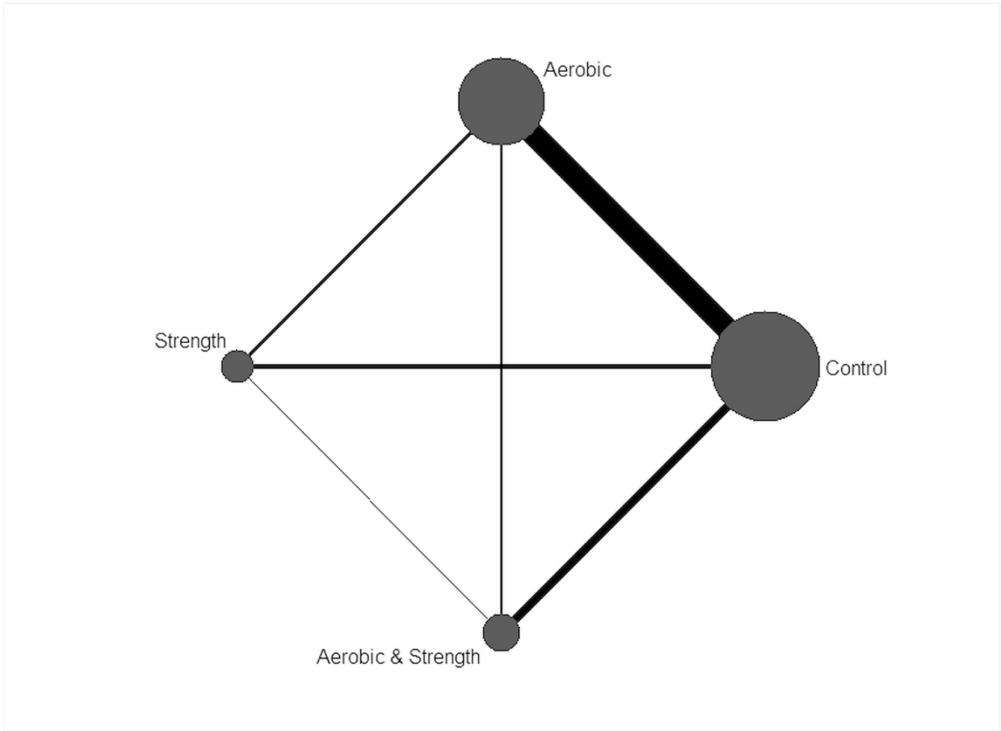
173x126mm (300 x 300 DPI)





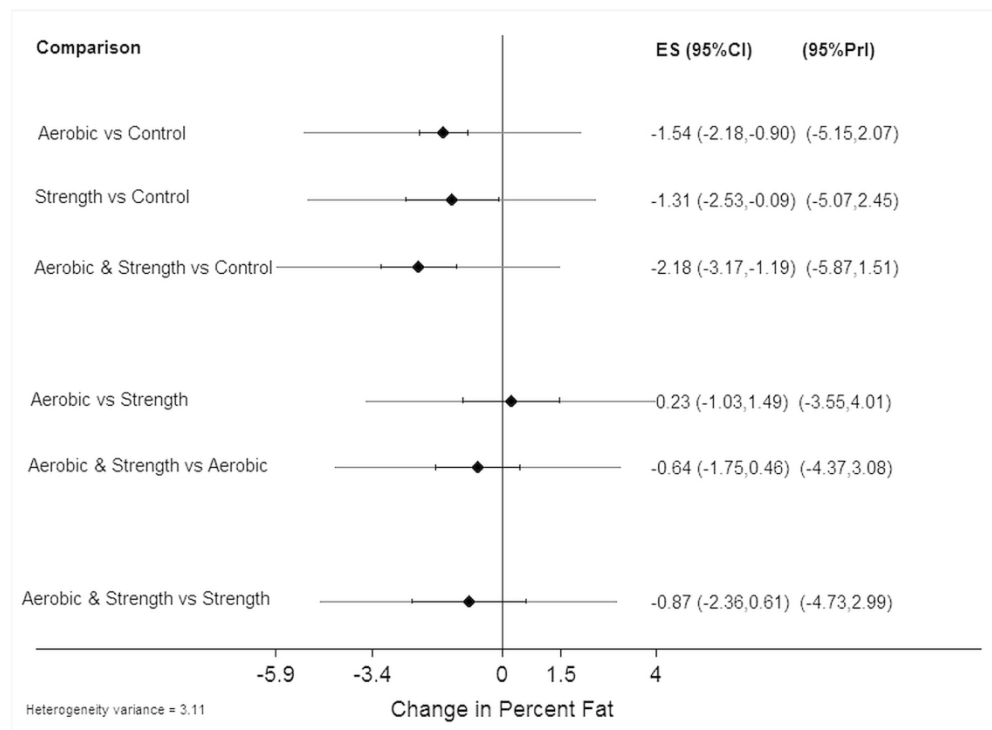
Interval plot for changes in fat mass (kg). Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 19/945 (aerobic vs. control), 7/271 (strength versus control), 10/376 (combined aerobic and strength versus control), 4/167 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

68x49mm (300 x 300 DPI)



Network plot for percent body fat. Network plot for study comparisons included in the percent body fat network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively.

173x126mm (300 x 300 DPI)



Interval plot for changes in percent body fat. Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 32/1602 (aerobic vs. control), 8/327 (strength versus control), 12/480 (combined aerobic and strength versus control), 6/201 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

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Supplementary file 1. PubMed search.

(exercise OR physical activity OR physical fitness OR strength training OR weight training) AND (children OR adolescen\* OR boys OR girls) AND (overweight OR obes\*) AND random\* AND ( "1973/01/01"[125] : "2018/08/22"[125] ) AND Humans[Mesh] AND (infant[MeSH] OR child[MeSH] OR adolescent[MeSH])

For peer review only

## Supplementary file 2. Planned covariates to examine.

Characteristics	Variable
Study	Publication year, impact factor of journal, country study conducted, type of control group, bias (sequence generation, allocation concealment, blinding of participants & personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting), type of analysis, funding
Participant	Age, gender, race/ethnicity, maturational stage
Exercise	Type (aerobic, strength, both), length, frequency, intensity, duration, total minutes, total minutes (adjusted for compliance), mode, compliance, exercise supervision, setting, number of sets, number of repetitions, rest between sets, number of exercises, type of resistance, equipment used, fidelity (design, training, delivery, receipt, enactment)
Outcome	Baseline values for primary outcomes (BMI in kg·m <sup>2</sup> , fat mass, percent fat), method used to assess adiposity, i.e., instrumentation



Supplementary file 3. Reference list of excluded studies, including the reasons for exclusion.

1. Notation of Additional Studies. *J Teach Phys Educ.* 1986;6(1):78-89. inappropriate study design
2. Fitness Can and Should Be Fun. *Journal of Sport Psychology.* 1987;9(2):87-88. inappropriate study design
3. Obesity and Cardiovascular Disease Risk Factors in Black and White Girls: The NHLB Growth and Health Study. *American journal of public health.* 1992;82(12):1613-1620. inappropriate study design
4. Health Related Fitness and Blood Pressure in Boys and Girls Ages 10 to 17 Years. *Pediatric exercise science.* 1992;4(2):128-135. inappropriate study design
5. Caltrac Validity for Estimating Caloric Expenditure With Children. *Pediatric exercise science.* 1992;4(2):166-179. inappropriate study design
6. Research Digest. *Pediatric exercise science.* 1992;4(1):5-9. inappropriate study design
7. Program schedule. *American journal of public health.* 1994;84(8):P-7. inappropriate outcomes
8. Two-Year Follow-Up on the Impact of Physical Fitness and Body Fatness on Children's Heart Growth and Rising Blood Pressure: The Muscatine Study. *Pediatric exercise science.* 1995;7(4):364-378. inappropriate study design
9. Children's Ratings of Effort During Cycle Ergometry: An Examination of the Validity of Two Effort Rating Scales. *Pediatric exercise science.* 1995;7(4):407-421. inappropriate outcomes
10. Program Schedule. *American journal of public health.* 1995;85(8):P-9-P-143. inappropriate outcomes
11. Bone Mineral and Muscle Strength Characteristics in Children With Turner Syndrome. *Pediatric exercise science.* 1995;7(1):80-93. inappropriate study design
12. Implementation of treatment protocols in the Diabetes Control and Complications Trial. *Diabetes care.* 1995;18(3):361-376. <http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/332/CN-00118332/frame.html>. inappropriate intervention
13. Is There a Scientific Rationale Supporting the Value of Exercise for the Present and Future Cardiovascular Health of Children? The Pro Argument. *Pediatric exercise science.* 1996;8(4):294-302. inappropriate study design
14. Exercise Regulation During Cycle Ergometry Using the Children's Effort Rating Table (CERT) and Rating of Perceived Exertion (RPE) Scales. *Pediatric exercise science.* 1996;8(4):337-350. inappropriate outcomes
15. Program Schedule. *American journal of public health.* 1996;86(8):P-9-P-176. inappropriate study design
16. Physical Activity, Fitness, and Adiposity of Prepubertal Girls. *Pediatric exercise science.* 1996;8(3):259-267. inappropriate study design
17. Validity and Reliability of the 1/2-Mile Run-Walk as an Indicator of Aerobic Fitness in Children With Mental Retardation. *Pediatric exercise science.* 1996;8(2):130-142. inappropriate outcomes

18. Response to Resistance Training in Pediatric Wheelchair Users. *Pediatric exercise science*. 1996;8(1):6-14. inappropriate study design
19. Conference Proceedings. *Canadian Journal of Applied Physiology*. 1997;22:1P-66P. other
20. Of interest from the journals. *Australian Journal of Nutrition & Dietetics*. 1998;55(4):178-193. other
21. PART IV: PHYSIOLOGY. *Journal of sports sciences*. 1998;16(1):31-68. other
22. PART V: PSYCHOLOGY. *Journal of sports sciences*. 1998;16(1):68-110. other
23. 3rd Baltic bone and cartilage conference. *Acta Orthopaedica Scandinavica*. 1999;70:1. other
24. Of interest from the journals. *Australian Journal of Nutrition & Dietetics*. 2000;57(4):247-247. other
25. Body Attitude, Gender, and Self-Concept: A 30-Year Perspective. *Journal of Psychology*. 2001;135(4):413. inappropriate population
26. Carbohydrate advantage-going the distance in weight management Proceedings of the Kellogg's Nutrition Symposium 2000 Sydney. 8 August 2000. *Australian Journal of Nutrition & Dietetics*. 2001;58(1):S2-S32. other
27. Of interest from the journals. *Nutrition & Dietetics*. 2002;59(4):270-272. other
28. Policy Statements Adopted by the Governing Council of the American Public Health Association, October 24, 2001. *American journal of public health*. 2002;92(3):451-483. other
29. Of interest from the journals. *Nutrition & Dietetics*. 2003;60(3):218. other
30. PART III: KINANTHROPOMETRY. *Journal of sports sciences*. 2003;21(4):293. other
31. Position of the American Dietetic Association, Society for Nutrition Education, and American School Food Service Association: Nutrition Services: An Essential Component of Comprehensive School Health Programs. *Journal of Nutrition Education & Behavior*. 2003;35(2):57. other
32. Using skinfold calipers while teaching body fatness-related concepts: cognitive and affective outcomes. *Journal of science and medicine in sport / Sports Medicine Australia*. 2003. inappropriate outcomes
33. Thursday 12th August 2004. *International Journal of Psychology*. 2004;39(5/6):346-472. inappropriate study design
34. Other Publications. *Pediatric exercise science*. 2004;16(3):296-297. other
35. Abstracts for the International Society for Aging and Physical Activity's 6th World Congress on Aging and Physical Activity: From Research to Action for an Aging Society London, Ontario, Canada, August 3-7, 2004. *Journal of Aging & Physical Activity*. 2004;12(3):246-460. inappropriate study design
36. FREE COMMUNICATIONS. *Journal of sport & exercise psychology*. 2004;26:S25-S206. other
37. Use of air displacement plethysmography in the determination of percentage of fat mass in african american children. *Pediatric research*. 2004. inappropriate study design
38. ABSTRACTS. *Canadian Journal of Applied Physiology*. 2005;30:3-S88. inappropriate study design
39. DataBase Citations Chart. *Am J Health Promot*. 2005;19(6):450-452. other

40. Research Digest. *Pediatric exercise science*. 2005;17(2):201. inappropriate outcomes
41. The following abstracts were presented at the biennial meeting of the North American Society for Pediatric Exercise Medicine, held in St. Andrews, New Brunswick, August 13-16, 2004. *Pediatric exercise science*. 2005;17(1):72. inappropriate study design
42. Efficacy of an internet-based behavioral weight loss program for overweight adolescent African-American girls. *Eating and weight disorders : EWD*. 2005. inappropriate intervention
43. Position of the American Dietetic Association: individual-, family-, school-, and community-based interventions for pediatric overweight. *Journal of the American Dietetic Association*. 2006;106(6):925-945. inappropriate study design
44. Abstracts. *Am J Health Promot*. 2006;21(2):141-144. inappropriate study design
45. Determinants of Physical Activity in an Inclusive Setting. *Adapted Physical Activity Quarterly*. 2006;23(4):390-409. inappropriate study design
46. Abstracts of the 85th Scientific Meeting of the Society for the Study of Human Biology held at University of Westminster, London, 11 May 2006. *Annals of human biology*. 2006;33(5/6):651-661. inappropriate study design
47. Real Men Do Not Read Labels: The Effects of Masculinity and Involvement on College Students' Food Decisions. *Journal of American College Health*. 2006;55(2):91-98. inappropriate study design
48. Weightlifting may help overweight teens reduce risk of diabetes. *O&P Business News*. 2006;15(17):57-57. inappropriate study design
49. Smaller bowls and spoons may curb consumption. *O&P Business News*. 2006;15(17):57-58. inappropriate outcomes
50. Secular Changes in Anaerobic Test Performance in Australasian Children and Adolescents. *Pediatric exercise science*. 2006;18(3):314-328. inappropriate study design
51. Secular Changes in Shuttle-Run Performance: A 23-Year Retrospective Comparison of 9- to 11-Year-Old Children. *Pediatric exercise science*. 2006;18(3):364-373. inappropriate study design
52. Poster Session Abstracts. *Psychophysiology*. 2006;43:S20-S110. inappropriate study design
53. RETRIEVAL AND REVIEW. *J Teach Phys Educ*. 2006;25(3):329-340. other
54. Abstracts of the Canadian Society for Clinical Nutrition's 5th Annual Scientific Meeting with guest societies the Canadian Society for Nutritional Sciences and the Canadian Society for Exercise Physiology / Résumés de la 5e assemblée annuelle de la Société Canadienne de Nutrition Clinique avec les sociétés invitées La Société Canadienne de Sciences de la Nutrition et La Société Canadienne de Physiologie de l'Exercice. *Applied Physiology, Nutrition & Metabolism*. 2006;31(3):331-365. inappropriate study design
55. Speaker Abstracts. *Isokinetics & Exercise Science*. 2006;14(2):111-152. inappropriate study design
56. APAC ACTION: New Executive Director. *Palaestra*. 2006;22(3):8-9. other
57. ECAS 2006 Abstracts and Program. European Cardiac Arrhythmia Society 2nd Annual Congress, April 2-4, 2006, Palais des Congrès, Parc Chanot Marseille,

- France. *Pacing & Clinical Electrophysiology*. 2006;29:S1-S103. inappropriate study design
58. Abstracts – Oral Presentations. *Nutrition & Dietetics*. 2006;63:A1-A24. inappropriate study design
59. Abstracts – Poster Presentations. *Nutrition & Dietetics*. 2006;63:A25-A56. inappropriate study design
60. DIGEST. *Adapted Physical Activity Quarterly*. 2006;23(1):98-101. other
61. Effective dietary interventions for overweight and obese children. *Australian nursing journal (July 1993)*. 2007;14(11):31-34. inappropriate intervention
62. Proceedings of the 2(nd) International Symposia on Lifestyle-related Disease Perspective for Primary Prevention and Treatment in Animal Models and Humans, 21--22 October 2006, Nishinomiya, Japan. *Clinical & Experimental Pharmacology & Physiology*. 2007;34:S1-S97. other
63. Abstracts of the 86th Scientific Meeting of the Society for the Study of Human Biology held at University of Oxford, 31 May 2007. *Annals of human biology*. 2007;34(6):684-696. inappropriate study design
64. THE DIGEST. *Journal of sport & exercise psychology*. 2007;29(5):673-680. inappropriate study design
65. 2007 CSEP Annual Scientific Conference / 2007 Conférence Scientifique Annuel de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2007;32:S1-S98. other
66. Abstracts. *Nutrition & Dietetics*. 2007;64:S77-S97. inappropriate study design
67. Annual conference of the british association of sport and exercise sciences. *Journal of sports sciences*. 2007;25(3):235-369. inappropriate study design
68. Stress reactivity and adiposity of youth. *Obesity*. 2007. inappropriate outcomes
69. Contents / Sommaire. *Applied Physiology, Nutrition & Metabolism*. 2008;33(6):C-1-C-9. other
70. Abstracts. *Psychology & health*. 2008;23:15-278. inappropriate study design
71. 2008 CSEP Annual Scientific Conference / 2008 Conférence scientifique annuelle de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2008;33:S1-S113. inappropriate study design
72. Abstracts of the Canadian Society for Clinical Nutrition's 7th Annual Scientific Meeting: The Road to Excellence in Canadian Nutrition / Résumés de la 7e rencontre scientifique annuelle intitulée « The Road to Excellence in Canadian Nutrition » de la Société canadienne de nutrition clinique. *Applied Physiology, Nutrition & Metabolism*. 2008;33(3):603-640. inappropriate study design
73. Oral program. *Nutrition & Dietetics*. 2008;65:A1-A24. inappropriate study design
74. Posters. *Nutrition & Dietetics*. 2008;65:A25-A48. inappropriate study design
75. APPM MEETING ABSTRACTS. *Pain Medicine*. 2008;9(1):88-141. inappropriate study design
76. Promoting physical activity in middle school girls: Trial of Activity for Adolescent Girls. *American journal of preventive medicine*. 2008. inappropriate population
77. Effects of a classroom-based weight-control intervention on cardiovascular disease in elementary-school obese children. *Acta paediatrica Taiwanica = Taiwan er ke yi xue hui za zhi*. 2008. inappropriate intervention
78. Author and content indices. *International Journal of Food Sciences & Nutrition*. 2009;60(8):728-757. other



79. Changing Health Practitioner's Attitudes to Physical Activity Promotion: Is More Than a Pedometer Needed? *Journal of sport & exercise psychology*. 2009;31(5):675-676. inappropriate outcomes
80. Overweight Adolescents: Don't Blame It on the Television! *Journal of sport & exercise psychology*. 2009;31(5):676-677. inappropriate study design
81. Illness and Medical Bills Linked to Nearly Two-Thirds of All Bankruptcies. *O&P Business News*. 2009;19(18):62-63. other
82. Poster and oral presentations (In alphabetical order by first author). *Psychology & health*. 2009;24:71-419. inappropriate study design
83. Abstracts of the Canadian Society for Clinical Nutrition's 8th Annual Scientific Meeting / Résumés de le 8e rencontre scientifique annuelle intitulée de la Société canadienne de nutrition clinique. *Applied Physiology, Nutrition & Metabolism*. 2009;34(3):495-550. inappropriate study design
84. RESEARCH DIGEST. *Pediatric exercise science*. 2009;21(2):240-246. inappropriate study design
85. Abstracts of the Canadian Obesity Network's 1st National Obesity Summit / Résumés du premier congrès national sur l'obésité du Réseau canadien en obésité. *Applied Physiology, Nutrition & Metabolism*. 2009;34(2):235-305. inappropriate study design
86. Oral Program. *Nutrition & Dietetics*. 2009;66:A1-A24. inappropriate study design
87. Socio-economic differentiation of the growth and the dietary intake of Polish boys aged 7-16 years. *Annals of human biology*. 2009;36(2):199-210. inappropriate study design
88. The Use and Effectiveness of a Teaching Style Centered on Self-Determination Theory in an Exercise Setting. *Journal of sport & exercise psychology*. 2009;31(1):119-120. inappropriate population
89. A Complex Ecological System Is Hindering Youth Weight Management Practices. *Journal of sport & exercise psychology*. 2009;31(1):122-123. inappropriate study design
90. Thin and Happy, or Fat and Sad: Are They Related? *Journal of sport & exercise psychology*. 2009;31(1):123-123. inappropriate study design
91. Abstracts. *Journal of sports sciences*. 2009;27:1-133. inappropriate study design
92. Sixth International Conference on Sport, Leisure and Ergonomics: 14-16 November 2007. *Journal of sports sciences*. 2009;27:1-35. inappropriate study design
93. Psychopharmacological Treatment of Oppositional Defiant Disorder. *CNS Drugs*. 2009;23(1):1-17. inappropriate outcomes
94. The effect of a physical activity intervention on bias in self-reported activity. *Annals of epidemiology*. 2009. inappropriate study design
95. School randomised trial on prevention of excessive weight gain by discouraging students from drinking sodas. *Public health nutrition*. 2009. inappropriate intervention
96. An adolescent weight-loss program integrating family variables reduces energy intake. *Journal of the American Dietetic Association*. 2009. inappropriate outcomes
97. Design of a family-based lifestyle intervention for youth with type 2 diabetes: the



- TODAY study. *International journal of obesity* (2005). 2010;34(2):217-226. inappropriate study design
98. Türkiye'de Medulla Spinalis Yaralanması Rehabilitasyonunun Tarihçesi. / The Short History of Spinal Cord Injury Rehabilitation in Turkey. *Turkish Journal of Physical Medicine & Rehabilitation / Türkiye Fiziksel Tıp ve Rehabilitasyon Dergisi*. 2010;56:59-63. other
  99. Contents / Sommaire. *Applied Physiology, Nutrition & Metabolism*. 2010;35(6):C-1-C-6. inappropriate study design
  100. SYMPOSIA SUMMAIRES. *Journal of physical activity & health*. 2010;7:S313-S367. inappropriate study design
  101. Physical activity and adolescents: An exploratory randomized controlled trial investigating the influence of affective and instrumental text messages. *British Journal of Health Psychology*. 2010;15(4):825-840. inappropriate intervention
  102. To Be Thin: Disordered Eating Among Adolescent Elite Athletes and Non-Athletes. *Journal of sport & exercise psychology*. 2010;32(5):740-741. other
  103. Abstracts of the 2010 CSEP General Meeting / Résumés de la 2010 Congrès annuelle de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2010;35(s):S1-S116. inappropriate study design
  104. Poster Session Abstracts. *Psychophysiology*. 2010;47:S21-S105. inappropriate study design
  105. Abstracts from the 11th International Congress of Behavioral Medicine. *International journal of behavioral medicine*. 2010;17:1-329. inappropriate study design
  106. Oral presentations (In alphabetical order by first author). *Psychology & health*. 2010;25:15-100. inappropriate study design
  107. Symposia (In alphabetical order by convenor). *Psychology & health*. 2010;25:101-131. inappropriate study design
  108. Poster presentations (In alphabetical order by first author). *Psychology & health*. 2010;25:137-376. inappropriate study design
  109. Dr. Karola Messner Foundation. *Scandinavian journal of medicine & science in sports*. 2010;20(4):706-707. other
  110. Abstracts of the Canadian Nutrition Society's 9th Annual Scientific Meeting / Résumés de la 9e rencontre scientifique annuelle intitulée de la Société canadienne de nutrition. *Applied Physiology, Nutrition & Metabolism*. 2010;35(3):365-437. inappropriate study design
  111. Poster Program: Programs are listed alphabetically by first author. *Nutrition & Dietetics*. 2010;67:22-68. inappropriate study design
  112. Programs are listed alphabetically by first author. *Nutrition & Dietetics*. 2010;67:xiv-xxiii. inappropriate study design
  113. Abstracts of the 51st Symposium of the Society for the Study of Human Biology, 18–20 June 2009, Rome, Italy. *Annals of human biology*. 2010;37(3):451-474. inappropriate study design
  114. On Avoiding Rejection, Revisited. *Pediatric exercise science*. 2010;22(2):173-175. other
  115. DIFFERENCES BETWEEN BOYS AND GIRLS IN TERMS OF PHYSICAL ACTIVITY. / RAZLIKE IZMEĐU DJEČAKA I DJEVOJČICA U FIZIČKOJ

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- AKTIVNOSTI. *Facta Universitatis: Series Physical Education & Sport*. 2010;8(1):1-7. inappropriate study design
116. Vitamin D status in female military personnel during combat training. *Journal of the International Society of Sports Nutrition*. 2010;7:38-42. inappropriate population
117. A randomized controlled trial of culturally tailored dance and reducing screen time to prevent weight gain in low-income African American girls: Stanford GEMS. *Archives of pediatrics & adolescent medicine*. 2010. inappropriate population
118. Serving of free school lunch to secondary-school pupils - a pilot study with health implications. *Public health nutrition*. 2010. inappropriate intervention
119. Abstracts. *Drug & Alcohol Review*. 2011;30:2-92. inappropriate study design
120. RESUMO. *Motricidade*. 2011;7:5-80. inappropriate study design
121. Abstracts of the 2011 CSEP General Meeting / Résumés de la 2011 Congrès annuelle de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2011;36:S299-S360. inappropriate study design
122. A. Oral presentations. *Psychology & health*. 2011;26:6-72. inappropriate study design
123. B. Interactive poster presentations. *Psychology & health*. 2011;26:73-253. inappropriate study design
124. D. Symposium. *Psychology & health*. 2011;26:281-338. inappropriate study design
125. Poster Session Abstracts. *Psychophysiology*. 2011;48(S1):S21-S119. inappropriate study design
126. Poster und Freie Mitteilungen. *Schweizerische Zeitschrift für Sportmedizin & Sporttraumatologie*. 2011;2011(3):137-140. inappropriate study design
127. The use of silhouette to determine body distortion and body dissatisfaction in African American and Caucasian college age females. *International Journal of Fitness*. 2011;7(2):1-8. inappropriate population
128. Dietitians Association of Australia 29. *Nutrition & Dietetics*. 2011;68:1-22. inappropriate study design
129. Backward walking training improves balance in school-aged boys. *SMARTT: Sports Medicine, Arthroscopy, Rehabilitation, Therapy & Technology*. 2011;3(1):24-30. inappropriate outcomes
130. Australian and New Zealand Obesity Society Annual Scientific Meeting 2011. *Obesity research & clinical practice*. 2011;5. <http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/813/CN-01003813/frame.html>. inappropriate study design
131. Abstracts of the 18th European Congress on Obesity, ECO 2011. *Obes Rev*. 2011;12. <http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/422/CN-01003422/frame.html>. inappropriate study design
132. Cardiometabolic biomarkers in young black girls: relations to body fatness and aerobic fitness, and effects of a randomized physical activity trial. *International journal of pediatrics*. 2011. inappropriate population
133. A 10-month physical activity intervention improves body composition in young black boys. *Journal of obesity*. 2011. inappropriate population

134. The Effect of Dietary Fish Oil in addition to Lifestyle Counselling on Lipid Oxidation and Body Composition in Slightly Overweight Teenage Boys. *Journal of nutrition and metabolism*. 2011. inappropriate intervention
135. The 'Healthy Dads, Healthy Kids' randomized controlled trial: efficacy of a healthy lifestyle program for overweight fathers and their children. *EvidenceUpdates*. 2011. inappropriate intervention
136. Impact of intensive school-based nutrition education and lifestyle interventions on insulin resistance,  $\beta$ -cell function, disposition index, and subclinical inflammation among Asian Indian adolescents: a controlled intervention study. *Metabolic syndrome and related disorders*. 2011. inappropriate intervention
137. Pilot evaluation of the HELENA (Healthy Lifestyle in Europe by Nutrition in Adolescence) Food-O-Meter, a computer-tailored nutrition advice for adolescents: a study in six European cities. *Public health nutrition*. 2011. inappropriate intervention
138. UP1 HomeStyles: Shaping Home Environments and Lifestyle Practices to Prevent Childhood Obesity: A Randomized Controlled Trial. *Journal of Nutrition Education & Behavior*. 2012;44(4S1):S81-S81. inappropriate study design
139. UP6 Healthy Caregivers-Healthy Children (HC2): A Childcare Center-based Obesity Prevention Program. *Journal of Nutrition Education & Behavior*. 2012;44(4S1):S82-S82. inappropriate study design
140. Serum leptin is not correlated with body fat in severe food restriction. *Applied Physiology, Nutrition & Metabolism*. 2012;37(6):1063-1071. inappropriate population
141. Physical activity, energy intake, and obesity prevalence among urban and rural schoolchildren aged 11-12 years in Japan. *Applied Physiology, Nutrition & Metabolism*. 2012;37(6):1189-1199. inappropriate study design
142. Abstracts of XVIIth FINA World Sports Medicine Congress. *Journal of Sports Science & Medicine*. 2012;11(4):775-791. inappropriate study design
143. Beverage patterns among Canadian children and relationship to overweight and obesity. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):900-906. inappropriate study design
144. Discussion of 'Overweight and obese boys reduce food intake in response to a glucose drink but fail to increase intake in response to exercise of short duration'. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):1014-1015. inappropriate study design
145. Reply to the discussion of 'Overweight and obese boys reduce food intake in response to a glucose drink but fail to increase intake in response to exercise of short duration'. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):1016-1017. inappropriate study design
146. Abstracts from the ICBM 2012 Meeting. *International journal of behavioral medicine*. 2012;19:1-341. inappropriate study design
147. Conference Day 1 - Wednesday 5 September 2012. *Nutrition & Dietetics*. 2012;69:2-20. inappropriate study design
148. Conference Day 2 - Thursday 6 September 2012. *Nutrition & Dietetics*. 2012;69:20-47. inappropriate study design
149. Conference Day 3 - Friday 7 September 2012. *Nutrition & Dietetics*. 2012;69:47-

70. inappropriate study design
150. Final Session - Saturday 8 September 2012. *Nutrition & Dietetics*. 2012;69:70-71. inappropriate study design
151. Poster Session Abstracts. *Psychophysiology*. 2012;49(S1):S24-S121. inappropriate study design
152. Abstracts of 53rd Symposium of the Society for the Study of Human Biology celebrating the Human Biology of Jim Tanner held at Corpus Christi College, Cambridge, 13-15 December 2011. *Annals of human biology*. 2012;39(5):448-458. inappropriate study design
153. Cardiorespiratory and metabolic responses associated with children's physical activity during self-paced games. *Canadian Journal of Physiology & Pharmacology*. 2012;90(9):1269-1276. inappropriate study design
154. SYMPOSIA. *Journal of sport & exercise psychology*. 2012:S5-S63. inappropriate study design
155. Free Papers. *Knee Surgery, Sports Traumatology, Arthroscopy*. 2012;20:5-100. inappropriate study design
156. Posters. *Knee Surgery, Sports Traumatology, Arthroscopy*. 2012;20:101-370. inappropriate study design
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## Supplementary file 4. Study characteristics.

Study	Year	Country	N	Age (yrs) ( $\bar{X} \pm SD$ ) or Range	Sex	Overweight/Obesity Criteria
Ackel-D'Elia et al.[13]*	2014	Brazil	AE = 24 AE+ST = 24	AE, AE+ST = 16.5 $\pm$ 1.5	MF	All classified as obese (BMI $\geq$ 95th percentile) based on 2000 CDC BMI charts
Alberga et al.[14]	2013	Canada	AE+ST = 12 CON = 7	AE+ST = 10.0 $\pm$ 1.0 CON = 10.0 $\pm$ 2.0	MF	All classified as obese (BMI $\geq$ 95th percentile) based on 2000 CDC BMI charts
Alves et al.[15]	2008	Brazil	AE = 39 CON = 39	AE = 8.0 $\pm$ 1.8 CON = 7.9 $\pm$ 1.5	MF	BMI $\geq$ 85 percentile
Andre & Beguier[16]	2015	France	AE = 8 CON = 8	AE, CON 14.4 $\pm$ 1.5	MF	NA ( $\bar{X}$ BMI = 37.7 kg·m <sup>2</sup> )
Ben Ounis et al.[17]	2010	Tunisia	AE = 16 CON = 16	AE = 13.4 $\pm$ 0.4 CON = 13.2 $\pm$ 0.6	MF	All classified as obese (BMI $\geq$ 97 <sup>th</sup> percentile)

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3	Berntsen et al.[18]	2010	Norway	ST = 32	ST, CON = 12.1	MF	All classified as obese (BMI >97.5 percentile)
4				CON =			
5				16			
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7							
8	Cao et al.[19]	2012	China	AE = 20	AE = NA	M	All classified as obese (BMI ≥ 25 kg·m <sup>2</sup> )
9				CON =	CON = NA		
10				20			
11							
12							
13	Chang et al.[20]	2008	China	AE+ST =	AE+ST = 12.6 ±	MF	All classified as obese (BMIs ≥ 95th percentile for sex-specific age
14				25	0.8		group Chinese children aged 7–18 years)
15				CON =	CON = 12.2 ±		
16				24	0.1		
17							
18							
19	Chen et al.[21]	2015	China	AE =15	AE = 14.1 ± 3.1	NA	All classified as obese (BMI ≥ 25 kg·m <sup>2</sup> )
20				ST = 15	ST = 13.9 ± 2.2		
21				AE+ST =	AE+ST = 14.2 ±		
22				15	3.8		
23				CON =	CON = 14.4 ±		
24				15	3.2		
25							
26							
27							
28	Chen et al.[22]	2016	Taiwan	AE = 25	AE = 12.6 ± 0.7	MF	All classified as obese (BMI >24 kg·m <sup>2</sup> ), equivalent to the 95th
29				CON =	CON = 12.8 ±		percentile for Taiwan growth charts
30				25	0.8		
31							
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Cheng et al.[23]	2012	China	AE+ST = 30 CON = 30	AE+ST, CON = 13.0 to 14.0	M	All classified as obese (BMI $\geq 25$ kg·m <sup>2</sup> )
Davis et al.[24]	2012	US	AE (LD) = 71 AE (HD) = 73 CON = 78	AE (LD) = $9.3 \pm 0.9$ AE (HD) = $9.4 \pm 1.2$ CON = $9.4 \pm 1.1$	MF	BMI $\geq 85$ th percentile based on 2000 CDC growth charts
Elloumi et al.[25]	2011	Tunisia	AE = 7 CON = 8	AE = $13.1 \pm 1.0$ CON = $13.2 \pm 0.2$	M	All classified as obese (> 97th percentile)
Farpour-Lambert et al.[26]	2009	Switzerland	AE+ST = 22 CON = 22	AE+ST = $9.1 \pm 1.4$ CON = $8.8 \pm 1.6$	MF	All classified as obese (BMI > 97th percentile based on age and sex)
Fazelifar et al.[27]	2013	Iran	AE+ST = 12	AE+ST, CON = 11-13	M	All classified as obese (BMI > 28 kg·m <sup>2</sup> )

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				CON =			
				12			
Fiorilli et al.[28]	2017	Italy	AE = 12	AE, ST(MI),	MF	Overweight or obese (BMI >85th percentile and body fat $\geq$ 25% for	
			ST(MI) =	ST(HI) = 12-15		boys and $\geq$ 30% for girls)	
			15				
			ST(HI) =				
			14				
Ghorbanian et	2013	Iran	AE = 15	AE = 17.4 $\pm$ 1.1	M	NA, but all classified overweight or obese by authors (BMI ( $\bar{X} \pm SD$ )	
al.[29]			CON =	CON = 16.9 $\pm$		was 28.41 $\pm$ 2.36 kg·m <sup>-2</sup> )	
			15	1.2			
Gutin et al.[30]	1997	US	AE = 17	AE = 9.6 $\pm$ 0.8	MF	NA, but all classified as obese by authors ( $\bar{X}$ BMI was 31.4 kg·m <sup>2</sup> in	
			CON =	CON = 9.5 $\pm$ 1.3		exercise group and 28.8 kg·m <sup>2</sup> in control group)	
			18				
Hagstromer et	2009	Sweden	AE+ST =	AE+ST = 13.7 $\pm$	MF	All classified as obese according to International of Obesity Task	
al.[31]			16	2.0		Force cutpoints	
			CON =	CON = 13.6 $\pm$			
			15	2.2			
Hay et al.[32]	2016	Canada	AE(MI) =	AE(MI) = 15.1 $\pm$	MF	Overweight or obese based on age- and sex-specific BMI standards	
			32	1.8			



				AE(HI) =	AE(HI) = $15.3 \pm$		
				38	1.7		
				CON =	CON = $15.2 \pm$		
				33	1.7		
11	Karacabey[33]	2009	Turkey	AE = 20	AE = $11.8 \pm 0.5$	M	All classified as obese (BMI $\geq 30.0$ kg.m <sup>2</sup> )
12				CON =	CON = $11.2 \pm$		
13				20	0.2		
17	Kelly et al.[34]	2004	US	AE = 10	AE = $11.0 \pm 2.0$	MF	Overweight or obese (BMI $\geq 85^{\text{th}}$ percentile)
18				CON =	CON = $11.0 \pm$		
19				10	2.3		
22	Kelly et al.[35]	2015	US	ST = 13	ST = $15.2 \pm 0.9$	MF	All classified as obese (BMI $\geq 95^{\text{th}}$ percentile) based on 2000 CDC
23				CON =	CON = $15.5 \pm$		BMI charts
24				13	0.9		
28	Kim et al. [36]	2007	SK	AE = 14	AE = $17 \pm 0.4$	M	NA, but classified as obese ( $\bar{X} \pm SD$ BMI in group was, $29.5 \pm 2.2$
29				CON =	CON = $17.0 \pm$		kg.m <sup>2</sup> )
30				12	0.4		
34	Kim et al. [37]	2008	SK	AE+ST =	AE+ST, CON =	M	Overweight or obese (BMI $\geq 85^{\text{th}}$ percentile based 1999 growth
35				8	NA		charts for Korean children and adolescents aged 2–18 years)
36				CON = 9			

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Lau et al.[110]	2015	China	AE(LI) = 21	AE(LI) = 9.9 ± 0.9	MF	Overweight according to age-specific BMI cut-off values (boys >20.20 kg·m <sup>2</sup> and girls >20.29 kg·m <sup>2</sup> )
			AE(HI) = 15	AE(HI) = 11.0 ± 0.6		
			CON = 12	CON = 10.6 ± 0.6		
Lee et al.[39]	2012	US	AE = 16	AE = 15.2 ± 0.9	M	All classified as obese (BMI ≥ 95th percentile) based on 2000 CDC BMI charts
			ST = 16	ST = 14.6 ± 1.5		
			CON = 13	CON = 14.8 ± 1.4		
Lee et al.[40]	2013	US	AE = 16	AE = 14.6 ± 1.9	F	All classified as obese (BMI ≥ 95th percentile) based on 2000 CDC BMI charts
			ST = 16	ST = 14.8 ± 1.9		
			CON = 12	CON = 15.0 ± 2.2		
Li et al.[111]	2014	China	AE = 20	AE = 15.4 ± 2.6	M	All classified as obese (BMI ≥ 25 kg·m <sup>2</sup> )
			CON = 20	CON = 14.6 ± 3.5		
Maddison et al.[42]	2011	NZ	AE = 160	AE, CON = 11.6 ± 1.1	MF	Overweight or obese according to International Obesity Task Force international cutoffs for child obesity
			CON = 162			

McNarry et al.[43]	2015	UK	AE = 15 CON = 11	AE, CON = 9.3 $\pm 0.9$	MF	Obese, defined as BMI $\geq$ 95 <sup>th</sup> percentile
Meyer et al.[44]	2006	Germany	AE = 33 CON = 34	AE = 13.7 $\pm$ 2.1 CON = 14.1 $\pm$ 2.4	MF	Obese, defined as > 95 <sup>th</sup> percentile for German pediatric population
Monteiro et al.[45]	2015	Brazil	AE = 11 AE+ST = 14	AE = 11.0 $\pm$ 1.0 AE+ST = 11.0 $\pm$ 1.3	MF	Obese according to BMI
Murphy et al.[46]	2009	US	AE = 23 CON = 12	AE = 10.3 $\pm$ 1.9 CON = 10.0 $\pm$ 1.3	MF	Overweight (BMI $\geq$ 85 <sup>th</sup> percentile)
Nobre et al.[47]	2017	Brazil	AE = 40 CON = 19	AE = 9.8 $\pm$ 5.7 CON = 9.9 $\pm$ 4.8	M	Overweight (BMI = 85 <sup>th</sup> to 95 <sup>th</sup> percentile) and obese BMI $\geq$ 95 <sup>th</sup> percentile)
Owens et al.[48]	1999	US	AE = 35 CON = 39	AE = 9.5 $\pm$ 1.2 CON = 9.4 $\pm$ 1.3	MF	Obese, classified as a triceps skinfold greater than the 85 <sup>th</sup> percentile for gender, age, and ethnicity
Park et al.[49]	2012	SK	AE+ST = 15	AE+ST = 12.1 $\pm$ 0.4	MF	BMI $\geq$ 85 <sup>th</sup> percentile for age and gender according to WHO cut-off points

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			CON =	CON = 12.2 ±		
			14	0.4		
Racil et al.[50]	2013	Tunisia	AE(MI) =	AE(MI) = 16.3 ±	F	BMI >97th percentile according to French standards
			11	0.5		
			AE(HI) =	AE(HI) = 15.6 ±		
			11	0.7		
			CON =	CON = 15.9 ±		
			12	1.2		
Racil et al.[51]	2016	Tunisia	AE = 23	AE = 16.6 ± 0.9	F	Obese according to CDC growth charts
			AE+ST =	AE+ST = 16.5 ±		
			26	1.2		
			CON =	CON = 16.9 ±		
			19	1.0		
Rooney et al.[52]	2005	US	AE = 26	AE = 8.9 ± 2.2	MF	Overweight or obese (BMI ≥ 84.5 percentile)
			CON =	CON = 8.6 ± 2.1		
			33			
Saygin & Ozturk	2011	Turkey	AE = 20	AE, CON = 10.0	F	NA, but authors classified all participants as obese (baseline BMI
[53]			CON =	to 12.0		$\bar{X} \pm SD = 25.9 \pm 2.1$ in exercise group and $26.1 \pm 1.4$ in control
			19			group)



Schranz et al.[54]	2014	Australia	ST = 26	ST = $14.9 \pm 1.4$	M	Overweight or obese according to Cole et al. BMI cutpoints
			CON =	CON = $15.1 \pm$		
			23	1.6		
Seo et al.[55]	2012	SK	AE = 10	AE = $14.7 \pm 1.5$	M	Obese, defined as BMI >95th percentile based on French population
			CON =	CON = $14.6 \pm$		standards
			10	3.0		
Shaibi et al.[56]	2006	US	ST = 11	ST = $15.1 \pm 1.7$	M	Overweight or obese (BMI $\geq$ 85 <sup>th</sup> percentile based on 2000 CDC
			CON =	CON = $15.6 \pm$		growth charts)
			11	1.7		
Sigal et al.[57]	2014	Canada	AE = 75	AE = $15.5 \pm 1.4$	MF	Obese (BMI $\geq$ 95th percentile for age and sex)
			ST = 78	ST = $15.9 \pm 1.5$		
			AE+ST =	AE+ST = $15.5 \pm$		
			75	1.3		
			CON =	CON = $15.6 \pm$		
			76	1.3		
Silva et al.[58]	2012	Brazil	AE = 9	AE, CON = 13	MF	Overweight or obese according to Cole et al. BMI cutpoints
			CON = 5	to 17 yrs		
Song et al.[59]	2012	SK	AE = 12	AE = $12.7 \pm 0.7$	M	Obese (> 30% body fat)
			CON =	CON = $12.6 \pm$		
			10	0.6		

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3	Staiano et al.[60]	2017	US	AE = 20	AE = 15.3 ± 1.2	F	Overweight or obese (BMI ≥ 85 <sup>th</sup> percentile)
4				CON =	CON = 16.1 ±		
5				18	1.4		
6							
7							
8	Sun et al.[61]	2011	China	AE = 25	AE, CON 13.6 ±	MF	Overweight or obese (>85 <sup>th</sup> percentile) based on China Obesity
9				CON =	0.7		Task Force Recommendations
10				17			
11							
12							
13	Tan et al.[62]	2010	China	AE = 30	AE = 9.4 ± 0.5	MF	Obese (body mass greater than 20% of standard body-mass-for
14				CON =	CON = 9.5 ± 0.5		height of Chinese children)
15				30			
16							
17							
18	Vasconcellos et	2016	Brazil	AE = 10	AE = 14.1 ± 1.3	MF	Obese (BMI >2 standard deviations above age and sex specific
19				CON =	CON = 14.8 ±		WHO reference medians)
20	al.[63]			10	1.5		
21							
22							
23							
24	Watts et al.[64]	2004	Australia	AE+ST =	AE+ST, CON =	MF	Obese according to Cole et al. BMI cutpoints
25				19	14.3 ± 1.5		
26				CON =			
27				19			
28							
29							
30							
31							
32							
33	Watts et al.[65]	2004	Australia	AE = 14	AE, CON = 8.9	MF	Obese according to Cole et al. BMI cutpoints
34				CON =	± 1.6		
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Weintraub et al.[66]	2008	US	AE = 9 CON = 12	AE = $9.5 \pm 0.6$ CON = $10.3 \pm 0.8$	MF	Overweight or obese (BMI $\geq$ 85th percentile based on 2000 CDC BMI growth charts)
Wong et al.[67]	2008	Singapore	AE+ST = 12 CON = 12	AE+ST = $13.8 \pm 1.1$ CON = $14.3 \pm 1.5$	M	Obese according to Cole et al. BMI cutpoints
Youssef et al.[68]	2015	Lebanon	AE = 14 CON = 9	AE = $16.1 \pm 1.1$ CON = $16.3 \pm 1.5$	F	Overweight or obese according to Cole's BMI cutpoints
Zehsaz et al.[69]	2017	Iran	AE = 16 CON = 16	AE = $10.8 \pm 0.9$ CON = $10.3 \pm 0.9$	M	Overweight or obese (BMI $\geq 25$ kg·m <sup>2</sup> )

Notes: US, United States; SK, South Korea; NZ, New Zealand; UK, United Kingdom; N, number of participants; yrs, years; AE, aerobic exercise, LPA, leisure physical activity; ST, strength training; CON, control;  $\bar{X} \pm SD$ , mean  $\pm$  standard deviation; LI, lower intensity; MI, moderate-intensity; HI, high-intensity; M, males; F, females; NA, not available; LD, low-dose; HD, high-dose; BMI, body mass index; CDC, Centers for Disease Control and Prevention; WHO, World Health Organization \*, study also included a leisure intervention but was excluded because it didn't meet our eligibility criteria.

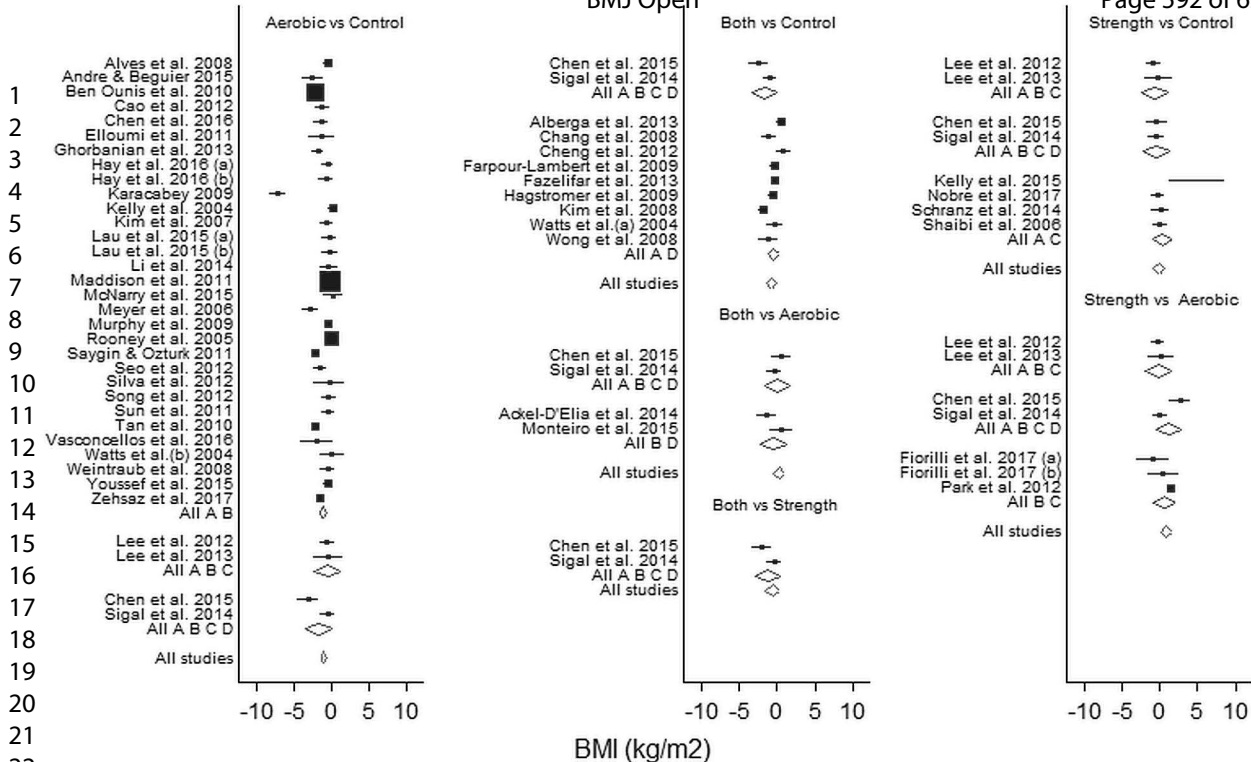
Supplementary file 5. Study-level risk of bias assessment results.

Study	Random sequence generation	Allocation concealment	Blinding (participants & personnel)	Blinding (outcome assessors)	Incomplete outcome data	Selective reporting	Physically inactive
Ackel-D'Elia et al.*	low	unclear	high	unclear	unclear	low	unclear
Alberga et al.	low	low	high	unclear	high	unclear	unclear
Alves et al.	low	unclear	high	unclear	low	unclear	unclear
Andre & Beguier	low	unclear	high	unclear	unclear	unclear	unclear
Ben Ounis et al.	low	unclear	high	unclear	unclear	unclear	low
Berntsen et al.	low	unclear	high	unclear	low	unclear	unclear
Cao et al.	low	unclear	high	unclear	unclear	unclear	unclear
Chang et al.	high	unclear	high	unclear	unclear	unclear	unclear
Chen et al.	low	unclear	high	unclear	unclear	unclear	unclear
Chen et al.	low	unclear	high	unclear	high	unclear	unclear
Cheng et al.	low	unclear	high	unclear	unclear	unclear	unclear
Davis et al.	low	low	high	high	low	low	low
Elloumi et al.	low	unclear	high	unclear	unclear	unclear	high
Farpour-Lambert et al.	low	low	high	low	low	low	low
Fazelifar et al.	low	unclear	high	unclear	low	unclear	low
Fiorilli et al.	low	unclear	high	unclear	low	unclear	low
Ghorbanian et al.	low	unclear	high	unclear	unclear	unclear	low
Gutin et al.	low	unclear	high	unclear	low	unclear	unclear
Hagstromer et al.	low	unclear	high	unclear	high	low	high
Hay et al.	low	low	high	low	low	low	unclear

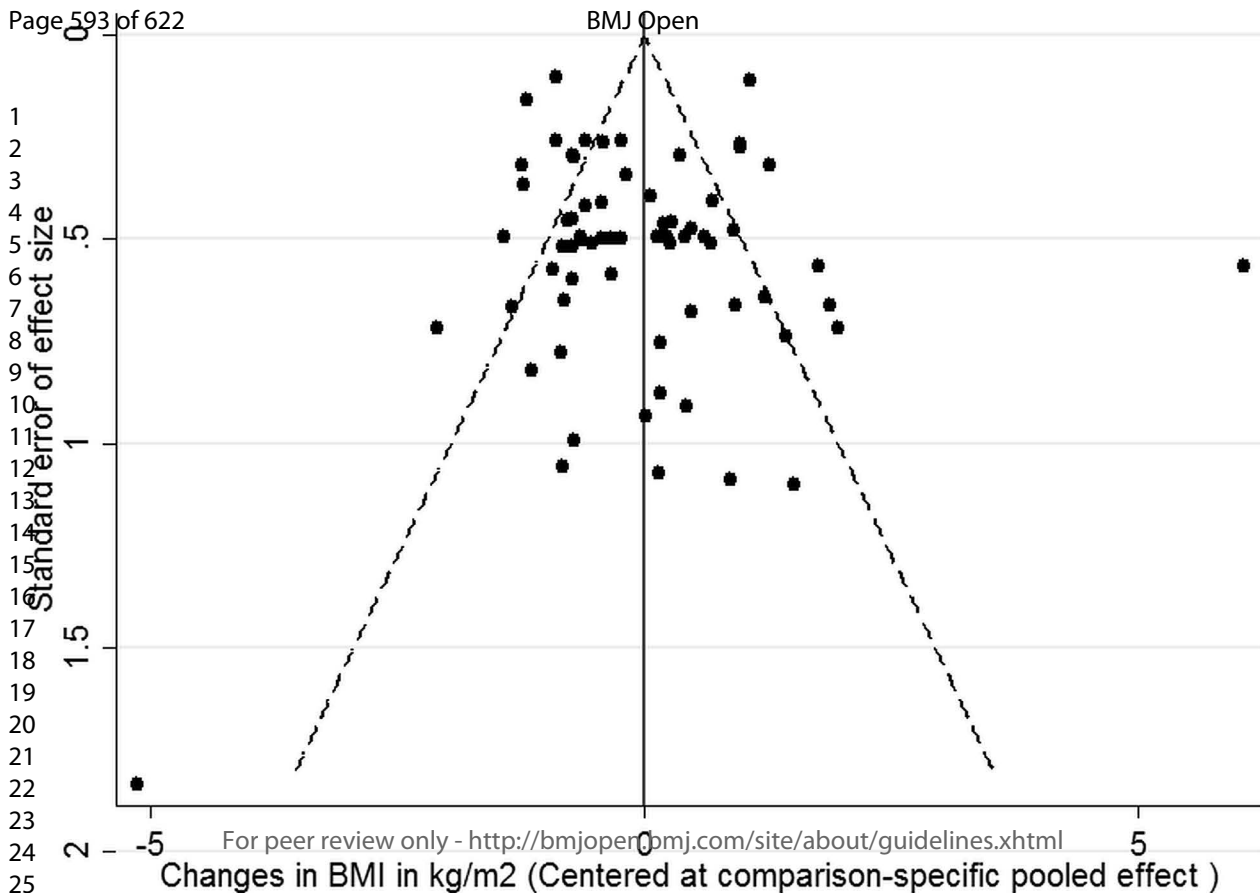


1	Karacabey	low	unclear	high	unclear	unclear	unclear	low
2								
3	Kelly et al.	low	unclear	high	unclear	unclear	low	unclear
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5	Kelly et al.	low	low	high	unclear	low	unclear	unclear
6								
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8	Kim et al.	low	unclear	high	unclear	unclear	unclear	low
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11	Kim et al.	low	unclear	high	unclear	high	unclear	unclear
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14	Lau et al.	low	unclear	high	unclear	unclear	unclear	unclear
15								
16	Lee et al.	low	low	high	unclear	low	unclear	low
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18								
19	Lee et al.	low	low	high	unclear	low	unclear	low
20								
21								
22	Li et al.	low	unclear	high	unclear	low	unclear	unclear
23								
24								
25	Maddison et al.	low	low	high	high	low	low	high
26								
27	McNarry et al.	low	low	high	unclear	unclear	high	unclear
28								
29								
30	Meyer et al.	low	unclear	high	unclear	high	low	low
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33	Monteiro et al.	low	unclear	high	unclear	unclear	low	unclear
34								
35								
36	Murphy et al.	low	unclear	high	unclear	unclear	low	unclear
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39	Nobre et al.	low	unclear	high	unclear	unclear	unclear	unclear
40								
41	Owens et al.	low	unclear	high	unclear	low	unclear	unclear
42								
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44	Park et al.	low	unclear	high	unclear	low	low	unclear
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47	Racil et al.	low	unclear	high	unclear	unclear	unclear	low
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50	Racil et al.	low	unclear	high	unclear	unclear	unclear	low
51								
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53	Rooney et al.	low	unclear	high	unclear	low	low	unclear
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55	Saygin & Ozturk	low	unclear	high	unclear	unclear	unclear	unclear
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1	Schranz et al.	low	unclear	high	high	low	low	unclear
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3	Seo et al.	low	unclear	high	unclear	high	unclear	unclear
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5	Shaibi et al.	low	unclear	high	unclear	high	low	unclear
6								
7								
8	Sigal et al.	low	low	high	unclear	low	unclear	low
9								
10								
11	Silva et al.	low	unclear	high	unclear	high	unclear	unclear
12								
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14	Song et al.	low	unclear	high	low	high	unclear	low
15								
16	Staiano et al.	low	low	high	low	low	low	unclear
17								
18								
19	Sun et al.	low	unclear	high	unclear	low	unclear	unclear
20								
21								
22	Tan et al.	high	high	high	unclear	low	unclear	unclear
23								
24								
25	Vasconcellos et al.	low	low	high	low	high	low	low
26								
27	Watts et al.	low	unclear	high	unclear	unclear	unclear	unclear
28								
29								
30	Watts et al.	low	unclear	high	unclear	unclear	unclear	unclear
31								
32								
33	Weintraub et al.	low	unclear	high	high	low	low	unclear
34								
35								
36	Wong et al.	low	unclear	high	unclear	low	unclear	unclear
37								
38								
39	Youssef et al.	low	low	high	unclear	unclear	unclear	low
40								
41	Zehsaz et al.	low	unclear	high	unclear	unclear	unclear	unclear
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Supplementary file 8. Simple meta-regression results for changes in BMI (kg.m<sup>2</sup>).

Variable	Aerobic			Strength			Both		
	$\beta_1$			$\beta_1$			$\beta_1$		
	( $\bar{X} \pm SE$ )	z(p)	95% CI	( $\bar{X} \pm SE$ )	z(p)	95% CI	( $\bar{X} \pm SE$ )	z(p)	95% CI
<i>Study characteristics</i>									
- Year	0.02±0.56	0.32(.75)	-0.9,0.1	-0.007±0.13	-0.06(.95)	-0.3,0.2	-0.02 ± .10	-0.17(.87)	-0.2,0.18
- Impact factor	0.07±0.09	0.85(.39)	-0.1,0.2	-0.18±0.14	-1.30(.19)	-0.5,0.1	0.001±0.09	0.02(.99)	-1.7,1.7
- Country (other vs USA)	<b>-1.06±0.51</b>	<b>-2.1(.04)*</b>	<b>-2.1,-0.05</b>	-0.36±0.79	0.46(.64)	-1.9,1.2	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.81±0.46	-1.8(.08)	-1.7,0.09	-0.07±0.78	-.08(.93)	-1.6,1.5	-0.69±0.73	-0.95(.34)	-2.1,0.7
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	0.44±1.1	0.42(.68)	-1.6,2.5	ID	ID	ID	ID	ID	ID
-- Unclear	-0.32±0.69	-0.48(.63)	-2.9,2.3	-0.30±1.3	-0.22(.82)	-2.9,2.3	-0.41± 1.2	-0.34(.74)	-2.8,2.0
- Incomplete data (ref = low)									
-- High	-0.93±0.63	-1.5(.14)	-2.2,0.3	0.01±1.3	0.01(.99)	-2.6, 2.6	0.004±0.88	0(1.0)	-1.7,1.7
-- Unclear	-0.84±0.44	-1.9(.06)	-1.7,0.03	0.28±0.95	0.29(0.77)	-1.6,2.1	-0.39±0.77	-0.51(.61)	-1.9,1.1
- Selective reporting	-0.58±0.44	-1.3(0.18)	-1.4,0.3	-0.70±0.83	-0.85(0.4)	-2.3,0.9	-0.02±0.73	-0.02(.98)	-1.5,1.4

1										
2										
3	(unclear vs. low)									
4	- Inactive (ref = low)									
5										
6	-- High	1.0±0.93	1.1(0.28)	-0.8,2.8	ID	ID	ID	0.35±1.3	0.27(.78)	-2.2,2.9
7										
8	-- Unclear	0.81±0.43	1.9(.06)	-0.04,1.7	<b>1.83±0.77</b>	<b>2.4(.02)*</b>	<b>0.3,3.3</b>	0.02±0.73	0.02(.98)	-1.4,1.5
9										
10	- Funding (yes vs no)	<b>1.06±0.40</b>	<b>2.6(.008)*</b>	<b>0.3,1.8</b>	0.56±0.89	0.63(.53)	-1.2,2.3	-0.09±0.72	-0.13(.90)	-1.5,1.3
11										
12	- Matching	-0.76±0.64	1.2(.23)	-0.5,2.0	0.39±0.98	0.40(.69)	-1.5,2.3	-0.26±0.80	-0.32(.75)	-1.8,1.3
13										
14	- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID
15										
16	- Control type (other vs	0.41±0.53	0.76(.44)	-0.6,1.4	-0.82±1.13	-0.72(.47)	-3.5,1.4	-0.81±0.75	-1.07(.28)	-2.3,0.7
17	none)									
18										
19	- Analysis type (abp vs	-0.51±0.43	-1.2(.22)	-1.3,0.3	0.34±0.78	0.43(.66)	-1.2,1.9	-0.27±0.77	-0.35(.73)	-1.8,0.8
20	itt)									
21										
22										
23	- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
24										
25	- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
26										
27	- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
28										
29	- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
30										
31	- Fidelity (enactment)	-0.22±0.64	-0.35(.73)	-1.5,1.0	-0.10±0.73	-0.13(.90)	1.5,1.3	0.92±0.79	1.2(.24)	-0.6,2.5
32										
33	(yes vs no)									
34										
35	<i>Participant</i>									
36										
37	<i>characteristics</i>									
38										
39	- Age (years)	-0.04±0.08	-0.51(.61)	-0.2, 0.1	-0.06±0.23	-0.26(.79)	-0.5,0.4	-0.20±0.17	-1.2(.23)	-0.5,0.1
40										
41	- Gender (females vs	-0.51±0.98	0.52(.60)	-1.4,2.4	-0.55±1.6	-0.34(.74)	-3.8,2.7	-0.45±0.48	-0.92(.35)	-1.4,0.5
42	males)									
43										
44										
45										
46										
47										

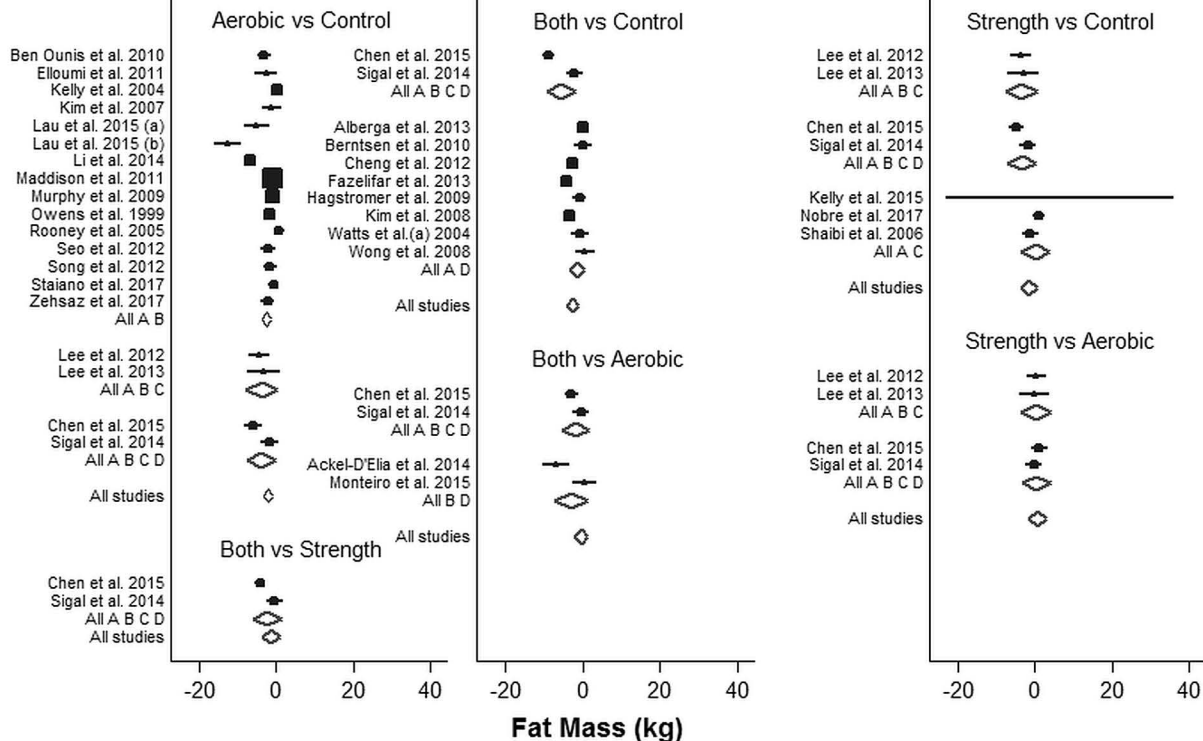
- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Maturation stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
<i>Exercise</i>									
<i>characteristics</i>									
- Length (weeks)	-0.02±0.03	0.77(0.44)	-0.04,0.09	-0.03±0.07	-0.39(.70)	-0.2,0.1	-0.03±0.04	-0.77(.44)	-0.1, 0.05
- Frequency	-0.18±0.17	1.06(.29)	-0.1,0.5	-0.67±0.63	-1.06(.29)	-1.9,0.6	-0.31±0.37	-0.84(.40)	-1.0,0.4
(days/week)									
- Intensity (high vs moderate)	-0.88±0.45	-1.9(.05)	-1.8,0.01	ID	ID	ID	ID	ID	ID
- Duration	-0.01±0.01	-1.8(.07)	-0.03,0.001	-0.01±0.02	-0.53(.59)	-	-0.01±0.02	-	-
(min/session)						0.05,0.03		0.67(0.50)	0.06,0.03
- Compliance (%)	<b>-0.02±0.01</b>	<b>-2.1(.03)*</b>	<b>-.04,-.002*</b>	-	-0.25(.80)	-	0.03±0.06	0.46(.64)	-0.08,0.1
				0.008±0.03		0.08,0.06			
- Minutes per week	<b>-0.01±.002</b>	<b>-2.6(.01)*</b>	<b>-.009,-.001</b>	NA	NA	NA	NA	NA	NA
(total) <sup>a</sup>									
- Minutes per week	<b>-.01±.0004</b>	<b>13.3(&lt;0.001)*</b>	<b>-0.007,-</b>	NA	NA	NA	NA	NA	NA
(adjusted total) <sup>a</sup>			<b>0.005</b>						
- Sets <sup>b</sup>	NA	NA	NA	-0.03±0.05	-0.55(.58)	-0.1,0.07	NA	NA	NA
- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Number of exercises <sup>b</sup>	NA	NA	NA	-0.21±0.80	-0.27(.79)	-1.8,1.3	NA	NA	NA
- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA

1										
2										
3	- Type of strength	NA	NA	NA	0.01±0.75	0.01(.99)	-2.2,2.2	NA	NA	NA
4	program <sup>b</sup> (c vs t)									
5										
6	- Type of strength	NA	NA	NA	ID	ID	ID	NA	NA	NA
7	equipment <sup>b</sup>									
8										
9										
10	- Supervision (no vs	0.94±0.67	1.4(.16)	-0.4,2.3	<b>5.1±2.2</b>	<b>2.4(.02)*</b>	<b>0.9,9.4</b>	ID	ID	ID
11	yes)									
12										
13										
14	- Location (home	-0.77±0.44	1.7(.08)	-0.1,1.6	<b>5.1±2.0</b>	<b>2.6(.01)*</b>	<b>1.2,9.0</b>	ID	ID	ID
15	versus facility)									
16										
17										
18	Outcome									
19	characteristics									
20										
21										
22	- Baseline BMI (kg·m <sup>2</sup> )	-0.08±0.05	-1.7(.10)	-0.2,0.01	-0.09±0.0	-0.99(.32)	-0.3,.08	-0.07±0.10	-0.67(.50)	-0.3,0.1
23										
24	- Assessment method	NA	NA	NA	NA	NA	NA	NA	NA	NA
25										

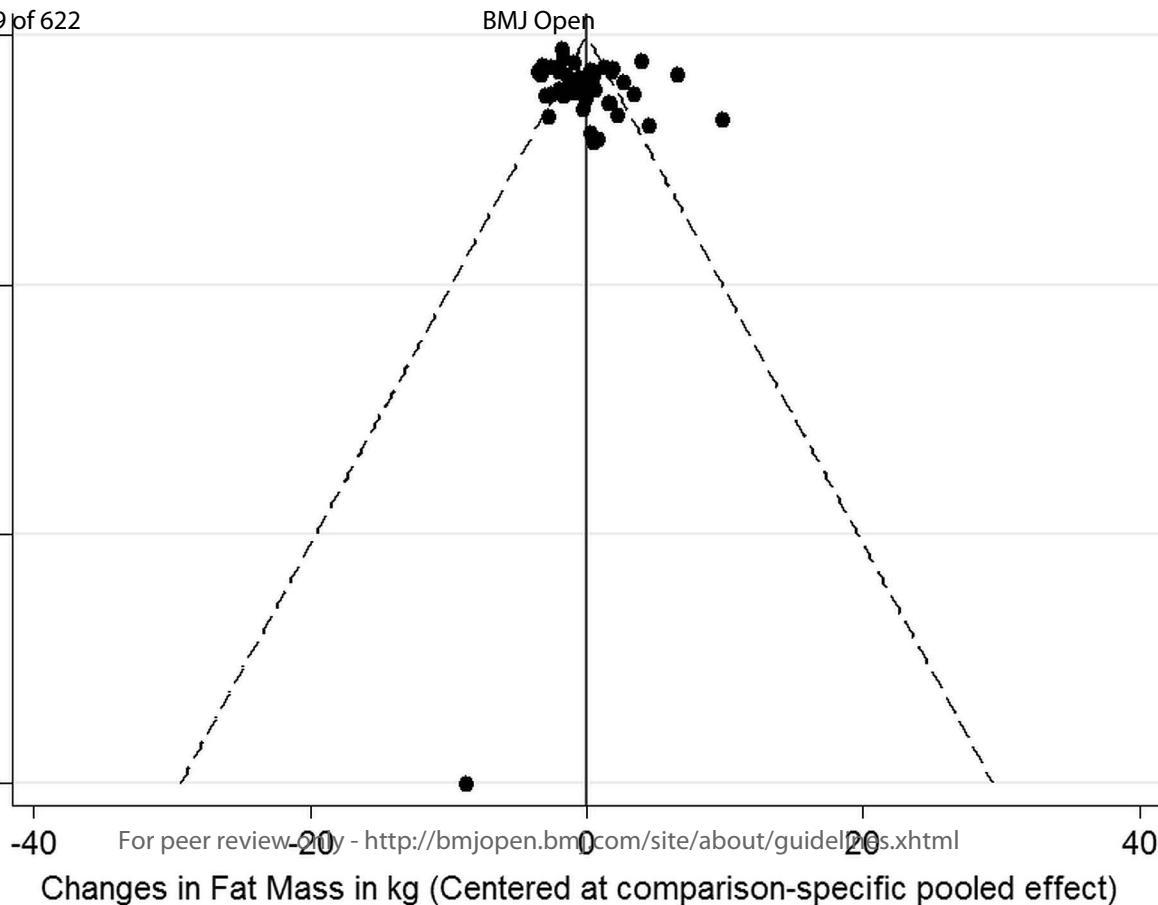
Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; BMI, body mass index; c vs t, circuit versus traditional; **boldface** items indicate statistically significant findings; \*, statistically significant (two-tailed p ≤ 0.05); total number of observations for statistically significant results from multivariate models were 53 for country, 53 for funding, 16 for compliance, 32 for total minutes per week of exercise, 12 for compliance-adjusted minutes per week of exercise, 51 for supervision, and 51 for location.



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Standard error of effect size

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Supplementary file 11. Simple meta-regression results for changes in fat mass (kg).

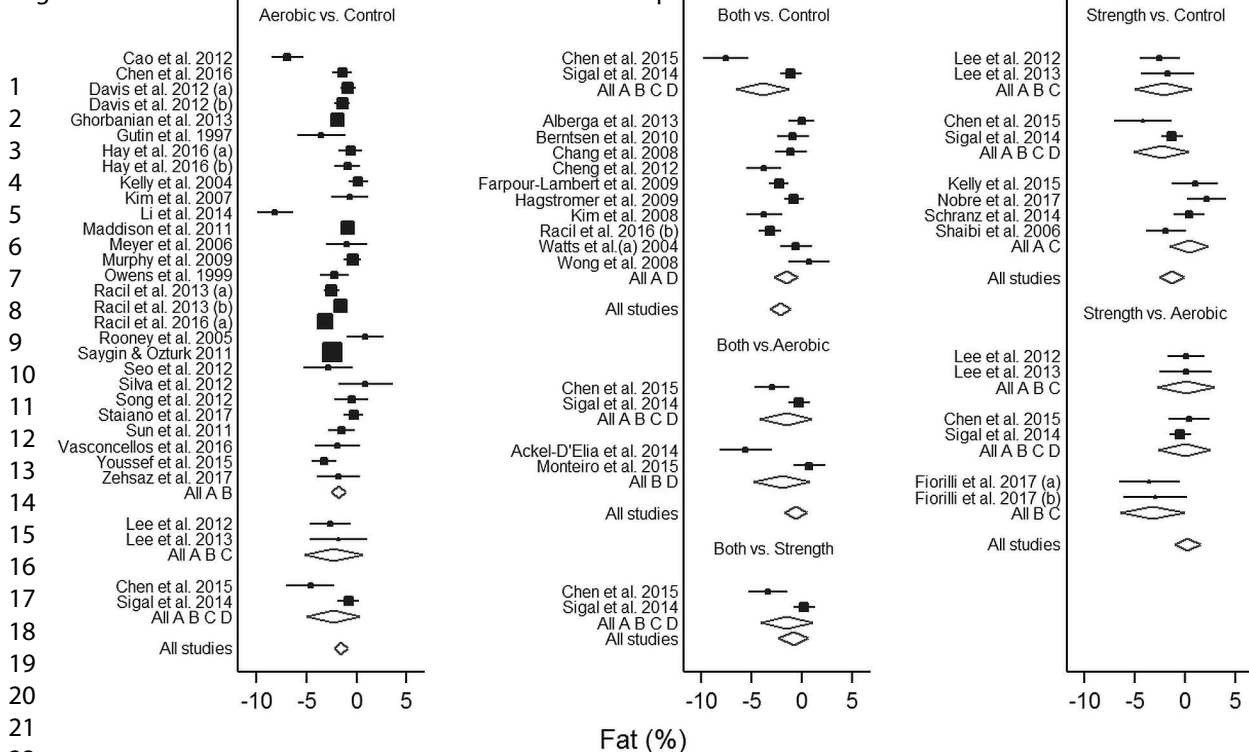
Variable	Aerobic			Strength			Both		
	$\beta_1$			$\beta_1$			$\beta_1$		
	( $\bar{X} \pm SE$ )	z(p)	95% CI	( $\bar{X} \pm SE$ )	z(p)	95% CI	( $\bar{X} \pm SE$ )	z(p)	95% CI
<i>Study characteristics</i>									
- Year	-0.23±0.1	-1.9(.06)	-0.5,0.01	0.09±0.30	0.31(.76)	-0.5,0.7	<b>0.48±0.22</b>	<b>-2.1(.03)*</b>	<b>-0.9,-0.4</b>
- Impact factor	0.16±0.27	0.58(.56)	-0.4,0.7	-0.12±0.35	-0.35(.73)	-0.8,0.6	0.25±0.28	0.91(.36)	-0.3,0.8
- Country (other vs usa)	-1.7±1.2	-1.4(.17)	-4.1,0.7	0.54±2.1	0.26(.79)	-3.5,4.6	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.66±1.4	-0.46(.64)	-3.5,2.1	1.3±2.2	0.60(.55)	-2.9,5.5	-1.8±2.0	-0.92(.35)	-5.7,2.1
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	ID	ID	ID	ID	ID	ID	ID	ID	ID
-- Unclear	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Incomplete data (ref = low)									
-- High	0.37±2.2	0.17(.87)	-4.0,4.7	1.0±3.3	0.31(.76)	-5.4,7.4	0.22±2.1	0.11(.91)	-3.9,4.3
-- Unclear	-0.69±1.3	-0.52(.61)	-3.3,1.9	1.3±2.4	.056(.58)	-3.3,6.0	-2.8±1.9	-1.5(.13)	-6.5,0.9
- Selective reporting (unclear vs. low)	<b>-3.2±1.2</b>	<b>-2.6(.009)*</b>	<b>-5.7,-0.8</b>	-0.68±2.8	-0.24(.81)	-6.2,4.9	-0.40±1.9	-0.21(.83)	-4.1,3.3
- Inactive (ref = low)									
-- High	0.93±2.4	0.39(.69)	-3.7,5.6	ID	ID	ID	2.4±3.4	0.72(.47)	-4.2,9.1
-- Unclear	0.15±1.5	0.10(.92)	-2.7,3.0	2.1±2.2	0.94(.35)	-2.3,6.5	0.62±2.1	0.30(.77)	-3.5,4.7
- Funding (yes vs no)	2.5±1.5	1.7(.09)	-0.4,5.5	1.7±2.4	0.69(.49)	-3.0,6.4	<b>3.6±1.6</b>	<b>2.3(.02)*</b>	<b>0.5,6.8</b>
- Matching	2.3±1.4	1.67(.09)	-0.4,4.9	-0.20±2.7	-0.08(.94)	-5.4,5.0	-0.47±2.0	-0.23(.82)	-4.4,3.5
- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID

1										
2										
3	- Control type (other vs none)	2.6±1.9	1.4(.16)	-1.0,6.3	0.45±2.8	0.16(.87)	-5.0,5.9	1.4±1.8	0.79(.43)	-2.2,5.0
4	- Analysis type (abp vs itt)	0.63±1.3	0.47(.64)	-2.0,3.2	1.9±2.1	0.91(.36)	-2.3,6.2	-1.3±1.9	-0.69(.49)	-5.0,2.4
5										
6	- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
7										
8	- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
9										
10	- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
11	- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
12										
13	- Fidelity (enactment) (yes vs no)	-1.2±1.0	-1.2(.25)	-3.2,0.8	-1.2±1.7	-0.74(.46)	-4.5,2.0	ID	ID	ID
14										
15	<i>Participant characteristics</i>									
16										
17	- Age (years)	-0.02±0.26	-0.10(.92)	-0.5,0.5	-0.62±0.54	-1.1(.25)	-1.7,0.4	-0.67±0.44	-1.5(.13)	-1.5,0.2
18	- Gender (females vs males)	ID	ID	ID	ID	ID	ID	ID	ID	ID
19										
20	- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
21										
22	- Maturation stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
23										
24	<i>Exercise characteristics</i>									
25										
26	- Length (weeks)	<b>0.26±0.11</b>	<b>2.3(.02)*</b>	<b>0.04,0.48</b>	0.07±0.22	0.33(.74)	-0.4,0.5	0.13±0.15	0.83(.41)	-0.2,0.4
27	- Frequency (days/week)	0.54±0.44	1.2(.22)	-0.3,1.4	-1.7±1.5	-1.2(.24)	-4.6,1.1	-1.6±0.96	-1.7(.09)	-3.5,0.2
28										
29	- Intensity (high vs moderate)	<b>-4.9±1.7</b>	<b>-2.9(.003)*</b>	<b>-8.2,1.6</b>	ID	ID	ID	ID	ID	ID
30	- Duration (min/session)	0.02±0.03	0.86(.39)	-0.03,0.09	-0.02±0.06	-0.39(.69)	-0.1,.1	0.09±0.06	1.6(.11)	-0.02,0.2
31										
32	- Compliance (%)	<b>-0.07±0.02</b>	<b>-3.9(&lt;0.001)*</b>	<b>-0.1,-0.03</b>	-0.26±0.37	-0.72(.47)	-1.0,0.4	0.002±.03	0.06(.95)	-0.07,.07
33										
34	- Minutes per week (total) <sup>a</sup>	0.007±0.01	0.69(.49)	-0.01,0.03	NA	NA	NA	NA	NA	NA
35	- Minutes per week (adjusted total) <sup>a</sup>	<b>-0.006±.003</b>	<b>-2.1(.03)*</b>	<b>-0.01,-0.0006</b>	NA	NA	NA	NA	NA	NA
36										
37	- Sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
38										
39	- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
40										
41	- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
42										
43	- Number of exercises <sup>b</sup>	NA	NA	NA	0.10±1.2	0.08(.93)	-2.3,2.5	NA	NA	NA
44	- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
45										
46										
47										



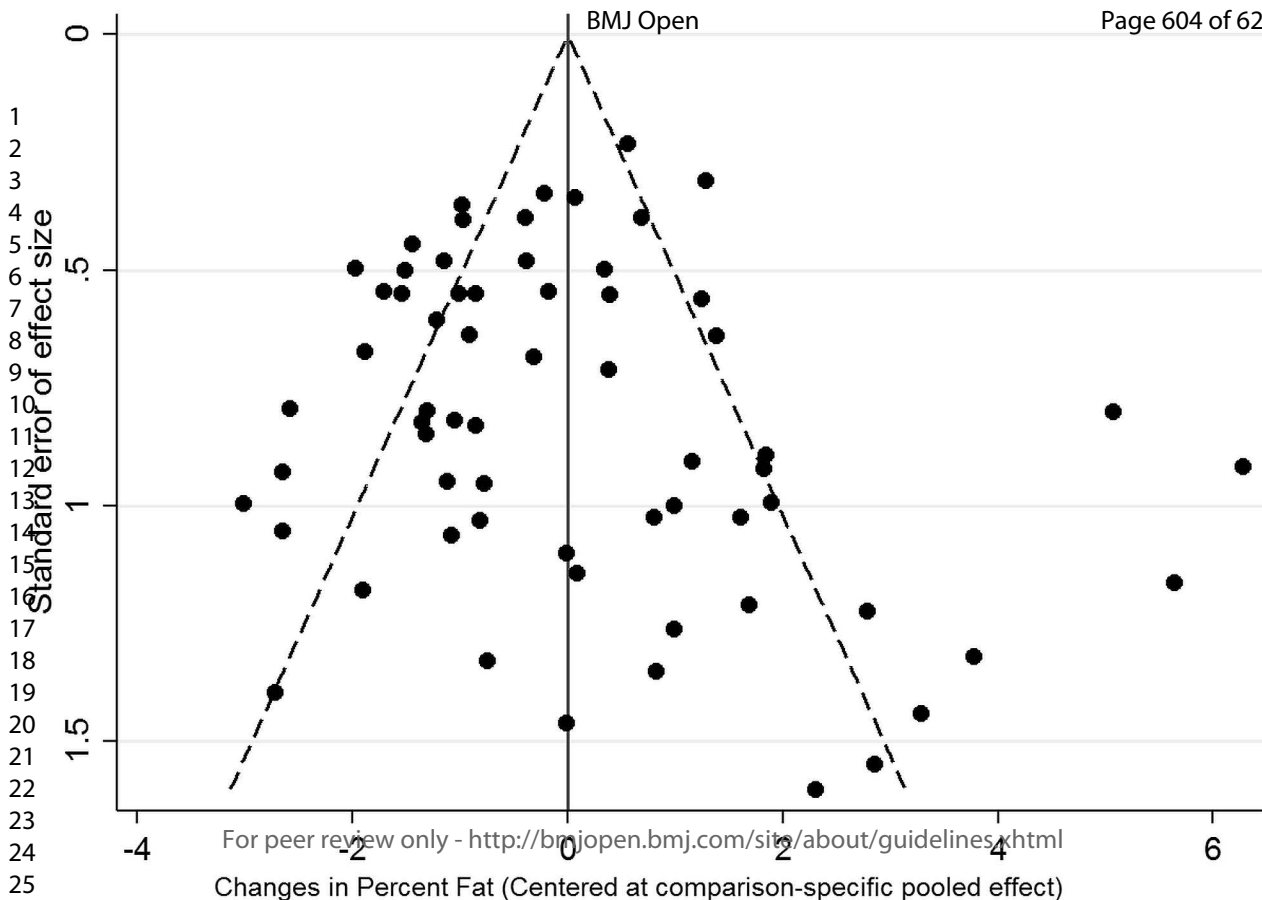
- Type of strength program <sup>b</sup> (c vs t)	NA	NA	NA	-0.85±1.3	-0.65(.52)	-3.4,1.7	NA	NA	NA
- Type of strength equipment <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Supervision (no vs yes)	2.3±1.7	1.3(.18)	-1.1,5.6	8.1±15.3	0.53(.59)	-21.8,38.1	ID	ID	ID
- Location	2.2±1.6	1.4(.17)	-0.9,5.3	8.3±15.2	0.54(.59)	-21.6,38.1	ID	ID	ID
<i>Outcome characteristics</i>									
- Baseline fat mass (kg)	-0.09±0.05	-1.8(.07)	-0.2,0.007	-0.10±0.08	-1.3(.18)	-0.3,0.5	-0.01±0.08	-.17(.86)	-0.2,0.1
- Assessment method (ref = DEXA)									
-- MRI	-2.5±2.1	-1.2(.22)	-6.7,1.6	-1.9±3.2	-0.59(.56)	-8.1,4.3	-1.3±2.6	-0.51(.61)	-6.4,3.8
-- BI	-2.2±1.7	-1.3(.20)	-5.6,1.2	ID	ID	ID	-2.7±2.7	-0.98(.33)	-8.1,2.7
-- Skinfolds	-3.1±1.7	-1.8(.07)	-6.4,0.3	2.1±3.7	0.55(.58)	-5.3,9.4	0.65±2.8	0.23(.82)	-4.8,6.1

Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; c vs t, circuit versus traditional; DEXA, dual-energy x-ray absorptiometry; MRI, magnet resonance imaging; BI, bioelectrical impedance; **boldface** items indicate statistically significant findings; \*, statistically significant (two-tailed  $p \leq 0.05$ ); total number of observations for statistically significant findings from multivariate models were 32 for year of publication, selective reporting, funding, length of training and intensity of training, 10 for compliance, and 8 for adjusted minutes per week of exercise.



• Studies Pooled within design Pooled overall

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Supplementary file 14. Simple meta-regression results for changes in percent body fat.

Variable	Aerobic			Strength			Both		
	$\beta_1$			$\beta_1$			$\beta_1$		
	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI
<i>Study characteristics</i>									
- Year	-0.003±0.07	-0.04(.97)	-0.1,0.1	0.03±0.20	0.16(.87)	-0.38,0.44	-0.26±0.15	-1.8(.08)	-0.6, 0.03
- Impact factor	0.04±0.05	0.86(.39)	-0.05,0.1	-0.07±0.22	-0.34(.73)	-0.5,0.4	0.12±0.14	0.83(.41)	-0.2,0.4
- Country (other vs usa)	-0.68±0.72	-0.94(.35)	-2.1,0.74	-0.34±1.3	-0.27(.79)	-2.8,2.2	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.43±0.70	-0.62(.54)	-1.8,0.9	-0.24±1.3	-0.19(.85)	-2.7,2.2	-1.3±1.2	-1.1(.27)	-2.7,2.2
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	-0.23±1.4	-0.17(.87)	-2.9,2.5	ID	ID	ID	ID	ID	ID
-- Unclear	-0.97±0.96	-1.0(.31)	-2.8,0.91	-2.0±2.1	-0.96(.34)	-6.1,2.1	0.06±1.9	0.03(.98)	-3.8,3.9
- Incomplete data (ref = low)									
-- High	0.21±0.96	0.22(.83)	-1.7,2.1	-0.31±2.1	-0.14(.88)	-4.5,3.9	-0.35±1.4	-0.25(.80)	-3.1,2.4
-- Unclear	-0.66±0.71	-0.93(.35)	-2.0,0.7	1.6±1.5	1.07(.28)	-1.4,4.6	-0.35(1.4)	-0.25(.80)	-3.1,2.4
- Selective reporting (unclear vs. low)	<b>-1.6±0.66</b>	<b>-2.4(.01)*</b>	<b>-2.9,-0.30</b>	-1.0±1.5	-0.66(.51)	-4.0,2.0	-0.19±1.1	-0.17(.86)	-2.4,2.0
- Inactive (ref = low)									
-- High	0.82±1.9	0.44(.66)	-2.8,4.5	ID	ID	ID	1.6±2.1	0.75(.45)	-2.5,5.6
-- Unclear	-0.04±0.67	-0.07(.95)	-1.4,1.3	<b>2.7±1.3</b>	<b>2.2(.03)*</b>	<b>0.25,5.2</b>	0.05±1.2	0.75(.45)	-2.5,5.6
- Funding (yes vs no)	<b>2.1±0.70</b>	<b>3.0(0.003)*</b>	<b>0.7,3.5</b>	<b>4.1±1.3</b>	<b>3.07(.002)*</b>	<b>1.5,6.8</b>	<b>4.4±1.2</b>	<b>3.6(&lt;0.001)*</b>	<b>2.0,6.8</b>



- Matching	1.1±0.77	1.4(.16)	-0.4,2.6	-0.21±1.7	-0.12(.90)	-3.6,3.2	0.41±1.2	0.34(.73)	-1.9,2.7
- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Control type (other vs none)	-0.03±0.82	-0.03(.97)	-1.6,1.6	-1.2±1.7	-0.72(.47)	-4.6,2.1	0.78±1.1	0.71(.48)	-1.4,2.9
- Analysis type (abp vs itt)	0.22±0.70	0.32(.75)	-1.1,1.6	0.09±1.3	0.07(.94)	-2.4,2.6	-1.1±1.1	-1.02(.31)	-3.3,1.1
- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (enactment) (yes vs no)	-0.59±0.43	-1.4(.17)	-1.4,0.26	-1.5±0.84	-1.7(.08)	-3.1,0.17	-0.78±0.87	-0.89(.37)	-2.5,0.93
<i>Participant characteristics</i>									
- Age (years)	-0.12±0.11	-1.05(.29)	-0.34,0.10	-0.64±0.35	-1.83(.07)	-1.3,0.05	-0.31±0.2	-1.5(.12)	-0.7,0.08
- Gender (females vs males)	0.51±0.98	0.52(.60)	-1.4,2.4	-0.55±1.6	-0.34(.74)	-3.8,2.7	ID	ID	ID
- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Maturation stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
<i>Exercise characteristics</i>									
- Length (weeks)	<b>0.13±0.06</b>	<b>2.2(.03)*</b>	<b>0.01,0.25</b>	0.03±0.11	0.29(0.77)	-0.19,0.26	0.07±0.07	1.0(.31)	-0.06,0.20
- Frequency (days/week)	0.20±0.28	0.73(.47)	-0.3,0.7	-1.4,0.96	-1.5(.14)	-3.3,0.5	-0.40±0.58	-0.70(.49)	-1.5,0.7
- Intensity (high vs moderate)	0.33±0.81	0.41(.68)	-1.3,1.9	ID	ID	ID	-1.3±2.0	-0.62(.53)	-5.3,2.7
- Duration (min/session)	-0.006±0.01	-0.47(.64)	-0.03,0.02	-0.06±0.04	-1.6(.12)	-0.14,0.02	0.03±0.02	1.06(.29)	-0.02,0.07
- Compliance (%)	-0.03±0.02	-1.7(.10)	-0.07,0.006	-0.05±0.05	-0.92(.36)	-0.16,0.06	0.03±0.04	0.91(.36)	-0.04,0.1
- Minutes per week (total) <sup>a</sup>	-0.002±0.004	-0.48(.63)	-0.01,0.006	NA	NA	NA	NA	NA	NA
- Minutes per week (adjusted total) <sup>a</sup>	-0.005±0.004	-1.1(.26)	-0.01,0.003	NA	NA	NA	NA	NA	NA

1										
2	- Sets <sup>b</sup>	NA	NA	NA	0.13±0.09	1.3(.18)	-0.06,0.31	NA	NA	NA
3										
4	- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
5										
6	- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
7										
8	- Number of exercises <sup>b</sup>	NA	NA	NA	0.03±0.97	0.03(.97)	-1.9,1.9	NA	NA	NA
9										
10	- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
11										
12	- Type of strength program <sup>b</sup> (c vs t)	NA	NA	NA	ID	ID	ID	NA	NA	NA
13										
14	- Type of strength equipment <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
15										
16	- Supervision (no vs yes)	1.5±1.2	1.3(.18)	-0.7,3.8	2.5±2.3	1.1(.27)	-1.9,7.0	ID	ID	ID
17										
18	- Location	1.5±1.1	1.4(.17)	-0.67,3.7	2.6±2.2	1.2(.24)	-1.7,6.9	ID	ID	ID
19										
20	<i>Outcome characteristics</i>									
21										
22	- Baseline percent fat	0.06±0.05	1.3(.21)	-0.03,0.16	0.03±0.08	.39(.69)	-0.13,0.19	0.12±0.07	1.7(.08)	-0.02,0.27
23										
24	- Assessment method (ref = DEXA)	NA	NA	NA	NA	NA	NA	NA	NA	NA
25										
26	-- MRI	-0.38±1.2	-0.31(.76)	-2.8,2.1	-1.5±1.5	-0.99(.32)	-4.4,1.4	0.42±1.7	0.24(.81)	-3.0,3.8
27										
28	-- BI	-1.2±0.73	-1.7(.09)	-2.7,0.2	ID	ID	ID	-0.22±1.5	-0.15(.88)	-3.1,2.6
29										
30	-- Skinfolds	0.65±1.1	0.61(.54)	-1.4,2.7	-1.1±1.7	-0.67(.51)	-4.4,2.2	1.2±1.9	0.62(.53)	-2.5,4.9
31										
32	-- Plethysmography	1.3±316.2	0.00(1.0)	-618,621	ID	ID	ID	-3.6±316	-0.01(.99)	-623,616

Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; BMI, body mass index; c vs t, circuit versus traditional; DEXA, dual-energy x-ray absorptiometry; MRI, magnet resonance imaging; BI, bioelectrical impedance; **boldface** items indicate statistically significant findings; \*, statistically significant (two-tailed p ≤ 0.05); total number of observations for statistically significant results for multivariate models were 50 for selective reporting, being physically inactive, funding, and length of training.

## Supplementary file 15. Changes in secondary outcomes.

Variable	Aerobic				Strength				Both			
	ES/P	$\beta_1$			ES/P	$\beta_1$			ES/P	$\beta_1$		
	(#)	( $\bar{X} \pm SE$ )	z(p)	95% CI	(#)	( $\bar{X} \pm SE$ )	z(p)	95% CI	(#)	( $\bar{X} \pm SE$ )	z(p)	95% CI
Body weight (kg)	35/1478	<b>-1.9±0.34</b>	<b>-5.4(&lt;0.001)*</b>	<b>-2.5,-1.2</b>	8/331	0.28±0.71	0.39(.70)	-1.1,1.7	13/510	<b>-1.4± 0.50</b>	<b>-2.8(0.004)*</b>	<b>-2.4,-0.4</b>
Fat-free mass (kg)	16/177	0.07±0.40	0.18(.86)	-0.72,0.86	7/305	0.82±0.62	1.3(.19)	-0.40,2.0	11/431	<b>1.3±0.46</b>	<b>2.8(0.006)*</b>	<b>0.4,2.2</b>
WC (cm)	19/973	<b>-1.9±0.62</b>	<b>-3.1(.002)*</b>	<b>-3.1,-0.7</b>	5/195	-0.34±1.1	-0.32(.75)	-2.5,1.8	4/223	-2.2±1.3	-1.7(.08)	-4.6,0.3
VO <sub>2max</sub> (ml·kg <sup>-1</sup> ·min <sup>-1</sup> )	22/1167	<b>3.1±0.50</b>	<b>6.1(&lt;0.001)*</b>	<b>2.1,4.1</b>	6/248	1.2±0.84	1.4(.15)	-0.45,2.9	8/366	<b>3.0±0.82</b>	<b>3.6(&lt;0.001)*</b>	<b>1.4,4.6</b>
SBP (mmHg)	12/489	<b>-4.4±1.5</b>	<b>-2.9(.004)*</b>	<b>-7.5,-1.4</b>	3/151	-2.9±2.6	-1.1(.26)	-8.1,2.2	5/255	-2.3±2.3	-0.97(.33)	-6.9,2.3
DBP (mmHg)	11/421	<b>-2.5±1.1</b>	<b>-2.2(.03)*</b>	<b>-4.6,-0.3</b>	3/151	-1.5±1.8	-0.84(.40)	-5.0,2.0	5/255	-2.3±1.6	-1.4(.16)	-5.5,0.9
TC (mg/dl)	14/463	<b>-5.3±2.5</b>	<b>-2.1(.03)*</b>	<b>-10.2, -0.4</b>	2/125	0.07±5.5	0.01(.99)	-10.8,10.9	7/326	-3.5±3.6	-0.96(.34)	-10.5,3.6
HDL (mg/dl)	17/602	<b>3.3±0.89</b>	<b>3.7(&lt;0.001)*</b>	<b>1.6,5.1</b>	2/125	0.82±2.2	0.38(.71)	-3.5,5.1	7/326	0.95±1.4	0.67(.50)	-1.8,3.7
LDL (mg/dl)	16/570	<b>-6.2±2.3</b>	<b>-2.7(.006)*</b>	<b>-10.7,1.8</b>	2/125	-1.2±5.4	-0.23(.82)	-11.8,9.3	7/326	-4.8±3.3	-1.4(.15)	-11.4,1.7
TG (mg/dl)	16/560	<b>-14.8±3.4</b>	<b>-4.3(&lt;0.001)*</b>	<b>-21.4,-8.1</b>	2/125	-8.4±9.4	-0.90(.37)	-26.9,10	7/326	<b>-11.1±4.9</b>	<b>-2.2(.02)*</b>	<b>-20.8,1.4</b>
Fasting glucose (mg/dl)	19/753	-1.9±1.0	-1.9(.06)	-3.9,.08	5/195	0.06±1.8	0.03(.97)	-3.4,3.6	7/346	<b>-4.8±1.7</b>	<b>-2.82(.005)*</b>	<b>-8.2,-1.5</b>
Fasting insulin (uU/ml )	17/725	<b>-2.9±0.6</b>	<b>-4.6(&lt;0.001)*</b>	<b>-4.3,-1.7</b>	4/167	<b>-3.2±1.4</b>	<b>-2.2(.03)*</b>	<b>-6.0,-0.3</b>	5/240	<b>-3.6±1.1</b>	<b>-3.2(.002)*</b>	<b>-5.8,-1.4</b>

Notes: #ES/P, number of effect sizes and number of participants (exercise plus control); ID, insufficient data available to conduct meta-analysis; \*, **boldface** items statistically significant; \*, statistically significant (two-tailed  $p \leq 0.05$ ).

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Supplementary file 16. Original published protocol for study. See below.

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## Protocol

# BMJ Open Exercise and adiposity in overweight and obese children and adolescents: protocol for a systematic review and network meta-analysis of randomised trials

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## ABSTRACT

**Introduction** Overweight and obesity is a worldwide public health problem among children and adolescents. However, the magnitude of effect, as well as hierarchy of exercise interventions (aerobic, strength training or both), on selected measures of adiposity is not well established despite numerous trials on this issue. The primary purposes of this study are to use the network meta-analytical approach to determine the effects and hierarchy of exercise interventions on selected measures of adiposity in overweight and obese children and adolescents.

**Methods and analysis** Randomised exercise intervention trials >4 weeks, available in any language up to 31 August 2017 and which include direct and/or indirect evidence, will be included. Studies will be located by searching seven electronic databases, cross-referencing and expert review. Dual selection and abstraction of data will occur. The primary outcomes will be changes in body mass index (in kg/m<sup>2</sup>), fat mass and percent body fat. Risk of bias will be assessed using the Cochrane Risk of Bias assessment instrument while confidence in the cumulative evidence will be assessed using the Grading of Recommendations Assessment, Development and Evaluation instrument for network meta-analysis. Network meta-analysis will be performed using multivariate random-effects meta-regression models. The surface under the cumulative ranking curve will be used to provide a hierarchy of exercise treatments (aerobic, strength or both).

**Ethics and dissemination** This study does not require ethics approval. Findings will be presented at a professional conference and published in a peer-reviewed journal.

**PROSPERO registration number** CRD42017073103.

## INTRODUCTION

### Rationale

Overweight and obesity in children and adolescents is a major public health problem worldwide. Between 1980 and 2013, the worldwide prevalence of overweight and obesity in children and adolescents increased by 6.9%, from 16.9% to 23.8%, in boys and by 6.4%, from 16.2% to 22.6%, in girls from

## Strengths and limitations of this study

- To the best of the investigative team's knowledge, this is the first systematic review to use the network meta-analytical approach to determine the effects as well as hierarchy of exercise interventions (aerobic, strength training or both) on body mass index in kg/m<sup>2</sup>, fat mass and percent body fat in overweight and obese children and adolescents.
- The results of this systematic review with network meta-analysis should be useful to practitioners and policy-makers for making informed decisions about exercise in the treatment of overweight and obesity in children and adolescents.
- The results of this systematic review with network meta-analysis should be useful to researchers with respect to the conduct and reporting of future research on this topic.
- Common to most meta-analyses, the results may yield significant heterogeneity which cannot be explained.
- Like any aggregate data meta-analysis, the possibility of ecological fallacy exists, that is, that group averages are not reflective of an individual's values.

developed countries.<sup>1</sup> For developing countries, increases of 4.8%, from 8.1% to 12.9% for boys and 5%, from 8.4% to 13.4% in girls, were reported.<sup>1</sup>

The negative outcomes associated with obesity in children and adolescents are both immediate and long term.<sup>2</sup> For immediacy, a population-based study of children and adolescents 5–17 years of age found that approximately 70% of obese youth had a minimum of one cardiovascular disease risk factor (high cholesterol, high blood pressure, etc).<sup>3</sup> Obese children and adolescents are also more likely to be diagnosed with prediabetes,<sup>4</sup> as well as being at an increased risk for bone and joint difficulties, sleep apnoea,

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and social and psychological issues such as stigmatisation, poor self-esteem and poorer health-related quality of life.<sup>5 6</sup> Long-term, childhood and adolescent overweight and obesity has been demonstrated to track into adulthood,<sup>7–11</sup> thus placing overweight and/or obese adults at a greater risk for cardiovascular disease, type 2 diabetes, stroke, several types of cancer and osteoarthritis.<sup>2</sup>

One promising intervention in the treatment of overweight and obesity is exercise. However, previous randomised trials that were limited to or included overweight and obese children and adolescents have led to conflicting results,<sup>12–58</sup> with some reporting statistically significant reductions in adiposity (body mass index (BMI)) as a primary outcome<sup>12 13 16 17 22 27 28 31 41 51–56 59–63</sup> and others reporting no change.<sup>14 15 18–21 23–26 29 30 32–40 42–50 57 58 62 64 65</sup> When limited to overweight and obese male and female children and adolescents,<sup>12 14 17–20 22–26 28 31 33 36 38–41 45–57</sup> only 18 (45.0%) have reported statistically significant reductions in BMI.<sup>12 17 22 28 31 41 50–58</sup> While this may lead one to the general conclusion that exercise does little to reduce BMI in overweight and obese children and adolescents, this would be short-sighted since it relies on the vote-counting approach,<sup>66</sup> an approach that has been shown to be less valid than the meta-analytical approach.<sup>66 67</sup>

Previous systematic reviews with meta-analyses that have focused on the effects of exercise as an independent intervention on BMI as a primary outcome in male and female children and adolescents have reported conflicting findings with five reporting a significant improvement in BMI<sup>68–72</sup> and five others reporting no statistically significant improvement.<sup>73–77</sup> However, 9 of the 10 suffer from one or more of the following limitations: (1) inclusion of a small number of studies with exercise as the only intervention,<sup>71 73–75</sup> (2) inclusion of non-randomised trials,<sup>68 74</sup> (3) inclusion of children and adolescents who were not overweight or obese.<sup>70 72 74 76 77</sup> Relevant to this study, all 10 suffer from reliance on pairwise versus network meta-analyses, the latter of which incorporates both direct and indirect evidence. In addition, there was an absence of an established hierarchy for determining which types of exercise (aerobic, strength training or both) might be best for improving BMI based on both direct and indirect evidence.<sup>68–77</sup> To partially address this issue as well as demonstrate feasibility, the investigative team has recently used the network meta-analytical approach to examine the effects of exercise (aerobic, strength training or both) on BMI z-score in overweight and obese children and adolescents.<sup>78 79</sup> Statistically significant reductions in BMI z-score were found for aerobic exercise and combined aerobic and strength exercise, but not strength training alone (mean, 95% CI, aerobic, –0.10, –0.15 to –0.05; aerobic and strength, –0.11, –0.19 to –0.03; strength, 0.04, –0.07 to 0.15).<sup>79</sup> Combined aerobic and strength training was ranked best, followed by aerobic exercise and then strength training.<sup>79</sup> Consistency in evidence and risk of bias did not differ between direct and indirect studies.<sup>79</sup> It was concluded that combined aerobic exercise

and strength training as well as aerobic exercise alone are associated with reductions in BMI z-score.<sup>79</sup> The lack of effect on BMI z-score in the strength training studies may have been the result of increases in lean muscle mass. However, since BMI in kg/m<sup>2</sup> continues to be the most frequently assessed and reported measure of adiposity in both the clinical and public health setting, such an examination using the network meta-analytical approach is needed. In addition, since all types of BMI measures as well as body weight do not capture changes in body composition (fat mass, percent body fat, etc), the inclusion of such outcomes, as previously suggested,<sup>79</sup> is also necessary.

**Objectives**

The primary objectives of the current study are to conduct a systematic review with network meta-analysis of randomised trials to (1) determine the effects of exercise (aerobic, strength training or both) on adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents, and (2) establish a hierarchy of exercise interventions (aerobic, strength training or both) for treating adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents.

**METHODS**

**Overview**

This study will follow the guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension statement for network meta-analyses of healthcare interventions.<sup>80</sup>

**Eligibility criteria**

The inclusion criteria for this proposed network meta-analysis will be as follows: (1) direct evidence from randomised trials that compare two or more exercise interventions (aerobic, strength training, both) or indirect evidence from randomised controlled trials that compare an exercise intervention group to a comparative control group (non-intervention, attention control, usual care, wait-list control, placebo), (2) exercise-only intervention (aerobic, strength training or both), (3) studies lasting ≥4 weeks, (4) male and/or female children and adolescents 2–18 years of age, (5) participants overweight or obese, as defined by the authors, (6) studies published in any language up to 31 August 2017, (7) data available for BMI in kg/m<sup>2</sup>, fat mass or percent body fat.

Studies will be limited to randomised trials because it is the only way to control for confounders that are not known or measured as well as the observation that non-randomised controlled trials tend to overestimate the effects of healthcare interventions.<sup>81 82</sup> Indirect evidence studies will be limited to randomised controlled trials with at least one exercise arm that participates in either aerobic, strength training, or a combination of aerobic and strength training exercise. Direct evidence



studies will be limited to randomised trials that include at least two of the following exercise arms: (1) aerobic, (2) strength training, (3) aerobic and strength training exercise.

For the purposes of this study, exercise, aerobic exercise and strength training will be defined according to the 2008 Physical Activity Guidelines for Americans,<sup>83</sup> that is, movement which is 'planned, structured, and repetitive and purposive in the sense that the improvement or maintenance of one or more components of physical fitness is the objective',<sup>83 84</sup> aerobic exercise as 'exercise that primarily uses the aerobic energy-producing systems, can improve the capacity and efficiency of these systems, and is effective for improving cardiorespiratory endurance',<sup>83</sup> and strength training as 'exercise training primarily designed to increase skeletal muscle strength, power, endurance, and mass'.<sup>83</sup> Four weeks was chosen as the lower cut point for intervention length based on previous research demonstrating improvements in adiposity over this period of time in 11-year-olds.<sup>21</sup>

Participants will be limited to overweight and obese children and adolescents, as defined by the original study authors, because it has been shown that this population is at an increased risk for premature morbidity and mortality throughout their lifetime.<sup>85</sup>

While some research has suggested that studies yielding statistically significant and positive results are more likely to be published in English-language versus non-English-language journals,<sup>86</sup> other research has shown this to not be the case.<sup>87</sup> Given the former, studies from both English-language and non-English-language articles will be included with the latter translated into English by the second author using the freely available web-based Babelfish and Bing translators. For those studies that cannot be translated using Babelfish and/or Bing, professional translation services will be used.

BMI in kg/m<sup>2</sup> was included as one of the three primary adiposity outcomes because it is the most commonly used and understood variable by practitioners as well as others and can be easily measured from body weight and height. However, because BMI is an indirect measure of adiposity, fat mass and percent body fat will be included because they are more direct measures of adiposity. The inclusion of fat mass and percent body fat may be especially relevant for studies that include strength training given that decreases in adiposity as measured by BMI may be offset by increases in muscle mass, a secondary outcome that will be included.

### Information sources

The following seven electronic databases will be searched: (1) PubMed, (2) Web of Science, (3) Cochrane Central Register of Controlled Trials, (4) Cumulative Index to Nursing and Allied Health Literature, (5) Sport Discus, (6) Translating Research into Practice and (7) ProQuest Dissertations and Theses. In addition to electronic database searches, cross-referencing will be conducted by examining the reference lists of previous review articles as

well as each included study for potential articles that meet the inclusion criteria. On completion of initial searches, the third author will examine the reference list for thoroughness and completeness. Suggested studies will then be retrieved to see if they meet all inclusion criteria.

### Search strategy

Search strategies specific to each database will be developed by the investigative team. Major keywords, or forms of keywords to include will be 'random', 'children', 'adolescents', 'overweight', 'obese', 'exercise', 'physical fitness', 'body composition', 'fat mass', 'body fat', 'body composition', 'body mass index', 'adiposity'. A copy of a preliminary search strategy using PubMed, including limits, can be found in the online supplementary file. This search strategy will be adapted for other database searches. All database searches and article retrieval will be conducted by the second author with oversight from the first author.

### Study records

#### Study selection

All studies to be screened will be imported into EndNote (V.X8; Thomson-Reuters; 2016, New York, USA) and duplicates removed electronically and then manually by the second author. A copy of the database will then be provided to the first author for duplicate screening. To minimise selection bias, the first and second authors will select all studies, independent of each other. They will then review their selections for accuracy and consistency. The full report for each article will be retrieved for all titles and abstracts that appear to meet the inclusion criteria as well as those where uncertainty exists. Multiple reports for the same study will be addressed by including the most recently published article and drawing from prior reports, assuming the same methods and sample sizes are reported. Based on previous research suggesting neither a clinically nor statistically significant effect on results, blinding to journal titles, study authors or institutions of the authors will not be employed during the screening and data abstraction processes.<sup>88</sup> Reasons for excluded studies will be recorded using the following categories: (1) inappropriate population, (2) inappropriate intervention, (3) inappropriate comparison(s), (4) inappropriate outcome(s), (5) inappropriate study design, (6) other. On the conclusion of screening, the first and second authors will meet and review their selections. Cohen's  $\kappa$  statistic will be used to measure inter-selection agreement.<sup>89</sup> Any discrepancies will be resolved by consensus. If consensus cannot be reached, the third author will serve as an arbitrator. After selecting the final number of studies to include, the overall precision of the searches will be computed by dividing the number of included studies by the total number of studies screened after removing duplicates.<sup>90</sup> The number needed-to-read (NNR) will then be calculated as the reciprocal of the precision.<sup>90</sup> A flow diagram that describes the search procedure will be included as well as supplementary file

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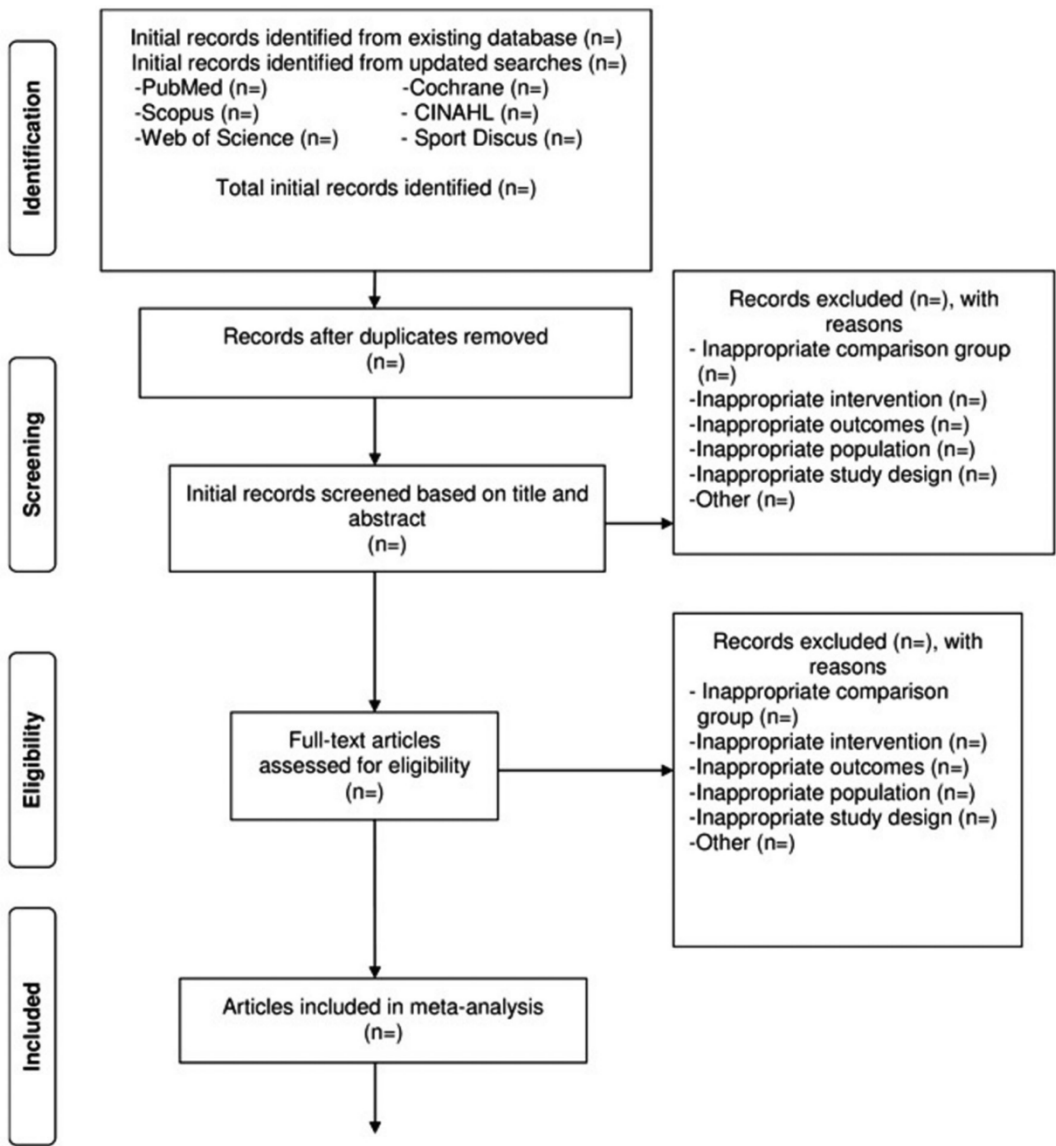


Figure 1 Proposed flow diagram to depict the search process.

a reference list of all excluded studies, including the reason(s) for exclusion. Figure 1 illustrates the proposed structure for the flow diagram.

Data abstraction

For this project, Microsoft Excel (V.2016; Microsoft Corporation, Redmond, Washington, USA) will be used to develop comprehensive electronic codebooks that will define the coding process for each of the variables coded. The codebook will be created by the first two authors with feedback from the third author. Consequently, the abstraction of data from the studies in this proposed project should require little subjective judgement on the part of the coder. The major groups of variables to code will include (1) study characteristics (author, journal, year of publication, etc), (2) participant characteristics (age, gender, height, body weight, etc) and (3) data for

primary and secondary outcomes (sample sizes, baseline and postexercise means and SD, etc). Table 1 contains a preliminary list of variables that will be coded. Based on previous research by the investigative team,<sup>79</sup> a codebook capable of including at least 242 items from each study is expected. To avoid data abstraction bias, the first two authors will independently code (dual-coding) all studies to ensure accuracy and consistency. Inter-rater agreement will be assessed using Cohen's  $\kappa$ .<sup>89</sup> Any disagreement in the items coded will be discussed until mutual agreement is reached. If agreement cannot be reached, the third author will serve as an arbitrator.

Outcomes and prioritisation

The primary outcomes in this study will be changes in BMI in  $\text{kg}/\text{m}^2$ , fat mass, and percent body fat in overweight and obese children and adolescents. Secondary



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**Table 1** Covariates to examine using simple meta-regression

Characteristics	Variable
Study	Publication year, impact factor of journal, country study conducted, type of control group, bias (sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting), type of analysis
Participant	Age, gender, race/ethnicity, maturational stage
Exercise	Type (aerobic, strength, both), length, frequency, intensity, duration, total minutes, total minutes (adjusted for compliance), mode, compliance, exercise supervision, setting, number of sets, number of repetitions, rest between sets, number of exercises, type of resistance, equipment used, fidelity (design, training, delivery, receipt, enactment)
Outcome	Baseline values for primary outcomes (BMI in kg/m <sup>2</sup> , fat mass, percent fat), method used to assess adiposity, that is, instrumentation, body weight, lean body mass, waist circumference, waist-to-hip ratio, diet, energy intake, energy expenditure, physical activity level, non-exercise activity, maximum oxygen consumption (relative and absolute), muscular strength, resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin

BMI, body mass index.

outcomes will include body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, maximum oxygen consumption (relative and absolute), muscular strength, resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high-density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin.

### Risk of bias assessment in individual studies

Risk of bias for included studies will be assessed using the Cochrane Risk of Bias Instrument.<sup>91</sup> Assessment is based on judgements of low, high or unclear risk of bias across six defined domains: (1) sequence generation, (2) allocation sequence concealment, (3) blinding of participants and personnel, (4) blinding of outcome assessors, (5) incomplete outcome data and (6) selective outcome reporting. A seventh domain, whether participants were exercising regularly, as defined by the original study authors, will also be assessed using the same approach as for the other six domains. As previously recommended, study-level results will be reported for each domain according to risk of bias (low, high or unclear) while the percentage of low, high or unclear results across each domain will also be reported.<sup>91</sup> This risk of bias approach has been recommended over the use of study quality rating scales given the lack of empirical evidence to support the latter.<sup>82 92 93</sup> Assessment for risk of bias will be limited to the primary outcomes of interest, that is, changes in BMI in kg/m<sup>2</sup>, fat mass and percent body fat. All studies will be classified as high risk of bias with respect to the category 'blinding of participants and personnel' given that it's virtually impossible to blind participants to group assignment in exercise intervention protocols. Based on previous research, no study will be excluded based on risk of bias results.<sup>94</sup>

### Data synthesis

#### Calculation of effect sizes

The primary outcomes for this study will be changes in BMI in kg/m<sup>2</sup>, fat mass (kg), and percent body fat using the original metric. Changes for indirect comparisons will be calculated by subtracting the change outcome difference in the exercise group minus the change outcome difference in the control group. Variances will be computed using the pooled SDs of change scores in the exercise and control groups. If change score SDs are not available, they will be calculated from 95% CIs for either change outcome or treatment effect differences as well as pre-SD and post-SD values, the latter according to procedures developed by Follmann *et al.*<sup>95</sup> For direct comparisons, that is, randomised trials with no control group, the same general procedures will be followed except that the control group data will be replaced with one of the exercise interventions as follows: (1) aerobic minus strength training, (2) aerobic and strength training combined minus aerobic training, (3) aerobic and strength training combined minus strength training. Ninety-five percent CI and  $z$ - $\alpha$  values will be calculated for each outcome from each study. For those studies that include both direct and indirect comparisons, only direct comparison data will be included since a primary purpose of the current meta-analysis is determining which exercise interventions(s) might work best for improving adiposity in children and adolescents. For studies in which adiposity outcomes are assessed at multiple intervention time points, for example, 0 weeks, 8 weeks and 16 weeks, only data from the initial and last assessment will be used. If follow-up data are available, results from such studies will also be analysed separately to determine the sustainability of changes in adiposity. If any cross-over trials are included, treatment effects will be calculated by using all assessments from the intervention and control periods and analysing them similar to a parallel group

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trial.<sup>96</sup> While the possibility of a unit-of-analysis error exists as well as studies being underweighted versus over-weighted, this method is believed to be better than alternative approaches, for example, limiting data from the first assessment point or trying to impute SDs, especially given the primary and secondary outcomes included and expected distribution of findings.<sup>96</sup>

Secondary outcomes (body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, maximum oxygen consumption (relative and absolute), resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high-density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin) will be handled using the same approach as for primary outcomes. However, given the different metrics expected and the inability to convert between them, changes in physical activity levels and muscular strength will be calculated using the standardised mean difference effect size, adjusted for small sample sizes.<sup>97</sup>

Pooled estimates for changes in outcomes

*Network (geometry) plots* for each outcome will be used to provide a visual representation of the evidence base with nodes (circles) weighted by the number of participants randomised to each treatment and edges (lines) weighted by the number of studies evaluating each pair of treatments.<sup>98 99</sup> *Contribution plots* for each outcome will be used to determine the most dominant comparisons for each network estimate as well as for the entire network.<sup>98</sup> The weights applied will be a function of the variance of the direct treatment effect and the network structure, the result being a percent contribution of each direct comparison to each network estimate.<sup>98</sup>

Network meta-analysis will be performed using *multivariate random-effects meta-regression models* that can be performed within a frequentist setting, allows for the inclusion of potential covariates, and correctly accounts for the correlations from multiarm trials.<sup>100 101</sup> A two-tailed  $\alpha$  value  $\leq 0.05$  and non-overlapping 95% CI will be considered to represent statistically significant changes. Separate network meta-analysis models will be used to examine for changes in each primary and secondary outcome. Potential *covariates* will be examined by (1) conducting simple meta-regression for statistically significant associations between covariates and changes in primary outcomes (BMI in  $\text{kg}/\text{m}^2$ , fat mass, percent fat), (2) examining for multicollinearity between covariates ( $r > 0.80$ ) and (3) building a multiple meta-regression model. A list of potential covariates to examine using simple meta-regression is shown in [table 1](#). While we will include all methods used to assess adiposity, we will also conduct sensitivity analyses to see if results differ according to method of assessment, for example, fat mass assessed using whole body MRI versus bioelectrical impedance. Secondary outcomes (energy intake and expenditure,

physical activity level, muscular strength) will be handled using the same approach. *Transitivity*, that is, similarity in the distribution of potential effect modifiers across the different pairwise comparisons for each outcome<sup>102</sup> will include those listed in [table 1](#). *Inconsistency*, that is differences in effect estimates between direct and indirect results for the same comparison,<sup>103</sup> will be checked by assessing differences in treatment effects between direct and indirect effect estimates as well as differences between trials with different designs, for example, two-arm versus multiarm trials.<sup>101 103 104</sup> However, the probability of inconsistency is considered small given recent research demonstrating that inconsistency was detected in only 2%–14% of tested loops, depending on the effect measure and heterogeneity estimation method.<sup>105 106</sup> Finally, *prediction intervals* will be used to enhance interpretation of results with respect to the magnitude of heterogeneity as well as provide an estimate of expected results in a future study.<sup>107–109</sup> For network meta-analysis, degrees of freedom (*df*) will be set to the number of studies–the number of comparisons–1.<sup>109</sup>

Meta-biases

*Small-study effects* (publication bias, etc) will be assessed using comparison-adjusted funnel plots.<sup>98</sup> In the absence of small-study effects, the comparison-adjusted funnel plot should be symmetrical around the zero line.

Confidence in cumulative evidence

*Quality analysis* of specific pairwise effect estimates in the network meta-analysis will be evaluated using a recently developed modification of the Grading of Recommendations Assessment, Development and Evaluation for network meta-analysis across five domains: (1) study limitations, (2) indirectness, (3) inconsistency, (4) imprecision and (5) small-study effects.<sup>110</sup> Assessment will be conducted using the same procedures as for study selection and data abstraction.

To establish a hierarchy of exercise interventions for selected outcomes in the current meta-analysis, *ranking analysis*, that is, the ability to rank all interventions for a single outcome under study, for example changes in BMI in  $\text{kg}/\text{m}^2$ , will be used based on probabilities. However, because the ranking of treatments based exclusively on the probability of each treatment being the best should be avoided given that it does not account for the uncertainty in the relative treatment effects and the possibility for assigning higher ranks for treatments in which little evidence is available, separate *rankograms* and *cumulative ranking probability plots* will be used to present ranking probabilities along with their uncertainty for changes in primary and secondary outcomes.<sup>98 111</sup> The surface under the cumulative ranking curve (SUCRA), a transformation of the mean rank, will be used to establish a hierarchy of exercise interventions (aerobic, strength, both) while accounting for the location and variance of all treatment effects.<sup>98 111</sup> Larger SUCRA values indicate better ranks for the treatment.<sup>98 111</sup> Interpretation of all rankings will



be approached from the perspective of absolute and relative treatment effects.<sup>99</sup>

### Software used for statistical analysis

All data will be analysed using Stata (V.14.1; Stata/SE for Windows, Stata Corporation, College Station, Texas, USA), Microsoft Excel (V.2016; Microsoft Corporation, Redmond, Washington, USA), and two add-ins for Excel, SSC-Stat (V.2.18; SSC-Stat, V.3.0.; Statistical Services Center; 2007; University of Reading, UK) and EZAnalyze (V.3.0; TA Poynton; 2007).

### Amendments to protocol

None to date. If this protocol is amended, the date of each amendment, a description of the change, as well as a rationale for the change, will be provided.

**Contributors** GAK is the guarantor. GAK, KSK and RRP drafted the manuscript. All authors contributed to the development of the data sources to search for relevant literature, including search strategy, selection criteria, data extraction criteria and risk of bias assessment strategy. GAK provided statistical expertise while RRP provided content expertise on exercise and adiposity in overweight and obese children and adolescents. All authors read, provided feedback and approved the final manuscript.

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PRISMA Network Meta-Analysis (NMA) Checklist			
Exercise and Adiposity in Overweight and Obese Children and Adolescents: A Systematic Review with Network Meta-Analysis of Randomised Trials			
Section/Topic	Item #	Checklist Item	Reported on Line # or page #
TITLE			
Title	1	Identify the report as a systematic review incorporating a network meta-analysis (or related form of meta-analysis).	1 and 2
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: <b>Background:</b> main objectives <b>Methods:</b> data sources; study eligibility criteria, participants, and interventions; study appraisal; and <i>synthesis methods, such as network meta-analysis</i> . <b>Results:</b> number of studies and participants identified; summary estimates with corresponding confidence/credible intervals; <i>treatment rankings may also be discussed. Authors may choose to summarize pairwise comparisons against a chosen treatment included in their analyses for brevity.</i> <b>Discussion/Conclusions:</b> limitations; conclusions and implications of findings. <b>Other:</b> primary source of funding; systematic review registration number with registry name.	21-48
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known, <i>including mention of why a network meta-analysis has been conducted.</i>	62-132
Objectives	4	Provide an explicit statement of questions being addressed, with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	133-143
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists and if and where it can be accessed (e.g., Web address); and, if available, provide registration information, including registration number.	146-152
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale. <i>Clearly describe eligible treatments included in</i>	156-169

		<i>the treatment network, and note whether any have been clustered or merged into the same node (with justification).</i>	
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	<b>170-1785</b>
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	<b>179-184, Supplementary file 1</b>
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	<b>186-198</b>
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	<b>200-202, 207-212</b>
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	<b>202-207, 213-227</b>
<b>Geometry of the network</b>	<b>S1</b>	Describe methods used to explore the geometry of the treatment network under study and potential biases related to it. This should include how the evidence base has been graphically summarized for presentation, and what characteristics were compiled and used to describe the evidence base to readers.	<b>258-261</b>
Risk of bias within individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	<b>228-240</b>
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means). <i>Also describe the use of additional summary measures assessed, such as treatment rankings and surface under the cumulative ranking curve (SUCRA) values, as well as modified approaches used to present summary findings from meta-analyses.</i>	<b>242-256, 292-297</b>
Planned methods of analysis	14	Describe the methods of handling data and combining results of studies for each network meta-analysis. This should include, but not be limited to: <ul style="list-style-type: none"> <li>• <i>Handling of multi-arm trials;</i></li> <li>• <i>Selection of variance structure;</i></li> <li>• <i>Selection of prior distributions in Bayesian analyses; and</i></li> <li>• <i>Assessment of model fit.</i></li> </ul>	<b>274-280</b>
<b>Assessment of Inconsistency</b>	<b>S2</b>	Describe the statistical methods used to evaluate the agreement of direct and indirect evidence in the treatment network(s) studied. Describe efforts taken to address its presence when found.	<b>262-273, 280-282</b>

1	Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	282-285
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4	Additional analyses	16	Describe methods of additional analyses if done, indicating which were pre-specified. This may include, but not be limited to, the following: <ul style="list-style-type: none"><li>• Sensitivity or subgroup analyses;</li><li>• Meta-regression analyses;</li><li>• <i>Alternative formulations of the treatment network; and</i></li><li>• <i>Use of alternative prior distributions for Bayesian analyses (if applicable).</i></li></ul>	286-291, <i>Supplementary file 2</i>
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19	<b>RESULTS†</b>			
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21	Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	315-325, <i>Figure 1, Supplementary file 3</i>
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26	<b>Presentation of network structure</b>	<b>S3</b>	Provide a network graph of the included studies to enable visualization of the geometry of the treatment network.	<i>Figures 3,5,7</i>
27				
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29	<b>Summary of network geometry</b>	<b>S4</b>	Provide a brief overview of characteristics of the treatment network. This may include commentary on the abundance of trials and randomized patients for the different interventions and pairwise comparisons in the network, gaps of evidence in the treatment network, and potential biases reflected by the network structure.	448-457, 489-503, 530-548
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36	Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	326-426, <i>Tables 1 and 2, Supplementary file 4</i>
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39	Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment.	<i>Supplementary file 5</i>
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42	Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: 1) simple summary data for each intervention group, and 2) effect estimates and confidence intervals. <i>Modified approaches may be needed to deal with information from larger networks.</i>	<i>Supplementary files 6, 9, and 12</i>
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48	Synthesis of results	21	Present results of each meta-analysis done, including confidence/credible intervals. <i>In larger networks, authors may focus on comparisons versus a particular comparator (e.g. placebo or standard care), with full findings presented in an appendix. League tables and forest plots may be considered to summarize pairwise comparisons. If additional summary measures were explored</i>	<i>Pages 458-474, 504-519, 549-566 Figures 4, 6, 8, Table 3, Supplementary file 15</i>
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		(such as treatment rankings), these should also be presented.	
<b>Exploration for inconsistency</b>	<b>S5</b>	Describe results from investigations of inconsistency. This may include such information as measures of model fit to compare consistency and inconsistency models, <i>P</i> values from statistical tests, or summary of inconsistency estimates from different parts of the treatment network.	<b>Pages 467-468, 513-514, 559-560, 584-585, 594-595, 611-612, 620-621, 628-629, 644-645, 652-653, 661-662, 670-671, 681-682</b> <b>Supplementary files 6, 9, and 12</b>
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies for the evidence base being studied.	<b>Pages 427-438, Figure 2, Supplementary files 7, 10, 13</b>
Results of additional analyses	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression analyses, <i>alternative network geometries studied, alternative choice of prior distributions for Bayesian analyses, and so forth</i> ).	<b>Pages 475-481, 520-529, 567-576</b> <b>Supplementary files 8, 11, and 14</b>
<b>DISCUSSION</b>			
Summary of evidence	24	Summarize the main findings, including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy-makers).	<b>Lines 687-871</b>
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review level (e.g., incomplete retrieval of identified research, reporting bias). <i>Comment on the validity of the assumptions, such as transitivity and consistency. Comment on any concerns regarding network geometry (e.g., avoidance of certain comparisons).</i>	<b>Lines 872-894</b>
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	<b>Lines 895-898</b>
<b>FUNDING</b>			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review. This should also include information regarding whether funding has been received from manufacturers of treatments in the network and/or whether some of the authors are content experts with professional conflicts of interest that could affect use of treatments in the network.	<b>Lines 910-914</b>

PICOS = population, intervention, comparators, outcomes, study design.

\* Text in italics indicates wording specific to reporting of network meta-analyses that has been added to guidance from the PRISMA statement.† Authors may wish to plan for use of appendices to present all relevant information in full detail for items in this section.

# BMJ Open

## Exercise and Adiposity in Overweight and Obese Children and Adolescents: A Systematic Review with Network Meta-Analysis of Randomised Trials

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Exercise and Adiposity in Overweight and Obese Children and Adolescents: A  
Systematic Review with Network Meta-Analysis of Randomised Trials

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Abstract = 300 words  
Text = 10,559 words  
Tables = 3  
Figures = 8  
Supplementary files = 17

## ABSTRACT

**Objectives:** Determine both the effects and hierarchy of effectiveness for exercise interventions (aerobic, strength training or both) on selected measures of adiposity (BMI in kg·m<sup>2</sup>, fat mass, and percent body fat) in overweight and obese children and adolescents.

**Design:** Network meta-analysis of randomised exercise intervention trials.

**Setting:** Any setting where a randomised trial could be conducted.

**Participants:** Overweight and obese male and/or female children and adolescents 2 to 18 years of age.

**Interventions:** Randomised exercise intervention trials  $\geq 4$  weeks, published between January 1, 1973 to August 22, 2018, and which included direct and/or indirect evidence for aerobic, strength training, or combined aerobic and strength training.

**Primary outcomes:** Changes in BMI in kg/m<sup>2</sup>, fat mass and percent body fat.

**Results:** Fifty-seven studies representing 127 groups (73 exercise, 54 control) and 2,792 participants (1,667 exercise, 1,125 control) met the criteria for inclusion. Length of training ( $\bar{X} \pm SD$ ) averaged  $14.1 \pm 6.2$  weeks, frequency,  $3.3 \pm 1.1$  days per week, and duration  $42.0 \pm 21.0$  minutes per session. Significant and clinically important reductions in BMI, fat mass, and percent body fat were observed in aerobic vs. control comparisons (BMI, mean, 95% CI, -1.0, -1.4 to -0.6; fat mass, -2.1, -3.3 to -1.0 kg; percent fat, -1.5, -2.2 to -0.9%) and combined aerobic and strength vs. control comparisons (BMI, -0.7, -1.4 to -0.1; fat mass, -2.5, -4.1 to -1.0 kg; percent fat, -2.2, -3.2 to -1.2%). A significant reduction in percent fat was also found for strength vs. control comparisons (-1.3, -2.5 to -0.1%). Combined aerobic and strength training was ranked



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first for improving both fat mass (kg) and percent body fat while aerobic exercise was ranked first for improving BMI.

**Conclusions:** Aerobic and combined aerobic and strength training are associated with improvements in adiposity outcomes in overweight and obese children and adolescents.

**Trial registration number:** PROSPERO # CRD42017073103

**Strengths and limitations of this study**

- **Major Strengths**
  - To the best of the authors' knowledge, this is the first network meta-analysis to examine the effects of exercise on adiposity outcomes in overweight and obese children and adolescents.
  - This study included methods to determine the clinical relevance of the reported outcomes.
- **Potential Limitations**
  - Since this was an aggregate data meta-analysis, the potential for ecological fallacy exists.
  - Meta-regression results should be considered exploratory and thus, do not support causal inferences.

**Keywords:** exercise, overweight, obesity, children, adolescents, network meta-analysis

## 62 BACKGROUND

63 Overweight and obesity among children and adolescents is a major public health  
64 problem worldwide. Between 1980 and 2013, the worldwide prevalence of overweight  
65 and obesity in children and adolescents increased by 6.9%, from 16.9% to 23.8%, in  
66 boys and by 6.4%, from 16.2% to 22.6%, in girls from developed countries.[1] For  
67 developing countries, increases of 4.8%, from 8.1% to 12.9% for boys and 5%, from  
68 8.4% to 13.4% in girls, were reported.[1] In terms of absolute values, 41 million children  
69 under the age of 5 and more than 340 million children and adolescents aged 5-19 were  
70 considered to be overweight or obese in 2016.[2]

71 The deleterious consequences associated with obesity in children and adolescents are  
72 both immediate and long-term.[3] For example, a study of children and adolescents 5 to  
73 17 years of age found that approximately 70% of obese youth had at least one  
74 cardiovascular disease risk factor (high cholesterol, high blood pressure, etc.).[4]  
75 Obese children and adolescents are also at an increased risk for prediabetes,[5] as well  
76 as more prone to bone and joint problems, sleep apnea, and social and psychological  
77 issues that include stigmatization, low self-esteem, and low health-related quality-of-life.  
78 [6, 7] Long-term, childhood and adolescent overweight and obesity has been shown to  
79 track into adulthood,[8-12] thus placing overweight and/or obese adults at a greater risk  
80 for cardiovascular disease, type 2 diabetes, stroke, several types of cancer, and  
81 osteoarthritis.[3]

82 One approach to treating overweight and obesity is exercise. However, previous  
83 randomised trials limited to overweight and obese male and female children and  
84 adolescents have reached conflicting results with respect to exercise-induced changes

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85 in adiposity.[13-69] For body mass index (BMI in kg·m<sup>2</sup>), fat mass, and percent body fat,  
86 statistically significant decreases were reported for 45.2%, 50.0%, and 40.0% of  
87 findings, respectively, as a result of exercise (aerobic, strength training, or both).[13-69]  
88 When limited to studies that included aerobic exercise as an intervention,[13, 15-17, 19,  
89 21, 22, 24, 25, 29, 30, 32-34, 36, 38-46, 48, 50-53, 55, 57-64, 66, 67, 69] statistically  
90 significant decreases in BMI in kg·m<sup>2</sup>, fat mass, and percent body fat, were reported for  
91 43.2%, 66.7%, and 75.0% of findings. For strength training interventions,[14, 21, 28, 35,  
92 39, 40, 47, 53, 54, 56, 57] statistically significant decreases were reported for 9.1% (BMI  
93 in kg·m<sup>2</sup>), 25.0% (fat mass) and 63.6% (percent fat) of findings. Finally, when restricted  
94 to combined aerobic and strength training,[13, 18-21, 23, 26, 27, 31, 37, 45, 49, 51, 57,  
95 64, 67, 69] statistically significant decreases were reported for 78.6% (BMI in kg·m<sup>2</sup>),  
96 44.4% (fat mass) and 69.2% (percent fat) of results. While this may lead one to question  
97 the benefits of exercise for improving adiposity in overweight and obese children and  
98 adolescents, this would be shortsighted since it relies on the vote-counting approach,  
99 [70] an approach that has been shown to be less valid than the meta-analytic approach.  
100 [70, 71] To address these discrepancies in findings, several previous systematic  
101 reviews with aggregate data meta-analyses limited to randomised trials focused on the  
102 effects of exercise (aerobic, strength, or both) as an independent intervention on one or  
103 more measures of adiposity as primary outcomes (BMI in kg·m<sup>2</sup>, fat mass, percent fat)  
104 in overweight and obese children and adolescents have been conducted.[72-76] Across  
105 all intervention types, two [74, 76] of four [72, 74-76] reported statistically significant  
106 reductions in BMI in kg·m<sup>2</sup>, one of one reported a statistically significant reduction in fat  
107 mass,[75] and one [72] of two [72, 76] a statistically significant reduction in percent fat.

Another meta-analysis focused on combined aerobic and resistance training reported statistically significant reductions in BMI in  $\text{kg}\cdot\text{m}^2$ , fat mass, and percent fat.[73] A lack of meta-analytic data was available on the effects of aerobic and resistance training alone on BMI in  $\text{kg}\cdot\text{m}^2$  as well as fat mass and percent fat.[72-76] In addition, randomised trials without a control group, i.e., direct evidence studies that assessed the effects of exercise on adiposity outcomes, were absent.[72-76] Furthermore, there was an absence of an established hierarchy for determining which types of exercise (aerobic, strength training, or both) might be best for improving adiposity outcomes based on both direct and indirect evidence.[72-76] Network meta-analysis is an approach that includes both direct and indirect evidence as well as allowing for the ranking of treatments. To demonstrate the feasibility of this approach, the authors recently used the network meta-analytic approach to examine the effects of exercise (aerobic, strength training, or both) on BMI z-score in overweight and obese children and adolescents.[77, 78] Statistically significant reductions in BMI z-score were found for aerobic exercise and combined aerobic and strength exercise, but not strength training alone (mean, 95% CI: aerobic, -0.10, -0.15 to -0.05; aerobic and strength, -0.11, -0.19 to -0.03; strength, 0.04, -0.07 to 0.15).[78] Combined aerobic and strength training was ranked best, followed by aerobic exercise and then strength training.[78] It was concluded that combined aerobic exercise and strength training as well as aerobic exercise alone are associated with reductions in BMI z-score.[78] While these results are encouraging, BMI in  $\text{kg}/\text{m}^2$  continues to be the most frequently assessed and reported measure of adiposity across all ages in both the clinical and public health setting. Thus, an examination of such using the network meta-analytic approach is needed. In addition, since all types of BMI



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measures as well as body weight do not capture changes in body composition (fat mass, percent body fat, etc.), the inclusion of such outcomes, as previously suggested, [78] is also necessary. Thus, given (1) the prevalence of overweight and obesity in children and adolescents, (2) the negative consequences associated with such, (3) the conflicting findings of previous randomised trials addressing the effects of exercise on adiposity outcomes in overweight and obese children and adolescents, and (4) the strengths of network meta-analysis, the two primary objectives of the current study were to conduct a systematic review with network meta-analysis of randomised trials to (1) determine the effects of exercise (aerobic, strength training, or both) on adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents, and (2) establish a hierarchy of exercise interventions (aerobic, strength training, or both) for treating adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents.

**METHODS**

**Overview**

This study followed the guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) extension statement for network meta-analyses of health care interventions.[79] The protocol for this network meta-analysis is registered in PROSPERO (trial registration number CRD42017073103) and has been published in BMJ Open.[80] We provide a brief description of the Methods used and include a description of any deviations from the original protocol, [80] including reasons. Detailed information regarding the Methods can be found in the originally published protocol.[80]

## 154 **Patient and Public Involvement**

155 No patient involved.

## 156 **Eligibility criteria**

157 The inclusion criteria for this proposed network meta-analysis were as follows: (1)  
158 direct evidence from randomised trials that compared two or more exercise  
159 interventions (aerobic, strength training, both) or indirect evidence from randomised  
160 controlled trials that compared an exercise intervention group to a comparative control  
161 group (non-intervention, attention control, usual care, wait-list control, placebo, etc.), (2)  
162 exercise-only intervention (aerobic, strength training, or both), (3) studies lasting  $\geq 4$   
163 weeks, (4) male and/or female children and adolescents 2 to 18 years of age, (5)  
164 participants overweight or obese, as defined by the authors, (6) studies published in any  
165 language up through August 22, 2018, (7) data available for BMI in  $\text{kg/m}^2$ , fat mass or  
166 percent body fat. The August 22, 2018 end date for searching was extended from the  
167 originally proposed end data of August 30, 2017 listed in the original protocol in order to  
168 stay as current as possible and while allowing for the time it takes to complete all stages  
169 of a network meta-analysis.[80]

## 170 **Information sources**

171 The following seven electronic databases were searched: (1) PubMed, (2) Web of  
172 Science, (3) Cochrane Central Register of Controlled Trials (CENTRAL), (4) Cumulative  
173 Index to Nursing and Allied Health Literature (CINAHL), (5) Sport Discus, (6) Translating  
174 Research into Practice (TRIP) and (7) ProQuest Dissertations and Theses. In addition  
175 to electronic database searches, cross-referencing was conducted by examining the  
176 reference lists of previous review articles as well as each included study for potential

articles that met the inclusion criteria. Upon completion of initial searches, the third author examined the reference list for thoroughness and completeness.

**Search strategy**

Search strategies specific to each database were developed by the investigative team. The searches covered the periods from January 1, 1973 to August 22, 2018. A copy of one of the databases searched (PubMed) is shown in Supplementary file 1. All database searches and article retrieval were conducted by the second author with oversight from the first author.

**Study records**

**Study selection**

To minimize selection bias, the first and second authors selected all studies independent of each other. They then reviewed their selections for agreement. Reasons for excluded studies were recorded using the following categories: (1) inappropriate population, (2) inappropriate intervention, (3) inappropriate comparison(s), (4) inappropriate outcome(s), (5) inappropriate study design, and (6) other. Upon completion of screening, the first and second authors met and reviewed all selections. Cohen's kappa statistic ( $\kappa$ ) was used to measure inter-selection agreement.[81] Any discrepancies were resolved by discussion. If agreement could not be reached, the third author served as an arbitrator. Upon selecting the final number of studies to include, the overall precision of the searches was computed by dividing the number of included studies by the total number of studies screened after removing duplicates.[82] The number needed-to-read (NNR) was then calculated as the reciprocal of the precision. [82]

**Data abstraction**

For this project, Microsoft Excel (version 2016; Redmond, WA: Microsoft Corporation; 2016) was used to develop comprehensive electronic codebooks that could hold up to 1,475 items from each study. The major categories of variables coded included (1) study characteristics (author, journal, year of publication, etc.), (2) participant characteristics (age, gender, height, body weight, etc.), (3) intervention characteristics (type, length, frequency, intensity, duration, compliance, etc.), and (4) data for primary and secondary outcomes (sample sizes, baseline and post-exercise means and standard deviations, etc.). To avoid data abstraction bias, the first two authors independently coded (dual-coding) all studies. The first two authors then met to review their decisions. Any disagreement in the items coded were discussed until mutual agreement was achieved. If agreement could not be reached, the third author provided a recommendation. Using Cohen's kappa statistic ( $\kappa$ ), [81] inter-rater agreement prior to correcting discrepant items was 0.95.

### **Outcomes and prioritization**

The a priori primary outcomes in this study were changes in BMI in  $\text{kg/m}^2$ , fat mass, and percent body fat in overweight and obese children and adolescents. Secondary a priori outcomes included body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, maximum oxygen consumption ( $\text{VO}_{2\text{max}}$  in  $\text{ml}\cdot\text{kg}^{-1}\cdot\text{min}^{-1}$ ), muscular strength, resting systolic and diastolic blood pressure, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated hemoglobin, fasting and non-fasting glucose and insulin. Missing data for primary outcomes were



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requested via electronic mail. Post hoc, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, muscular strength, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, glycosylated hemoglobin and non-fasting glucose and insulin were not examined because of a lack of data across the three treatments.

**Risk of bias assessment in individual studies**

Risk of bias for included studies was assessed using the Cochrane Risk of Bias Instrument.[83] Judgments of low, high or unclear risk of bias were made across seven domains. Assessment for risk of bias was limited to the primary outcomes of interest (changes in BMI in kg·m<sup>2</sup>, fat mass, and percent body fat). All studies were classified as high risk of bias with respect to the category “blinding of participants and personnel” given that it’s virtually impossible to blind participants to group assignment in exercise intervention protocols. No trial was excluded based on risk of bias results.[84] The first two authors independently assessed risk of bias (dual-coding) for all studies. Any disagreements in the items coded were discussed until mutual agreement was reached. If mutual agreement could not be achieved, the third author served as an arbitrator. Using Cohen’s kappa statistic ( $\kappa$ ),[81] inter-rater agreement prior to resolving disagreements was 0.72.

**Data Synthesis**

**Calculation of effect sizes**

Changes in outcomes for randomised controlled trials were calculated by subtracting the change outcome differences between the exercise and control groups. Variances were computed using the pooled standard deviations of change scores in the exercise

and control groups. If change score standard deviations were not available, they were calculated from 95% confidence intervals (CI) for either change outcome or treatment effect differences as well as pre and post standard deviation values, the latter according to procedures developed by Follmann et al.[85] For direct comparisons, i.e., randomised trials with no control arm, the same procedures were used as for randomised controlled trials by taking the differences and variances between the two treatment groups. For studies in which adiposity outcomes were assessed at multiple intervention time points, only data from the initial and last assessment were used. A post-hoc decision was made to not analyze follow-up data because of the lack of available endpoints. Cross-over trials were handled by using all assessments from the intervention and control periods and analyzing them similar to a parallel group trial.[86] Pooled estimates for changes in outcomes

Network (geometry) plots were used to provide a visual representation of the evidence base with nodes (circles) weighted by the number of participants randomised to each treatment and edges (lines) weighted by the number of studies evaluating each pair of treatments.[87, 88]

Transitivity, i.e., similarity in the distribution of potential effect modifiers across the different pairwise comparisons for each outcome,[89] was examined using chi-square tests for categorical variables and one-way-ANOVA tests for continuous variables. If statistically significant differences were found, follow-up tests were conducted, when necessary, using the Bonferroni approach for continuous data and 2 x 2 chi-square tests for categorical data. A two-tailed alpha value  $\leq 0.05$  was considered to be statistically significant. Variables analysed between treatment contrasts included risk of

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bias variables (sequence generation, allocation concealment, blinding of outcome assessors, incomplete outcome data, selective reporting, physical activity), type of control group, age, gender, training program characteristics (length, frequency, intensity, duration, compliance, exercise supervision status), baseline values for the outcome of interest, and method for assessing the outcome of interest.

Network meta-analysis was performed using random-effects, multivariate, restricted maximum likelihood models performed within a frequentist setting and which allowed for the inclusion of potential covariates while accounting for the correlations from multi-arm trials.[90, 91] A two-tailed alpha value  $\leq 0.05$  and non-overlapping 95% CI were considered to represent statistically significant changes. In addition, 95% prediction intervals were generated in order to examine the interval in which the outcome of interest in a future study would lie.[92] Global inconsistency across each network was examined using the Wald test,[93] with an alpha value  $\leq 0.05$  considered to represent statistically significant inconsistency. Small-study-effects (publication bias, etc.) across all comparisons were conducted using funnel plots and Egger’s regression-intercept test.[94, 95] An alpha value  $\leq 0.05$  was considered to represent statistically significant small-study effects.

Potential covariates were examined by conducting simple meta-regression for statistically significant associations between covariates and changes in the primary outcomes (BMI in kg/m<sup>2</sup>, fat mass, percent fat). A list of covariates examined using simple meta-regression is shown in Supplementary file 2. A post hoc decision was made to not conduct any type of multiple meta-regression because of missing data for different variables from different studies.

292 To establish a hierarchy of exercise interventions for all outcomes in the current meta-  
293 analysis, the surface under the cumulative ranking curve (SUCRA), a transformation of  
294 the mean rank, was used and while accounting for the location and variance of all  
295 treatment effects.[87, 96] Larger SUCRA values indicate better ranks for the  
296 treatment.[87, 96] Interpretation of all rankings was approached from the perspective of  
297 both absolute and relative treatment effects.[88]

#### 298 Confidence in cumulative evidence

299 The a priori plan was to examine for the strength of evidence for network meta-  
300 analyses using the approach described by Salanti et al.[97] However, since that time,  
301 an alternative approach has been suggested,[98] with no clear consensus and  
302 continuing controversy on the best approach for network meta-analysis, including the  
303 validity and reliability of these assessment tools. Therefore, a post hoc decision was  
304 made to use a qualitative approach versus a formal assessment instrument to examine  
305 for the strength of the evidence.

#### 306 Software used for statistical analysis

307 All data were analysed using Stata (V.14.1; Stata/SE for Windows, version 14.0.  
308 College Station, TX: Stata Corporation LP; 2015), Microsoft Excel (version 2016;  
309 Redmond, WA: Microsoft Corporation; 2016), and two add-ins for Excel, SSC-Stat  
310 (V.2.18; SSC-Stat, version 3.0. University of Reading, United Kingdom: Statistical  
311 Services Center; 2007), and EZ-Analyze (V.3.0; EZ Analyze, version 3.0. TA Poynton;  
312 2007).

## 313 RESULTS

### 314 Study Characteristics



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Of the 6,478 citations screened after removing duplicates both electronically and manually, 57 studies representing 127 groups (73 exercise, 54 control) and 2,792 participants (1,667 exercise, 1,125 control) met the criteria for inclusion.[13-37, 39, 40, 42-69, 99, 100] The number needed to screen was 0.88% while the NNR was 114. Reasons for exclusion, in order of prevalence, included inappropriate study design (48.4%), inappropriate population (20.5%), inappropriate intervention (13.6%), other, for example, editorials (9.6%), inappropriate outcome (6.9%), inappropriate comparison (1.0%), and unable to retrieve data (0.03%). A flow diagram that depicts the search process is shown in Figure 1 while a list of the 6,421 excluded studies, including the reasons for exclusion, can be found in Supplementary File 3. A total of 4 different requests for data were made to authors, 2 (50%) of which provided such.

General study characteristics are shown in Supplementary file 4. The included studies were published in 45 different journals since 1997 ( $\bar{X} \pm SD = 2011 \pm 4$ , Median = 2012). Fifty-two studies (91.2%) were published in the English language,[13, 14, 16-18, 20, 22, 24-37, 39, 40, 42-69, 99] while the remaining 5 (8.8%) were published in either Chinese [19, 21, 23, 100] or Spanish.[15] The location in which studies were conducted included 20 different countries, 12 in the United States,[24, 30, 34, 35, 39, 40, 46, 48, 52, 56, 60, 66] 8 in China,[19-23, 61, 62, 99, 100] 6 in Brazil,[13, 15, 45, 47, 58, 63] 5 in South Korea,[36, 37, 49, 55, 59] 4 in Tunisia,[17, 25, 50, 51] 3 each in Australia,[54, 64, 65] Canada,[14, 32, 57] and Iran,[27, 29, 69] 2 in Turkey,[33, 53] and 1 each in either France,[16] Germany,[44] Italy,[28] Lebanon,[68] New Zealand,[42] Norway,[18] Singapore,[67] Sweden,[31] Switzerland,[26] Taiwan,[22] or the United Kingdom [43]. Of the 57 included studies, 45 (78.9%) were two-arm randomised controlled trials limited to

1 exercise and 1 control group that met all eligibility criteria,[14-20, 22, 23, 25-27, 29-31, 33-37, 42-44, 46-49, 52-56, 58-69, 100] seven (12.3%) were three-arm randomised controlled trials that included 2 exercise arms,[24, 32, 39, 40, 50, 51, 99] and two (3.5%) were four-arm randomised controlled trials that included three exercise arms.[21, 57] The remaining three studies (5.3%) were randomised trials that compared two or more different exercise interventions directly but did not include an eligible control group.[13, 28, 45] Ten of 57 studies (17.5%) included matching procedures according to either race/ethnicity,[60] age, sex and BMI,[34] age and sex,[45] BMI,[45] sex and BMI, [13] race/ethnicity and sex,[24, 42, 48] sex [49] or sex and degree of overweight.[57] Two studies (3.5%) used a crossover design.[64, 65] With respect to the statistical analysis of data, 39 studies (68.4%) used the per protocol approach,[13, 14, 16, 17, 19-23, 25, 27-31, 33-37, 44, 46-48, 50-53, 55, 56, 58, 59, 63-65, 67-69, 99] 11 (19.3%) used intention-to-treat or reported that all subjects completed the study,[18, 24, 42, 43, 45, 49, 54, 61, 62, 66, 100] while 7 (12.3%) used both per protocol and intention-to-treat analyses.[15, 26, 32, 39, 40, 57, 60] Only 18 studies (31.6%) reported sample size estimates for their primary outcome(s) of interest.[15, 18, 22, 24, 26, 32, 35, 39, 42, 45, 48, 49, 54, 57, 59, 63, 65, 66] In relation to funding, 42 studies (73.7%) reported receiving financial support for their research,[13, 14, 17, 18, 20, 22, 24-26, 30-32, 34-37, 39, 40, 42, 44-52, 54-57, 59-61, 63-68, 99] 16 from government sources,[17, 18, 22, 24, 25, 30, 31, 47, 50, 51, 54, 55, 60, 61, 66, 68] 4 from private sources,[45, 52, 64, 65] 8 from universities,[14, 20, 37, 44, 49, 59, 67, 99] 8 from both government and private sources,[32, 34, 39, 40, 42, 46, 48, 63-68] 3 from government and university sources,[13, 26, 35] 2 from government, university and private sources,[56, 57] and 1

from university and private sources.[36] None of the studies reported any information on the cost-effectiveness of their interventions. Overweight and obesity was most commonly defined using age and sex-specific BMI cutpoints. However, variability existed in the criteria used to determine overweight and obesity (Supplementary file 4).

**Participant Characteristics**

Baseline characteristics of the participants are shown in Supplementary file 4 and Table 1. More than half the studies (57.1%) included both males and females,[13-18, 20, 22, 24, 26, 28, 30-32, 34, 42-46, 48, 49, 52, 57, 58, 61-65, 68, 99] followed by those limited to males (32.1%),[19, 23, 25, 27, 29, 33, 35-37, 39, 47, 54-56, 59, 67, 69, 100] and females (10.7%).[40, 50, 51, 53, 60, 68] Participants included those across all five stages of puberty.[13, 14, 16, 17, 24-26, 32, 34, 35, 39, 40, 43, 50, 56, 57, 63, 64, 68, 69] For those studies that reported race/ethnicity,[16-20, 23, 24, 30, 32, 35, 39, 40, 42, 48, 52, 56, 57, 59-62, 65, 66, 100] and as reported by the authors, participants included Whites, Blacks/African Americans, Asians, Hispanics/Latinos, Native Hawaiian/Pacific Islander, Maori, Aboriginal, Arabic, Chinese, Koreans, French, Norwegian, Tunisian and native Canadian. Some studies included one or more participants with hyperlipidemia,[17, 26, 52] hypertension,[26, 56] metabolic syndrome,[17, 34, 46, 56] and/or asthma.[46, 52] For those studies in which data were available, none reported that any of the participants smoked cigarettes [19, 27, 39, 40, 44, 64, 65, 67-69, 100] or consumed alcohol.[13, 100] For the 31 studies (54.4%) that reported data by group,[15, 20, 22, 24, 26, 28, 32, 34, 35, 37, 39, 40, 42, 44, 45, 48-51, 54-58, 60-63, 66, 68, 100] dropouts ranged from 0% to 60.9% in the exercise groups ( $\bar{X} \pm SD$ ,  $15.2 \pm 14.5$ , Median = 12.5) and 0% to 61.5% in the control groups ( $\bar{X} \pm SD$ ,  $14.9 \pm 14.9$ , Median = 13.8).

Reasons for dropouts in the exercise group were varied, consisting of such things as lack of time, personal reasons, dissatisfaction with program and logistics. For the control groups, reasons included such things as unhappiness with group assignment and logistics. Of the 11 studies (19.3%) that reported data on adverse events,[24, 32, 42, 47, 51, 57, 60, 62, 64-66] only one reported a serious adverse event (one foot fracture). [24]

Table 1. Baseline physical characteristics of participants.\*

Variable	Exercise				Control			
	S/G/P (#)	$\bar{X} \pm SD$	Mdn	Range	S/G/P (#)	$\bar{X} \pm SD$	Mdn	Range
Age (years)	51/65/1666	$13.1 \pm 2.6$	14	8-17	49/49/1117	$12.7 \pm 2.6$	13	8-17
Height (cm)	44/55/1342	$157.7 \pm 11.3$	163	130-176	42/42/910	$156.5 \pm 12.2$	161	127-175
Body Weight (kg)	52/65/1371	$76.3 \pm 17.2$	79	35-107	49/49/906	$75.4 \pm 17.3$	75	34-103
BMI (kg/m <sup>2</sup> )	52/66/1451	$29.4 \pm 3.9$	29	21-38	48/48/929	$29.3 \pm 3.7$	29	21-37
Fat mass (kg)	31/40/867	$33.4 \pm 11.5$	31	15-60	29/29/567	$31.2 \pm 10.2$	30	15-56
Body fat (%)	46/59/1364	$38.1 \pm 6.8$	38	27-52	42/42/840	$37.0 \pm 6.6$	37	23-51
Fat-free mass (kg)	33/42/764	$46.6 \pm 11.1$	48	25-64	29/29/435	$45.8 \pm 11.1$	47	25-64
WC (cm)	23/34/757	$95.1 \pm 9.2$	94	76-115	21/21/445	$95.5 \pm 8.8$	95	80-111
VO <sub>2max</sub> (ml·kg <sup>-1</sup> ·min <sup>-1</sup> )	28/38/980	$30.7 \pm 4.9$	31	20-41	26/26/524	$30.5 \pm 6.1$	30	20-44



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3	SBP (mmHg)	20/24/484	118.2 ±	118	98-	19/19/330	119.4 ±	118	100-
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5			8.7		139		9.1		134
6									
7	DBP (mmHg)	19/23/450	69.8 ± 6.8	68	56-81	18/18/296	69.7 ± 8.1	70	52-85
8									
9	TC (mg/dl)	21/27/454	157.8 ±	160	110-	20/20/301	163.1 ±	163	114-
10									
11			16.3		200		19.7		220
12									
13	HDL (mg/dl)	25/30/523	42.9 ± 5.2	43	34-56	23/23/371	44.0 ± 6.3	45	33-59
14									
15	LDL (mg/dl)	24/29/507	96.5 ±	98	75-	22/22/354	100.4 ±	98	81-
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17			11.4		124		14		142
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19	TG (mg/dl)	25/30/521	111.6 ±	107	53-	22/22/351	109.9 ±	102	102-
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21			27.2		173		27.4		187
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23	Fasting Glucose	25/33/684	88.5 ± 5.6	90	76-98	24/24/360	88.4 ± 5.3	88	74-97
24	(mg/dl)								
25									
26	Fasting Insulin	18/27/586	21.1 ± 9.2	21	6-46	17/17/230	21.0 ±	19	6-48
27	(uU/ml )								
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30 391 Notes: \*, Descriptive data for exercise characteristics calculated based on number of groups (G); S/G/P  
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32 392 (#), number of studies/groups/participants;  $\bar{X} \pm SD$ , mean  $\pm$  standard deviation; Mdn, median; BMI, body  
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34 393 mass index; WC, waist circumference; WHR, waist-to-hip ratio;  $VO_{2max}$ , maximum oxygen consumption;  
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36 394 SBP, resting systolic blood pressure; DBP, resting diastolic blood pressure; TC, total cholesterol; HDL,  
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38 395 high-density lipoprotein cholesterol; LDL, low-density lipoprotein cholesterol; TG, triglycerides; non-HDL,  
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40 396 non-high-density lipoprotein cholesterol, calculated as total cholesterol minus high-density lipoprotein  
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42 397 cholesterol; HbA1c, glycated hemoglobin.

43 398 **Exercise Intervention Characteristics**

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46 399 Characteristics of the exercise interventions are shown in Supplementary file 4 and  
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48 400 Table 2. Forty-one studies (71.9%) included aerobic exercise,[13, 15-17, 19, 21-25, 28-  
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50 401 30, 32-34, 36, 39, 40, 42-46, 48, 50-53, 55, 57-63, 65, 66, 68, 69, 99, 100] 9 (15.8%)  
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52 402 included strength training,[21, 28, 35, 39, 40, 47, 54, 56, 57] and 17 (29.8%) included  
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55 403 combined aerobic and strength training.[13, 14, 18, 20, 21, 23, 26, 27, 31, 37, 45, 49,

57, 58, 64, 67, 69] While methods for assessing the intensity of training for both aerobic and resistance exercise varied between the 38 studies (66.7%) that reported such information,[14, 17, 19-22, 24, 26-28, 30, 32-34, 37, 39, 40, 45, 48-51, 53, 55-59, 61-65, 67-69, 99, 100] the intensities most commonly reported ranged from moderate to vigorous based on American College of Sports Medicine cutpoints.[101] Specific types of activities performed included, but were not necessarily limited to, various non-video games (soccer, dodgeball, basketball, etc.), active video games, walking, running, cycling, swimming, stairclimbing, jumping rope, dance, and resistance training, including circuit training.[13-29, 31-34, 36, 37, 39, 40, 42-52, 54-69, 99, 100]

Table 2. Exercise program characteristics.\*

Variable	S/G/P	$\bar{X} \pm SD$	Mdn	Range
Length (weeks)	57/73/1663	14.1 $\pm$ 6.2	12	6-36
Frequency (days/week)	56/72/1655	3.3 $\pm$ 1.1	3	1-7
Duration (min/session)	53/55/1251	42 $\pm$ 21	40	6-90
Compliance (%)	19/25/580	81.9 $\pm$ 18.8	87	42-100
Minutes per week**	37/46/1092	132.6 $\pm$ 73.2	125	18-360
Minutes per week (adj)**	16/18/568	133.1 $\pm$ 74.2	124	39-360

Notes: Notes: \*, Descriptive data for exercise characteristics calculated based on number of groups (G); S/G/P (#), number of studies/groups/participants;  $\bar{X} \pm SD$ , mean  $\pm$  standard deviation; Mdn, median; min, minutes; \*\*, limited to aerobic exercise; Minutes per week of exercise, calculated as frequency per week x duration per session in minutes; Minutes per week (adj) of exercise, calculated as frequency per week x duration per session in minutes x compliance, defined as the percentage of exercise sessions attended. For those studies that included resistance training and provided additional data, [13, 14, 18, 20, 21, 23, 26-28, 31, 35, 37, 39, 40, 45, 47, 49, 51, 54, 56, 57, 64, 67, 69] the number of sets ranged from 1 to 3 ( $\bar{X} \pm SD$ , 2  $\pm$  1, Median = 3), repetitions from 5 to 17 ( $\bar{X} \pm SD$ , 11  $\pm$  5, Median = 11), and exercises from 3 to 13 ( $\bar{X} \pm SD$ , 9  $\pm$  3, Median = 9).

Types of resistance included one’s own body weight, heavy balls, elastic bands, free weights and machine weights. For the 56 studies (98.2%) that provided data on exercise delivery,[13-15, 17-37, 39, 40, 42-69, 99, 100] 51 (91.1%) were supervised,[13-15, 17-34, 36, 37, 39, 40, 43-45, 47-51, 53-56, 58-69, 99, 100] 4 (7.1%) were unsupervised,[35, 42, 46, 52] and 1 (1.8%) included both [57].

**Risk of Bias Assessment**

Summary results using the Cochrane Risk of Bias Instrument [83] are shown in Figure 2 while study-level results are shown in Supplementary file 5. With the exception of blinding of participants and personnel, the number of studies rated as being at a high risk of bias ranged from only 2% to 18%, with 5 of the 6 items being less than 10%. All studies were considered to be at a high risk of bias for blinding of participants and personnel because it is virtually impossible to blind participants to group assignment in exercise intervention studies. In contrast, the vast majority of studies (97%) were considered to be at a low risk of bias for random sequence generation. Finally, with the exception of random sequence generation and blinding of participants and personnel, 42% to 75% of studies were rated as being at an unclear risk of bias for the remaining 5 items.

**Data Synthesis**

Data are reported for primary outcomes (BMI in kg·m<sup>2</sup>, fat mass and percent body) according to (1) overall findings, (2) interval plot results, (3) ranking of treatments, and (4) meta-regression results. Separate results are then reported for all secondary outcomes: body weight, fat-free mass, waist circumference, maximum oxygen consumption, systolic blood pressure, diastolic blood pressure total cholesterol, high-

density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, fasting glucose and insulin.

## Primary Outcomes

*Body mass index (overall findings).* Data from 50 studies representing 67 effect sizes were included in the BMI in kg·m<sup>2</sup> analyses.[13-17, 19-23, 25-29, 31-37, 39, 40, 42-47, 49, 52-59, 61-69, 99, 100] The network geometry plot for BMI in kg·m<sup>2</sup> is shown in Figure 3. The most common group was the control group followed by the aerobic group. The most common comparison was aerobic versus control (n = 35) followed by combined aerobic and strength versus control (n = 11), strength versus control (n = 8), strength versus aerobic (n = 7), combined aerobic and strength versus aerobic (n = 4), and combined aerobic and strength versus strength (n = 2). An examination for transitivity found no statistically significant differences for potential effect modifiers across treatment comparisons (p > 0.05 for all, results not shown).

*Body mass index (interval plot).* An interval plot for changes in BMI in kg·m<sup>2</sup> is shown in Figure 4 while a study-level network forest plot that includes each comparison-specific effect size can be found in Supplementary file 6. As can be seen in Figure 4, non-overlapping 95% confidence intervals for BMI in kg·m<sup>2</sup> were observed for the aerobic versus control (n = 35) as well as the combined aerobic and strength versus control comparisons (n = 11) (p < 0.05 for both). Changes were equivalent to relative reductions of 3.8% for the aerobic versus control comparison and 2.4% for the combined aerobic and strength training versus control comparison. However, all 95% prediction intervals were overlapping. No statistically significant differences were observed for direct comparisons. In addition, the overall test for inconsistency was not



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3 468 statistically significant ( $\chi^2(7df) = 4.4$ ,  $p = 0.74$ , Supplementary file 6). No statistically  
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6 469 significant small-study effects (publication bias, etc.) were found ( $n = 67$ ,  $p = 0.51$ ,  
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8 470 Supplementary file 7).

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10 471 *Body mass index (ranking of treatments)*. The ranking of treatments for BMI in  $\text{kg}\cdot\text{m}^2$  is  
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12 472 shown in Table 3. As can be seen, aerobic exercise had the highest probability of being  
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15 473 ranked as the best treatment. This was followed by combined aerobic and strength  
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17 474 training and then strength training alone.

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19 475 *Body mass index (meta-regression)*. Meta-regression results, including sample sizes for  
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21 476 these models, can be found in Supplementary file 8. For aerobic exercise, statistically  
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23 477 significant associations ( $p < 0.05$ ) were found for greater reductions in BMI as a result of  
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26 478 (1) studies conducted in countries other than those in the United States, (2) unfunded  
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28 479 versus funded studies, (3) greater compliance to the exercise intervention, (4) greater  
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31 480 number of total minutes of exercise per week, and (5) greater number of total minutes  
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33 481 per week of exercise after adjusting for compliance. For

Table 3. Ranking analyses for treatments.

Variable	Best (%)	2 <sup>nd</sup> (%)	3 <sup>rd</sup> (%)	Worst (%)	$\bar{X}$ Rank	SUCRA
BMI $\text{kg}\cdot\text{m}^2$						
- Aerobic	78.0	21.6	0.4	0.0	<b>1.2</b>	<b>0.9</b>
- Strength	0.9	8.9	55.3	34.9	3.2	0.3
- Both	21.1	69.1	9.1	0.7	1.9	0.7
- Control	0	0.4	35.3	64.4	3.6	0.1
Fat mass (kg)						
- Aerobic	27.9	52.3	19.7	0	1.9	0.7
- Strength	11.3	18.7	61.6	8.4	2.7	0.4
- Both	60.7	29.0	10.3	0	<b>1.5</b>	<b>0.8</b>

- Control	0	0	8.4	91.6	3.9	0
Body fat (%)						
- Aerobic	9.9	57.0	33.1	0	2.2	0.6
- Strength	10.2	27.6	60.3	1.9	2.5	0.5
- Both	79.7	15.4	4.7	0	<b>1.2</b>	<b>0.9</b>
- Control	0	0	1.9	98.1	4	0

Notes: SUCRA, surface under the cumulative ranking curve analysis; **Boldface** values indicate best treatment;  $\bar{X}$  Rank, mean rank.

strength training, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in BMI and (1) studies at a low versus unclear risk of bias with respect to participants being physically inactive prior to study initiation, (2) supervised versus unsupervised exercise, and (3) facility versus home-based exercise. No other statistically significant associations were observed.

*Fat mass (overall findings).* Data from 31 studies representing 46 effect sizes were included in the fat mass (kg) analyses.[13, 14, 17, 18, 21, 23, 25, 27, 31, 34-37, 39, 40, 42, 45-48, 52, 55-57, 59, 60, 64, 67, 69, 99, 100] The network geometry plot for fat mass (kg) is shown in Figure 5. As can be seen, the control group was the most common followed by the aerobic group. The most common comparison was aerobic versus control ( $n = 19$ ) followed by combined aerobic and strength versus control ( $n = 10$ ), strength versus control ( $n = 7$ ), strength versus aerobic ( $n = 7$ ), combined aerobic and strength versus aerobic ( $n = 4$ ), and combined aerobic and strength versus strength ( $n = 2$ ) comparisons. An examination for transitivity revealed a statistically significant overall difference between comparisons for frequency of training in days per week ( $F(5,40df) = 3.4, p = 0.01$ ). Post-hoc follow-up testing revealed that frequency of training was greater in the aerobic versus control versus combined aerobic and strength versus

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control comparisons (4.0 versus 2.4 days per week,  $p = 0.008$ ). No other statistically significant between-comparison differences were observed ( $p > 0.05$  for all, results not shown).

*Fat mass (interval plot).* An interval plot for changes in fat mass in kg is shown in Figure 6 while a network forest plot that includes each comparison-specific effect size can be found in Supplementary file 9. As can be seen by the non-overlapping 95% confidence intervals in Figure 6, statistically significant reductions in fat mass in kg were found for the aerobic versus control ( $n = 19$ ) as well as the combined aerobic and strength versus control comparisons ( $n = 10$ ) ( $p < 0.05$  for both). Changes were equivalent to relative reductions of 8.3% for the aerobic versus control comparison and 8.4% for the combined aerobic and strength training versus control comparison. However, all 95% prediction intervals were overlapping. No statistically significant differences were observed for head-to-head comparisons. In addition, the overall test for inconsistency was not statistically significant ( $\chi^2$  (6df) = 7.5,  $p = 0.27$ , Supplementary file 9). No statistically significant small-study effects (publication bias, etc.) were found ( $n = 46$ ,  $p = 0.10$ , Supplementary file 10).

*Fat mass (ranking of treatments).* The ranking of treatments for fat mass in kg is shown in Table 3. As can be seen, combined aerobic and strength training exercise had the highest probability of being ranked as the best treatment followed by aerobic exercise.

*Fat mass (meta-regression).* Meta-regression results for fat mass (kg), including sample sizes for these models, are shown in Supplementary file 11. For aerobic exercise, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in BMI as a result of (1) studies at an unclear versus low risk of bias for selective reporting, (2)

shorter interventions (weeks), (3) high versus moderate intensity exercise, (4) greater compliance to the exercise protocol, and (5) greater total minutes per week of exercise, adjusted for compliance. For combined aerobic and strength training, statistically significant associations ( $p < 0.05$ ) were found for greater reductions in fat mass and more recent year of publication as well as unfunded versus funded studies. No other statistically significant associations were observed.

*Percent body fat (overall findings).* Data from 45 studies representing 64 effect sizes were included in the percent body fat analyses.[13, 14, 18-24, 26, 28-32, 34-37, 39, 40, 42, 44-48, 50-61, 63, 64, 67-69, 100] The network plot for fat mass (kg) is shown in Figure 7. As can be seen, the control group was the most common followed by the aerobic group. The most common comparison was the aerobic versus control group ( $n = 32$ ) followed by combined aerobic and strength versus control ( $n = 12$ ), strength versus control ( $n = 8$ ), strength versus aerobic ( $n = 6$ ), combined aerobic and strength versus aerobic ( $n = 4$ ), and combined aerobic and strength versus strength ( $n = 2$ ) comparisons. An examination for transitivity revealed a statistically significant difference between comparisons with respect to the method used for the assessment of percent body fat ( $\chi^2 (25df) = 43.7$ ,  $p = 0.01$ ). Post-hoc follow-up testing revealed that the difference was between the aerobic versus control and strength versus control comparisons ( $\chi^2 (4df) = 12.7$ ,  $p = 0.01$ ) as well as aerobic versus control and combined aerobic and strength training versus aerobic comparisons ( $\chi^2 (5df) = 12.3$ ,  $p = 0.03$ ). In addition, frequency of training was associated with specific comparisons ( $F (5, 58df) = 2.9$ ,  $p = 0.02$ ). Post hoc follow-up testing showed that frequency of training was lower in the combined aerobic and strength training comparison (2.6 days per week) versus the



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3 547 aerobic and control comparison (3.8 days per week,  $p = 0.02$ ). No other statistically  
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5 548 significant between-comparison differences were observed ( $p > 0.05$  for all).

7 549 *Percent body fat (interval plot)*. An interval plot for changes in percent body fat is shown  
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10 550 in Figure 8 while a network forest plot that includes each comparison-specific effect size  
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12 551 can be found in Supplementary file 12. As can be seen by the non-overlapping 95%  
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14 552 confidence intervals in Figure 8, statistically significant reductions ( $p < 0.05$ ) in percent  
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16 553 body fat were found for the aerobic versus control ( $n = 32$ ), strength versus control ( $n =$   
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18 554 8), and combined aerobic and strength versus control comparisons ( $n = 12$ )). Changes  
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20 555 were equivalent to relative reductions of 5.4% for the aerobic versus control  
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22 556 comparison, 2.8% for the strength versus control comparison, and 6.0% for the  
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24 557 combined aerobic and strength training versus control comparison. However, all 95%  
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26 558 prediction intervals were overlapping. No statistically significant differences were  
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28 559 observed for direct comparisons. In addition, the overall test for inconsistency was not  
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30 560 statistically significant ( $\chi^2$  (7df) = 11.9,  $p = 0.10$ , Supplementary file 12). No statistically  
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32 561 significant small-study effects (publication bias, etc.) were found ( $n = 64$ ,  $p = 0.65$ ,  
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34 562 Supplementary file 13).

39 563 *Percent body fat (ranking of treatment)*. The ranking of treatments for percent body fat is  
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41 564 shown in Table 3. As can be seen, combined aerobic and strength training exercise had  
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43 565 the highest probability of being ranked as the best treatment followed by aerobic  
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45 566 exercise alone and strength training alone.

48 567 *Percent body fat (meta-regression)*. Meta-regression results for percent body fat,  
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50 568 including sample sizes for statistically significant results, are shown in Supplementary  
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52 569 file 14. For aerobic exercise, statistically significant associations ( $p < 0.05$ ) were found  
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for greater reductions in percent body fat as a result of (1) studies at an unclear versus low risk of bias for selective reporting, (2) unfunded versus funded studies, and (3) shorter interventions (weeks). For strength training, greater reductions were associated with low versus unclear risk of bias for participants being physically active prior to study initiation as well as unfunded versus funded studies. For combined aerobic and strength training, greater reductions in percent body fat were associated with unfunded versus funded studies. No other statistically significant associations were observed.

## Secondary Outcomes

The overall results for secondary outcomes are shown in Supplementary file 15.

**Body weight.** Statistically significant reductions in body weight were observed for both aerobic exercise and combined aerobic and strength training. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative reductions of 3.0% and 4.0% respectively, for aerobic and combined exercise. In addition greater reductions were observed for the combined aerobic and strength versus strength training only comparison ( $\bar{X}$ , -1.7, 95% CI, -3.3 to -0.07). The global test for inconsistency was not statistically significant ( $\chi^2$  (7df) = 10.5, p = 0.16). Statistically significant small-study effects (publication bias, etc.) were observed (n = 67, p = 0.002). For ranking of treatments, aerobic exercise was ranked as the best treatment followed by combined aerobic and strength training.

**Fat free mass.** Statistically significant increases in fat free mass (kg) were observed for combined aerobic exercise and strength training but none of the other interventions. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative increases of 2.5%. In addition, increases in fat free mass were

greater for combined aerobic and strength versus aerobic comparisons ( $\bar{X}$ , 1.2, 95% CI, 0.1 to 2.3). The global test for inconsistency was not statistically significant ( $\chi^2$  (7df) = 2.8,  $p = 0.90$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $n = 45$ ,  $p = 0.008$ ). For ranking of treatments, combined aerobic and strength training was ranked first for increasing fat free mass.

Waist circumference. Statistically significant reductions in waist circumference were found for aerobic exercise. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative reductions of 2.2%. No statistically significant differences were observed for head-to-head comparisons ( $p < 0.05$  for all). The global test for inconsistency was not statistically significant ( $\chi^2$  (6df) = 8.1,  $p = 0.23$ ). No statistically significant small-study effects (publication bias, etc.) were observed ( $n = 36$ ,  $p = 0.39$ ). For ranking of treatments, combined aerobic and strength training was ranked first followed by aerobic exercise.

*Maximum oxygen consumption.* Statistically significant increases were found for  $VO_{2max}$  in  $ml \cdot kg^{-1} \cdot min^{-1}$  as a result of either aerobic exercise or combined aerobic exercise and strength training. However, 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative increases of 12.2% and 8.9%, respectively for aerobic exercise and combined aerobic and strength exercise. No statistically significant differences were observed for the three direct comparisons. The global test for inconsistency was also not statistically significant ( $\chi^2$  (6df) = 10.0,  $p = 0.12$ ). No statistically significant small-study effects (publication bias, etc.) were observed ( $n = 47$ ,  $p = 0.32$ ). For ranking of treatments, combined aerobic exercise was ranked first while combined aerobic and strength training was ranked second.

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3 616 *Systolic blood pressure.* Statistically significant decreases were found for resting  
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6 617 systolic blood pressure as a result of aerobic exercise. However, 95% prediction  
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8 618 intervals for all comparisons included zero. Changes were equivalent to a relative  
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10 619 reduction of 3.5%. No statistically significant differences were observed for the head-to-  
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12 620 head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2$   
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14 621 (4df) = 2.0, p = 0.74). Statistically significant small-study effects (publication bias, etc.)  
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17 622 were observed (n = 24, p = 0.01). For ranking of treatments, aerobic exercise was  
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19 623 ranked first.

21 624 *Diastolic blood pressure.* Statistically significant decreases for resting diastolic blood  
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23 625 pressure were found as a result of aerobic exercise. However, the 95% prediction  
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25 626 intervals for all comparisons included zero. Changes were equivalent to a relative  
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27 627 reduction of 3.4%. No statistically significant differences were observed for any of the  
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29 628 head-to-head comparisons. The global test for inconsistency was not statistically  
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31 629 significant ( $\chi^2$  (4df) = 0.53, p = 0.97). Statistically significant small-study effects  
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33 630 (publication bias, etc.) were observed (n = 23, p = 0.001). For ranking of treatments,  
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35 631 aerobic exercise was ranked first.

38 632 *Total cholesterol.* Statistically significant decreases in total cholesterol were found as a  
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40 633 result of aerobic exercise but none of the other interventions. However, the 95%  
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42 634 prediction intervals for all comparisons included zero. Changes were equivalent to a  
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44 635 relative reduction of 3.3%. No statistically significant differences were observed for the  
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46 636 three head-to-head comparisons. The global test for inconsistency was not statistically  
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48 637 significant ( $\chi^2$  (5df) = 1.8, p = 0.87). Furthermore, no statistically significant small-study  
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effects (publication bias, etc.) were observed ( $n = 28$ ,  $p = 0.70$ ). For treatment rankings, aerobic exercise was ranked as best.

*High-density lipoprotein cholesterol.* Statistically significant increases were found for high-density lipoprotein cholesterol as a result of aerobic exercise only. Conversely, the 95% prediction intervals for all comparisons included zero. Changes were equivalent to relative increases of 7.4%. No statistically significant differences were observed for any of the direct comparisons. The global test for inconsistency was not statistically significant ( $\chi^2$  (5df) = 2.6,  $p = 0.76$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $n = 31$ ,  $p = 0.04$ ). For treatment rankings, combined aerobic exercise was ranked as the best.

*Low-density lipoprotein cholesterol.* Statistically significant decreases in low-density lipoprotein cholesterol were found as a result of aerobic exercise but none of the other interventions. In addition, the 95% prediction interval did not include zero. Changes were equivalent to a relative reduction of 6.0%. No statistically significant differences were observed for the three head-to-head comparisons. The global test for inconsistency was not statistically significant ( $\chi^2$  (5df) = 2.4,  $p = 0.79$ ). Statistically significant small-study effects (publication bias, etc.) were observed ( $n = 30$ ,  $p = 0.006$ ). For treatment rankings, aerobic exercise was ranked as best.

*Triglycerides.* Statistically significant decreases in triglycerides were found as a result of aerobic exercise as well as combined aerobic and strength exercise. In addition, the 95% prediction intervals did not include zero for both treatments. Changes were equivalent to a relative reduction of 11.9% as a result of aerobic exercise and 14.4% as a result of combined aerobic and strength exercise. No statistically significant

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3 661 differences were observed for the three head-to-head comparisons. The global test for  
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5 662 inconsistency was not statistically significant ( $\chi^2$  (5df) = 1.4, p = 0.92). No statistically  
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7 663 significant small-study effects (publication bias, etc.) were observed (n = 30, p = 0.44).  
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10 664 For treatment rankings, aerobic exercise was ranked best, followed by combined  
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12 665 aerobic and strength training.  
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14 666 *Fasting Glucose.* Statistically significant decreases in fasting glucose were found as a  
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16 667 result of combined aerobic and strength exercise. In addition, the 95% prediction  
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18 668 interval did not include zero. Changes were equivalent to a relative reduction of 6.1%.  
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20 669 For head-to-head comparisons decreases, were greater for combined aerobic and  
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22 670 strength versus strength only interventions ( $\bar{X}$ , -4.9, 95% CI, -9.5 to -0.2). The global test  
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24 671 for inconsistency was not statistically significant ( $\chi^2$  (6df) = 2.2, p = 0.90). No statistically  
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26 672 significant small-study effects (publication bias, etc.) were observed (n = 37, p = 0.35).  
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28 673 For treatment rankings, combined aerobic and strength training was ranked as best.  
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30 674 *Fasting Insulin.* Statistically significant decreases in fasting insulin were observed for  
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32 675 aerobic exercise, strength exercise, and combined aerobic and strength exercise as a  
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34 676 result of combined aerobic and strength exercise. In addition, the 95% prediction  
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36 677 interval did not include zero for any of the three intervention types. Changes were  
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38 678 equivalent to relative reductions of 21.2% (aerobic exercise), 22.6% (strength exercise)  
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40 679 and 17.1% (combined aerobic and strength exercise). No statistically significant  
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42 680 differences were observed for the three head-to-head comparisons. The global test for  
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44 681 inconsistency was not statistically significant ( $\chi^2$  (7df) = 5.6, p = 0.59). However,  
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46 682 statistically significant small-study effects (publication bias, etc.) were observed (n = 33,  
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p = 0.008). For treatment rankings, combined aerobic and strength training was ranked as best, followed by strength training and aerobic exercise.

**DISCUSSION**

**Overall Findings for Primary Outcomes**

The primary purpose of the current study was to conduct a network meta-analysis of randomised trials on the effects of exercise (aerobic, strength training, or both) on adiposity outcomes (BMI in kg·m<sup>2</sup>, fat mass, percent fat) in overweight and obese children and adolescents. The overall findings suggest that exercise is associated with statistically significant reductions in all three primary outcomes. More specifically, aerobic exercise as well as combined aerobic and strength exercise were shown to decrease BMI in kg·m<sup>2</sup>, fat mass and percent fat while decreases as a result of strength training interventions were limited to percent fat only. Of the three exercise interventions, combined aerobic and strength exercise was ranked as best for reducing fat mass and percent fat while aerobic exercise was ranked best for reducing BMI in kg·m<sup>2</sup>. These findings are further strengthened by the lack of global inconsistency for all three primary outcomes as well as the lack of small study effects (publication bias, etc.) observed for all three adiposity outcomes. Alternatively, the positive findings could be questioned given the overlapping 95% prediction intervals across all three treatments. These findings suggest that in a future setting, some participants would benefit while others would not.[102]

A major question to address is the clinical importance of the observed changes in adiposity as a result of exercise. Generally, reductions in adiposity of at least 5% may be considered clinically important.[103] Using this threshold, none of the treatments that

were found to be statistically significant in the current study would meet this cutpoint for changes in BMI in  $\text{kg}\cdot\text{m}^2$ . However, the reductions in fat mass as a result of aerobic exercise (8.3%) as well as combined aerobic and strength exercise (8.4%) appear to be clinically important. In addition, the reductions observed for percent body fat as a result of aerobic exercise (5.4%) as well as combined aerobic and strength exercise (6.0%) also appear to be clinically important. Thus, clinically relevant benefits were derived when more direct measures of adiposity (fat mass and percent body fat) were used.

### 713 **Meta-regression Findings**

Simple meta-regression analyses yielded several statistically significant associations for those treatments and outcomes in which the overall findings were statistically significant. First, the statistically significant association between greater reductions in BMI in  $\text{kg}\cdot\text{m}^2$  as a result of aerobic exercise for studies conducted in countries other than the United States may reflect a tendency for other countries to submit studies that yield larger improvements in BMI in  $\text{kg}\cdot\text{m}^2$ . Alternatively, this association may be confounded by other factors. For example, differences in diet and exercise[104] habits between the US and other countries have been shown to exist, something that would appear plausible given the magnitude of the obesity problem in the US.[1] Second, greater reductions as a result of aerobic exercise for both BMI in  $\text{kg}\cdot\text{m}^2$  and percent fat were associated with unfunded versus funded studies. This same association was found for fat mass and percent body fat congruent with combined aerobic and strength training interventions as well as for percent body fat and strength training. One possible and broad explanation for these associations may be that funded studies are of higher quality than unfunded studies. Third, greater compliance, defined as the percentage of



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exercise sessions attended, was associated with greater reductions in both BMI in kg·m<sup>2</sup> as well as fat mass as a result of aerobic exercise. These associations appear plausible given that greater reductions should be expected if exercise attendance is greater.

Fourth, greater reductions in BMI in kg·m<sup>2</sup> were associated with greater total minutes of exercise per week as a result of aerobic exercise. When adjusted for compliance, total minutes of exercise per week were also associated with greater reductions in both BMI in kg·m<sup>2</sup> and fat mass as a result of aerobic exercise. These observed associations seem quite plausible. Fifth, larger reductions in both fat mass and percent fat were associated with studies that were at an unclear versus low risk of bias for selective reporting of study results. This might suggest a tendency for authors to selectively report results that are statistically significant. However, caution is warranted in the interpretation of these findings since a rating of unclear does not guarantee that selective reporting of results occurred, but rather, reflects a lack of available data to classify a study as either high or low risk. Sixth, the association between greater reductions in fat mass and percent fat as a result of shorter intervention length, i.e., weeks, as a result of aerobic exercise may represent a certain threshold in which no further benefits can be achieved. However, maintaining an exercise program is probably important as the cessation of training will most likely return adiposity levels back to their original values. Seventh, the association between greater reductions in fat mass as a result of high versus moderate-intensity aerobic exercise suggests that training regimes such as interval training may be optimal for reducing fat mass. However, this needs to be balanced with the possibility of placing the child and adolescent at an increased risk for injury as well as possible concerns about decreased compliance with high intensity

exercise programs. Eighth, the association between greater reductions in fat mass and more recent year of publication as a result of combined aerobic and strength exercise may reflect higher quality studies. In contrast, this may reflect an increased emphasis on investigators tending to report results that are large and statistically significant. Finally, the greater strength training reductions in percent fat as a result of studies that were at a low versus unclear risk of bias for participants not being physically active prior to study participation reflects the belief that those who are least active have the most to gain from an exercise program. Again however, a rating of unclear does not guarantee that subjects were physically active prior to study participation, but rather, reflects a lack of available data to classify a study as being at either a high or low risk of bias.

## Overall Findings for Secondary Outcomes

Across all three treatments, statistically significant improvements were observed for secondary outcomes. For aerobic exercise, these included reductions in body weight, waist circumference, resting systolic and diastolic blood pressure, total cholesterol, low density lipoprotein cholesterol, triglycerides, and fasting insulin, as well as increases in  $VO_{2max}$  in  $ml \cdot kg^{-1} \cdot min^{-1}$  and high-density lipoprotein cholesterol. For strength training, statistically significant reductions were limited to fasting insulin while combined aerobic and strength training resulted in statistically significant improvements in body weight, fat free mass,  $VO_{2max}$  in  $ml \cdot kg^{-1} \cdot min^{-1}$ , triglycerides, fasting glucose and fasting insulin. Thus, unlike most pharmacological interventions that are intended to target one condition and often include significant side effects, exercise, especially aerobic as well as combined aerobic and strength training, can yield significant improvements in both adiposity

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774 outcomes as well as a number of other outcomes in overweight and obese children and  
775 adolescents.

776 **Implications for Research**

777 There are several implications for reporting future randomised trials on exercise and  
778 adiposity in overweight and obese children and adolescents. First, given that reductions  
779 in adiposity are dependent on the balance between energy intake and expenditure,  
780 future randomised trials should track and report data on both energy intake and  
781 expenditure so that the independent effects of exercise on adiposity can be better  
782 quantified. Second, future studies should track and report the total physical activity  
783 levels of participants during the entire day in order to ensure that physical activity  
784 compensation is not occurring.[105] Third, a clear definition and accurate reporting of  
785 adverse events is needed so that the benefits and potential harms of exercise on  
786 adiposity in overweight and obese children can be more clearly delineated. Fourth, in  
787 order to better assess the quality of the study design, information should be provided  
788 about allocation concealment, blinding of outcome assessors, incomplete outcome data  
789 and reporting, as well as the physical activity levels of participants prior to taking part in  
790 the study. Fifth, given that less than half of the studies provided data on compliance to  
791 the exercise intervention, future studies should report this information since it can have  
792 a significant impact on outcomes. Along those lines, it is suggested that researchers  
793 adhere to the Consensus on Exercise Reporting Template (CERT) when designing their  
794 study and reporting exercise program information from their clinical trials.[106] Sixth,  
795 while none of the studies included waist-to-height ratio as an outcome and it was not  
796 part of our a priori protocol, future original studies may want to consider the inclusion of

797 such given that it has been shown to be an accurate predictor[107] and correlate[108] of  
798 cardiometabolic risk in children and adolescents.

799 In addition to reporting, there are several suggestions for the conduct of future  
800 research addressing the effects of exercise interventions on adiposity outcomes in  
801 overweight and obese children and adolescents. First, given the small number of direct  
802 studies included, a need exists for additional randomised trials that examine the effects  
803 of different exercise interventions head-to-head, as was done in the study by Sigal et al.  
804 [57] Ideally, this would include an aerobic, strength, and combined aerobic and strength  
805 training group as well as a control group. Such an approach would provide additional  
806 and possibly more valid information regarding the effects of each intervention on  
807 adiposity outcomes. Third, given the lack of follow-up data, a need exists for future  
808 studies that include follow-up assessment several weeks and/or months after the  
809 intervention period has ended. This would allow one to track both changes in adiposity  
810 outcomes as well as continued participation in exercise. Fourth, given the potential of  
811 calorie restriction for improving adiposity outcomes and the need to identify the best  
812 treatment, a need exists for a network meta-analysis that includes the following  
813 treatment arms: exercise, calorie restriction, exercise and calorie restriction, control.  
814 This would allow one to examine both the separate and combined effects of exercise  
815 and caloric restriction on adiposity outcomes in overweight and obese children and  
816 adolescents. In addition, research that includes a transition to a diet without processed  
817 foods[109] as well as sweetened beverages[110] would also be worthy of investigating.  
818 Finally, a need exists for cost-effectiveness analyses.

## 819 **Implications for Practice**



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820 The results of the current network meta-analysis have important implications for  
821 practice. First, given the statistically significant and clinically important improvements in  
822 adiposity outcomes, lack of adverse events for those that reported such data, and  
823 improvements observed for a number of secondary outcomes, exercise may be more  
824 vital than any other type of intervention for the overall physiological health of overweight  
825 and obese children and adolescents. While the current network meta-analysis was  
826 unable to determine the exact dose-response effects of exercise on adiposity in  
827 overweight and obese children and adolescents, it would appear reasonable to suggest  
828 that aerobic or combined aerobic and strengthening exercise would be optimal. Along  
829 those lines, it is suggested that adherence to the recent 2018 guidelines for exercise  
830 and physical activity in children and adolescents be followed.[111] These include at  
831 least 60 minutes per day of moderate to vigorous physical activity, including a minimum  
832 of 3 days of vigorous intensity activity, as well as muscle-strengthening activities at least  
833 three days per week.[111] More broadly, it is recommended that clinicians and other  
834 healthcare practitioners adhere to the recent recommendations from the United States  
835 Preventive Service Task Force regarding screening for obesity in children and  
836 adolescents.[103] These recommendations include screening for obesity in children and  
837 adolescents  $\geq 6$  years of age and offering or referring them to comprehensive, intensive  
838 behavioral interventions to promote improvements in weight status.[103] Multi-  
839 component behavioral interventions that include, but are not necessarily limited to,  
840 exercising, healthy eating, and reductions in screen time may be optimal.[103] Reducing  
841 adiposity in overweight and obese children and adolescents will probably require  
842 intensive efforts given the obesogenic environments in which most people reside today.

## 843 **Implications for Policy**

844 Evidence-based policies play a pivotal role in reducing childhood obesity.[112] The  
845 results of the current network meta-analysis provide evidence to support policies aimed  
846 at increasing the exercise and physical activity habits of overweight and obese children  
847 and adolescents. This is especially relevant for policy given that one of the main  
848 reasons for conducting a network meta-analysis is to identify the best treatment(s) for a  
849 disease or condition. Broadly, the development of policies aimed at making exercise  
850 and physical activity safer, easier, and more appealing might be best.[112] More  
851 specifically, policies directed towards increasing active transportation and recreation as  
852 well as reducing sedentary behavior are probably important.[112] In addition, and most  
853 pertinent to the current network meta-analysis, policies aimed at increasing the number  
854 of overweight and obese children and adolescents who participate in exercise and  
855 physical activity programs that include aerobic and strength training according to current  
856 guidelines [111] is probably relevant. Finally, policies aimed at increasing exercise and  
857 physical activity for reducing childhood obesity should probably work in concert with  
858 food policies that aim to do the same.[112]

## 859 **Strengths and Limitations**

860 There are several strengths to this study. First, to the best of the investigative team's  
861 knowledge, this is the largest as well as first systematic review to use the network meta-  
862 analytic approach to determine the effects as well as hierarchy of exercise interventions  
863 (aerobic, strength training, or both) on BMI in kg/m<sup>2</sup>, fat mass and percent body fat in  
864 overweight and obese children and adolescents. This work is important for determining  
865 which type of exercise treatment(s) is/are best for reducing adiposity. Second, the

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866 results of this systematic review with network meta-analysis should be useful to  
867 researchers with respect to the conduct and reporting of future research on this topic,  
868 including priority areas. Third, the findings of the current study should be useful to  
869 practitioners and policy-makers for making informed decisions regarding the use of  
870 exercise in the treatment of overweight and obesity in children and adolescents. For  
871 example, clinicians and other healthcare personnel can include this information along  
872 with their own clinical judgment and parent/child preferences when making evidence-  
873 based decisions regarding the use of exercise in the treatment of adiposity in  
874 overweight and obese children and adolescents.

875 In addition to strengths, there are also several potential limitations. First, the number of  
876 effect sizes for some treatments and comparisons, for example strength training and fat  
877 mass, were small. As a result, there may have been a lack of statistical power to detect  
878 a true effect, assuming such an effect exists. Second, the results could have been  
879 affected by the different criteria used across the studies for determining overweight and  
880 obesity. In addition, since many studies used BMI to determine overweight and obesity,  
881 one or more studies may have excluded some eligible children and adolescents given  
882 that BMI has been shown to fail to identify more than 25% of children with excess body  
883 fat percentage.[113] Third, common to any type of aggregate data meta-analysis, meta-  
884 regression results do not support causal inferences because the included studies are  
885 not randomly assigned to covariates.[114] Thus, any of the associations observed in the  
886 current network meta-analysis should be tested in original randomised controlled trials.  
887 Fourth, because a large number of statistical tests were conducted, some of the  
888 statistically significant results observed may have been nothing more than the play of

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3 889 chance. However, common to most aggregate data meta-analyses, no adjustments for  
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5 890 multiple testing were made because of concerns about missing possibly important  
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7 891 findings that could be tested in original randomised controlled trials.[115] Fifth, the  
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9 892 results for the secondary outcomes in the current study may be a biased sample since  
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11 893 studies were only included if one or more measures of adiposity, our primary outcomes,  
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13 894 were assessed. Finally, common to all aggregate data meta-analyses, there is the  
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15 895 possibility of ecological fallacy, i.e., that group averages are not reflective of an  
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17 896 individual's values for variables that were reported on the group versus individual  
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19 897 level.[116]

## 23 898 **CONCLUSIONS**

26 899 The findings of the current network meta-analysis suggest that aerobic exercise as  
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28 900 well as combined aerobic and strength training exercise are associated with clinically  
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30 901 important reductions in selected measures of adiposity.  
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**ORIGINAL PROTOCOL FOR STUDY**

See Supplementary file 16.

**PRISMA CHECKLIST FOR NETWORK META-ANALYSIS**

See Supplementary file 17.

**CONTRIBUTORS**

GAK is the guarantor. GAK, KSK and RRP drafted the manuscript. All authors contributed to the development of the data sources to search for relevant literature, including search strategy, selection criteria, data extraction criteria and risk of bias assessment strategy. GAK provided statistical expertise while RRP provided content expertise on exercise and adiposity in overweight and obese children and adolescents. All authors read, provided feedback and approved the final manuscript.

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**COMPETING INTERESTS**

None declared.

**DATA AVAILABILITY**

Data for this aggregate data systematic review with meta-analysis is available from the corresponding author upon request. This data derives from summary data previously reported in studies published in peer-review journals.

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**FIGURE LEGENDS**

Figure 1. Flow diagram for selection of studies. Flow of information through the different phases of the systematic review and network meta-analysis.

Figure 2. Summary results for risk of bias. Grouped risk of bias results using the Cochrane Risk of Bias Instrument.

Figure 3. Network plot for BMI in kg·m<sup>2</sup>. Network plot for study comparisons included in the BMI in kg·m<sup>2</sup> network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively. Data are presented as the mean and 95% confidence intervals for the following comparisons: aerobic vs. control, strength vs. control, aerobic and strength vs. control, strength vs. aerobic, aerobic and strength vs. aerobic, and aerobic and strength vs. strength.

Figure 4. Interval plot for changes in BMI in kg·m<sup>2</sup>. Interval plot for changes in in BMI kg·m<sup>2</sup> based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 35/1533 (aerobic vs. control), 8/331 (strength versus control), 11/426 (combined aerobic and strength versus control), 7/232 (strength versus aerobic), 4/175 (combined aerobic and strength versus aerobic), 2/121 (combined aerobic and strength versus strength).

Figure 5. Network plot for fat mass (kg). Network plot for study comparisons included in the fat mass network meta-analysis. The nodes (circles) represent the different

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3 treatments while the edges (lines) represent the available direct comparisons between  
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5 pairs of treatments. Both nodes and edges are weighted by the number of studies  
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7 involved in each treatment and comparison, respectively. Data are presented as the  
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9 mean and 95% confidence intervals for the following comparisons: aerobic vs. control,  
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11 strength vs. control, aerobic and strength vs. control, strength vs. aerobic, aerobic and  
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13 strength vs. aerobic, and aerobic and strength vs. strength.  
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17 Figure 6. Interval plot for changes in fat mass (kg). Interval plot for changes in in fat  
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19 mass (kg) based on all pairwise comparisons. The diamond represents the point  
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21 estimate, the black horizontal lines between the vertical lines the 95% confidence  
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23 intervals, and the horizontal lines that extend beyond the vertical lines the 95%  
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25 prediction intervals. The number of effect sizes/participants were 19/945 (aerobic vs.  
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27 control), 7/271 (strength versus control), 10/376 (combined aerobic and strength versus  
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29 control), 4/167 (strength versus aerobic), 4/174 (combined aerobic and strength versus  
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31 aerobic), 2/119 (combined aerobic and strength versus strength).  
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35 Figure 7. Network plot for percent body fat. Network plot for study comparisons included  
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37 in the percent body fat network meta-analysis. The nodes (circles) represent the  
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39 different treatments while the edges (lines) represent the available direct comparisons  
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41 between pairs of treatments. Both nodes and edges are weighted by the number of  
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43 studies involved in each treatment and comparison, respectively. Data are presented as  
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45 the mean and 95% confidence intervals for the following comparisons: aerobic vs.  
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Figure 8. Interval plot for changes in percent body fat. Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 32/1602 (aerobic vs. control), 8/327 (strength versus control), 12/480 (combined aerobic and strength versus control), 6/201 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

## SUPPLEMENTARY FILES LIST

**Supplementary file 1.** Results of PubMed search.

**Supplementary file 2.** Planned covariates to examine for in meta-regression analyses.

**Supplementary file 3.** Reference list of excluded studies, including the reasons for exclusion.

**Supplementary file 4.** Characteristics of included studies.

**Supplementary file 5.** Cochrane risk of bias results for each element from each study.

**Supplementary file 6.** Network forest plot for changes in BMI in kg·m<sup>2</sup> based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow diamonds.

**Supplementary file 7.** Funnel plot of small-study effects for changes in BMI in kg·m<sup>2</sup>.

**Supplementary file 8.** Simple meta-regression results for changes in BMI (kg·m<sup>2</sup>) and potential covariates.

**Supplementary file 9.** Network forest plot for changes in fat mass (kg) based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow diamonds.

**Supplementary file 10.** Funnel plot of small-study effects for changes in fat mass (kg).

**Supplementary file 11.** Simple meta-regression results for changes in fat mass (kg) and potential covariates.

**Supplementary file 12.** Network forest plot for changes in percent body fat based on individual study results, grouped by treatment contrast and design. Markers for each point estimate are proportional to the inverse square of the standard error. Individual study results are shown as point estimates (squares) and 95% confidence intervals (lines), pooled estimates and 95% CIs within designs as hollow diamonds, and overall pooled results and 95% CIs for each of the six treatment contrasts as hollow diamonds.

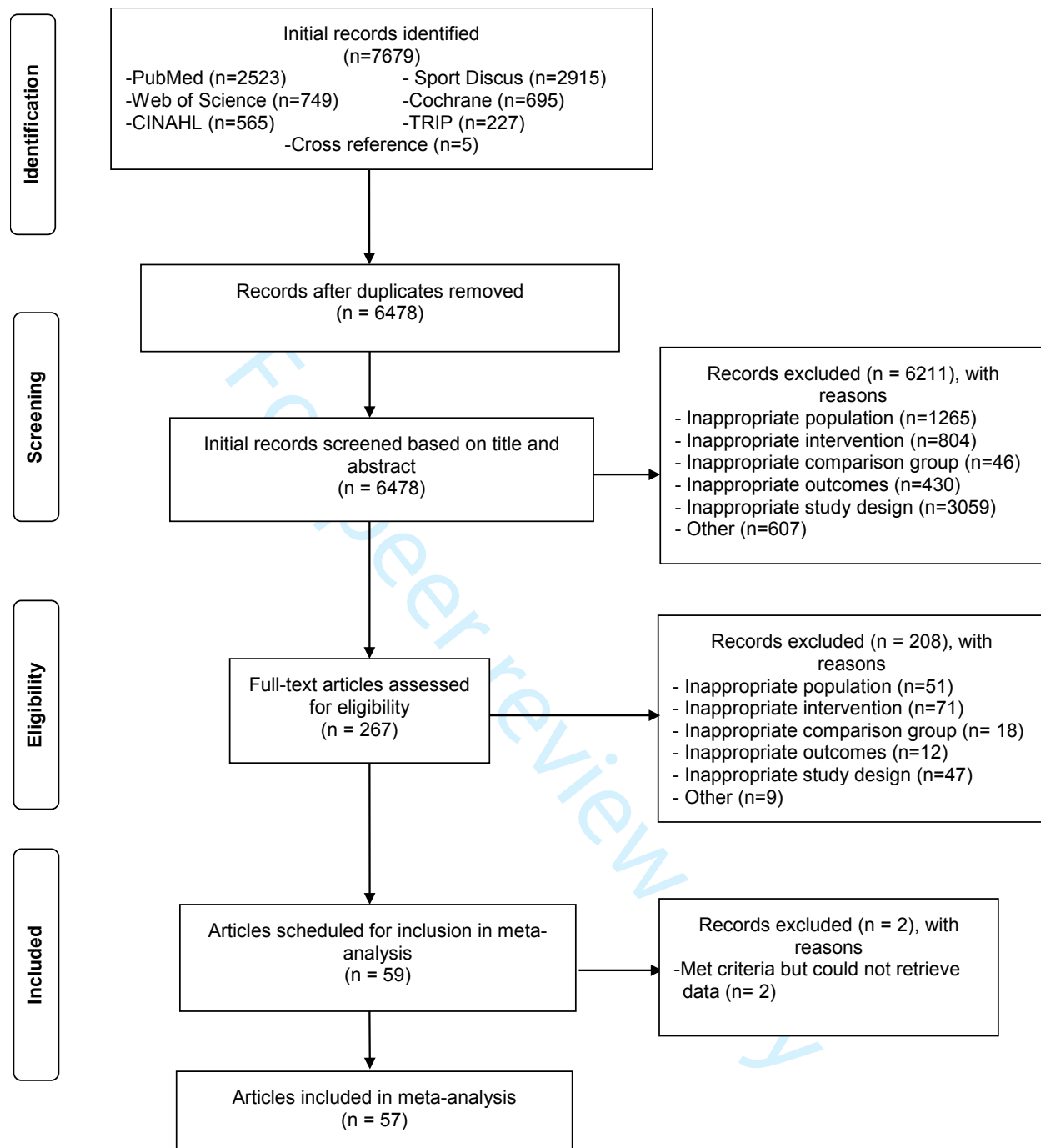
**Supplementary file 13.** Funnel plot of small-study effects for changes in percent body fat.

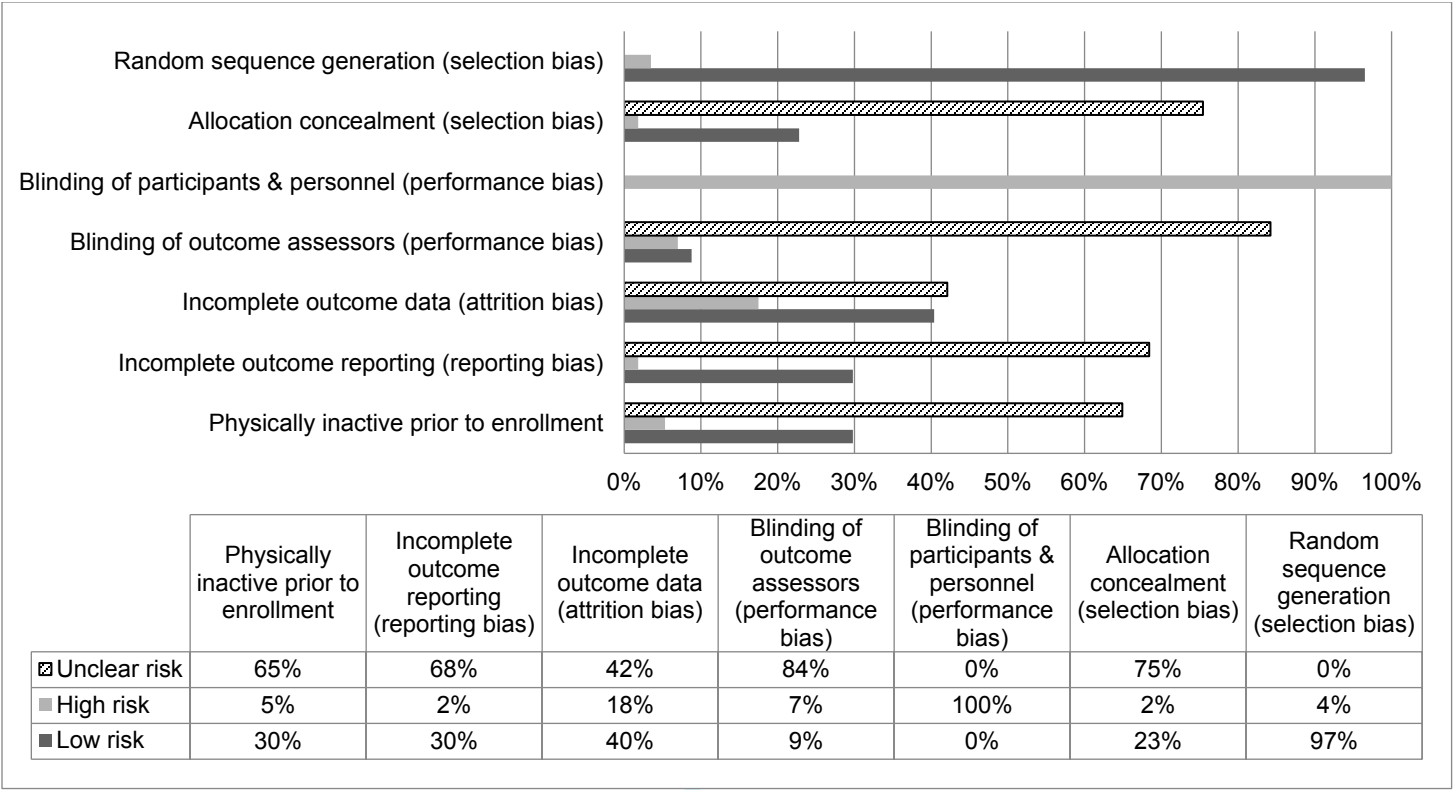
**Supplementary file 14.** Simple meta-regression results for changes in percent body fat and potential covariates.

**Supplementary file 15.** Treatment-specific changes in secondary outcomes.

**Supplementary file 16.** Original published protocol for study.

**Supplementary file 17.** PRISMA protocol checklist for a network meta-analysis.







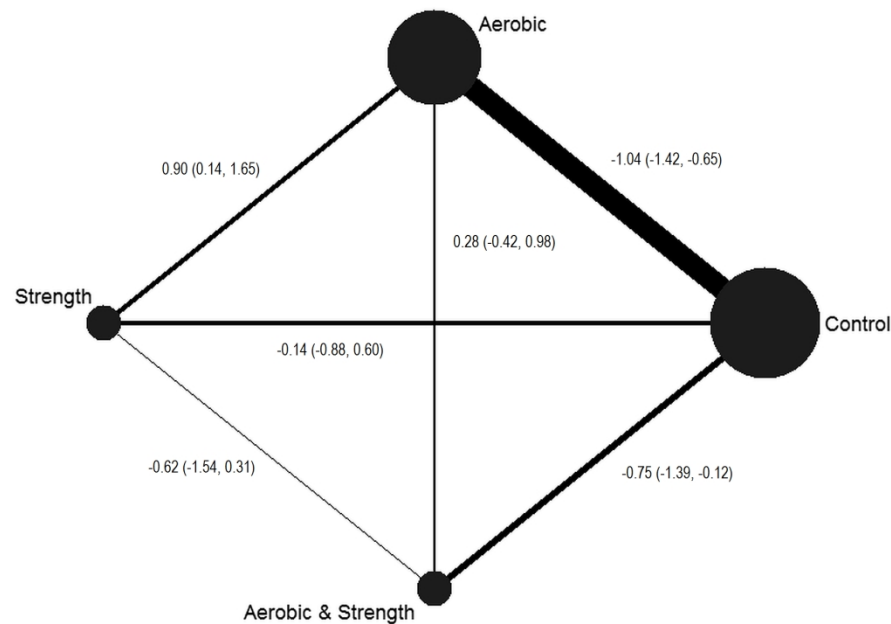
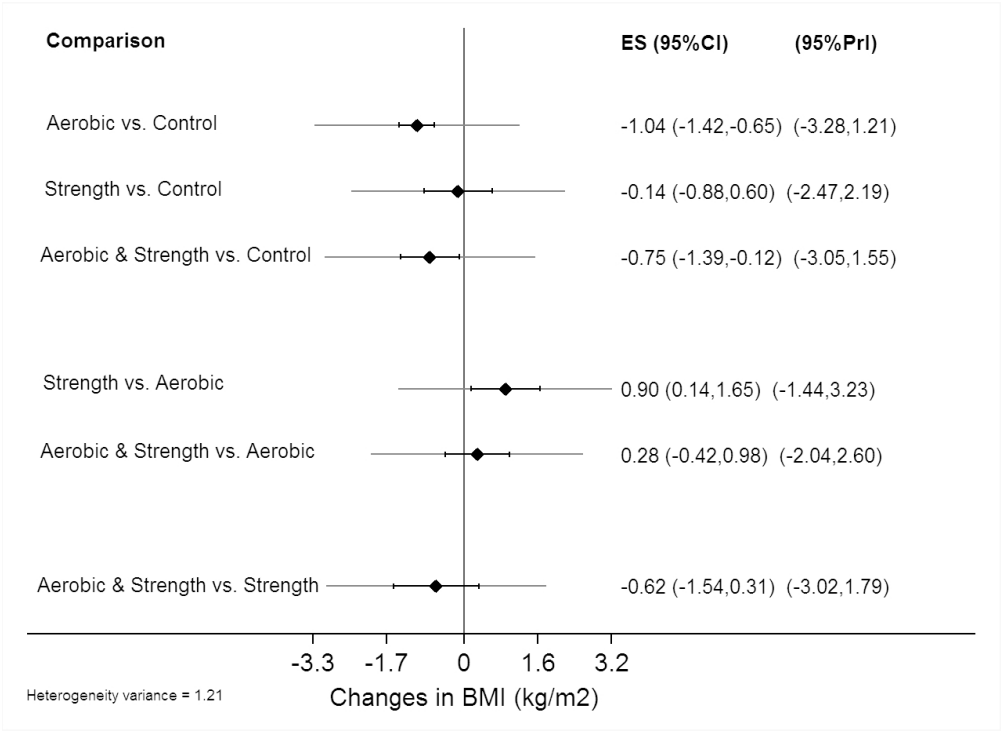


Figure 3. Network plot for BMI in  $\text{kg}\cdot\text{m}^2$ . Network plot for study comparisons included in the BMI in  $\text{kg}\cdot\text{m}^2$  network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively. Data are presented as the mean and 95% confidence intervals for the following comparisons: aerobic vs. control, strength vs. control, aerobic and strength vs. control, strength vs. aerobic, aerobic and strength vs. aerobic, and aerobic and strength vs. strength.

173x126mm (300 x 300 DPI)



Interval plot for changes in BMI in kg.m2. Interval plot for changes in in BMI kg.m2 based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 35/1533 (aerobic vs. control), 8/331 (strength versus control), 11/426 (combined aerobic and strength versus control), 7/232 (strength versus aerobic), 4/175 (combined aerobic and strength versus aerobic), 2/121 (combined aerobic and strength versus strength).

108x78mm (300 x 300 DPI)

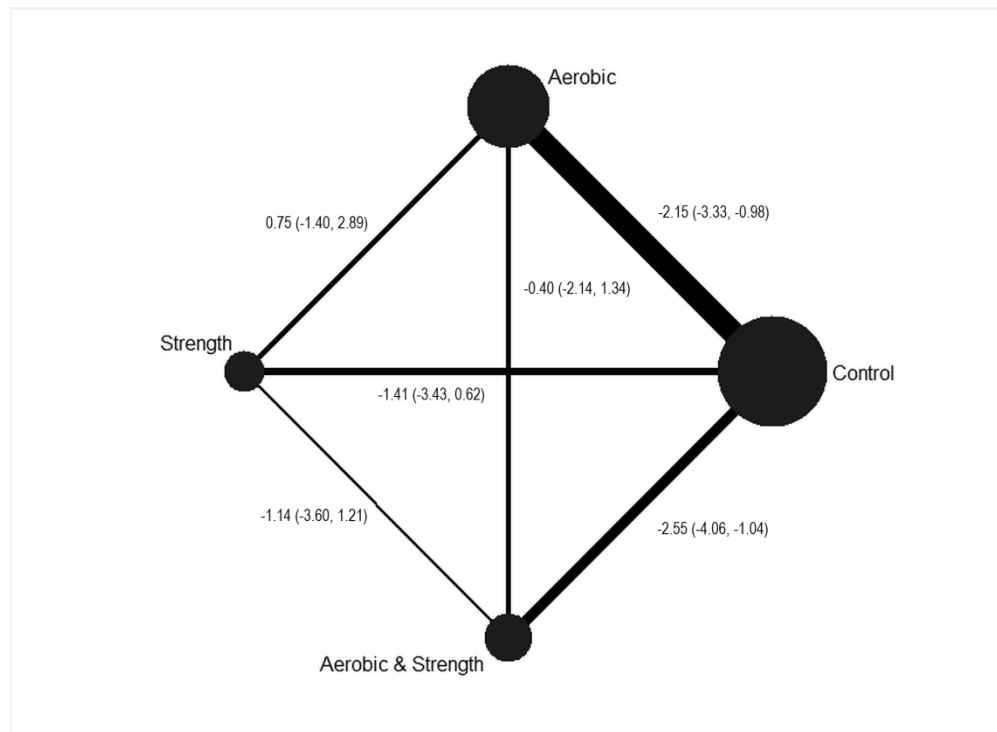
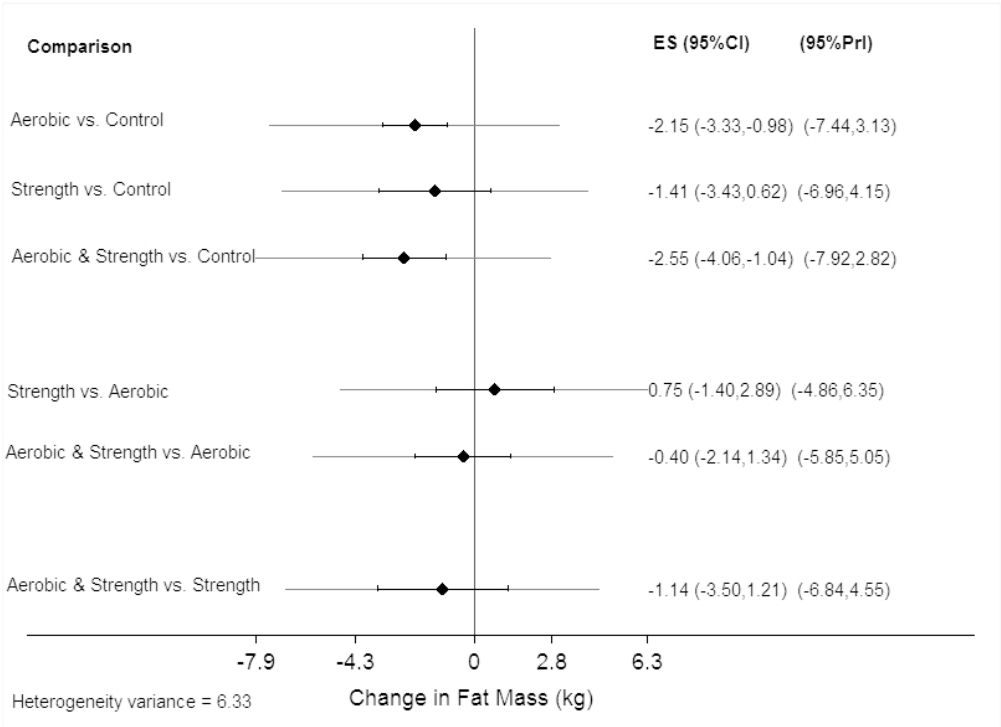


Figure 5. Network plot for fat mass (kg). Network plot for study comparisons included in the fat mass network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively. Data are presented as the mean and 95% confidence intervals for the following comparisons: aerobic vs. control, strength vs. control, aerobic and strength vs. control, strength vs. aerobic, aerobic and strength vs. aerobic, and aerobic and strength vs. strength.

173x126mm (300 x 300 DPI)



Interval plot for changes in fat mass (kg). Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 19/945 (aerobic vs. control), 7/271 (strength versus control), 10/376 (combined aerobic and strength versus control), 4/167 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

68x49mm (300 x 300 DPI)

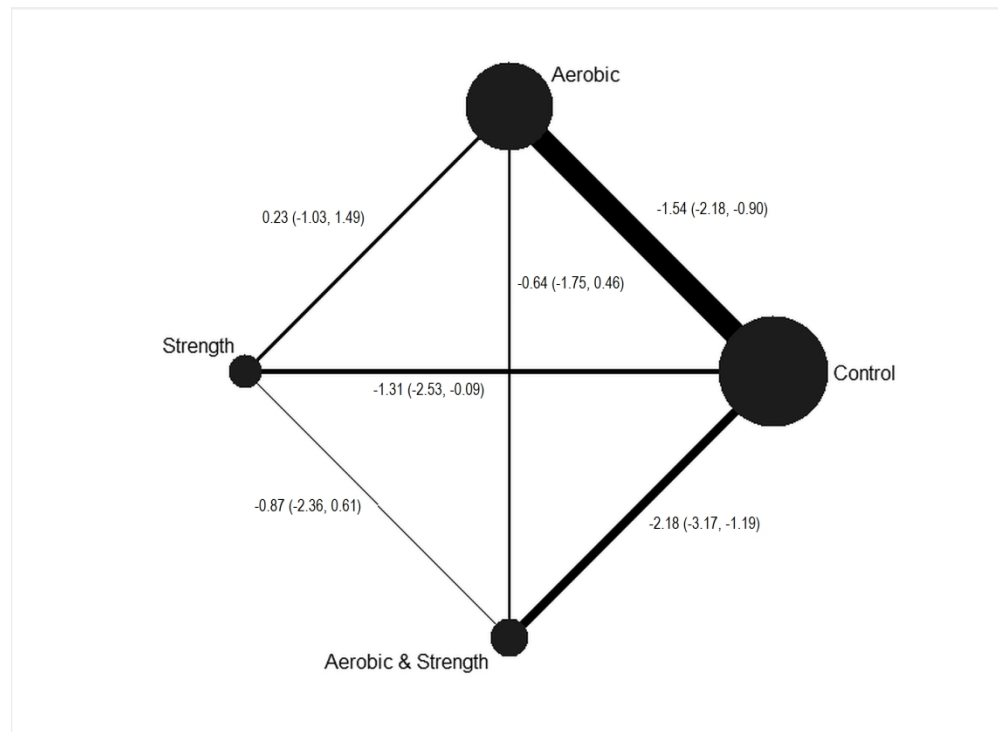
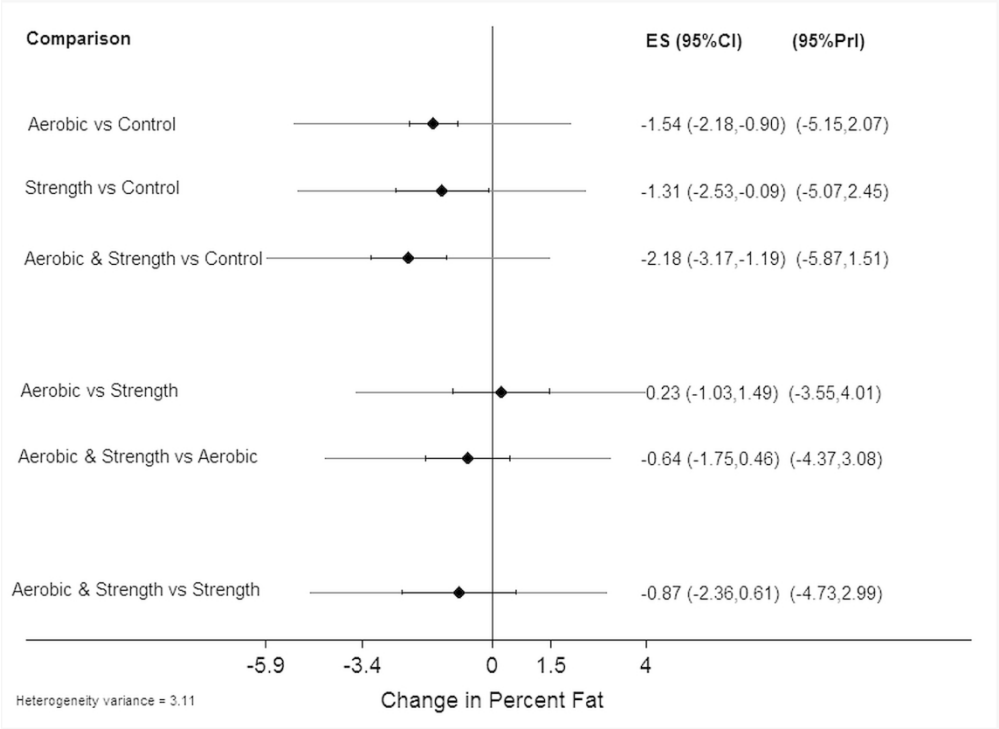


Figure 7. Network plot for percent body fat. Network plot for study comparisons included in the percent body fat network meta-analysis. The nodes (circles) represent the different treatments while the edges (lines) represent the available direct comparisons between pairs of treatments. Both nodes and edges are weighted by the number of studies involved in each treatment and comparison, respectively. Data are presented as the mean and 95% confidence intervals for the following comparisons: aerobic vs. control, strength vs. control, aerobic and strength vs. control, strength vs. aerobic, aerobic and strength vs. aerobic, and aerobic and strength vs. strength.

173x126mm (300 x 300 DPI)





Interval plot for changes in percent body fat. Interval plot for changes in in fat mass (kg) based on all pairwise comparisons. The diamond represents the point estimate, the black horizontal lines between the vertical lines the 95% confidence intervals, and the horizontal lines that extend beyond the vertical lines the 95% prediction intervals. The number of effect sizes/participants were 32/1602 (aerobic vs. control), 8/327 (strength versus control), 12/480 (combined aerobic and strength versus control), 6/201 (strength versus aerobic), 4/174 (combined aerobic and strength versus aerobic), 2/119 (combined aerobic and strength versus strength).

173x126mm (300 x 300 DPI)

Supplementary file 1. PubMed search.

(exercise OR physical activity OR physical fitness OR strength training OR weight training) AND (children OR adolescen\* OR boys OR girls) AND (overweight OR obes\*) AND random\* AND ( "1973/01/01"[125] : "2018/08/22"[125] ) AND Humans[Mesh] AND (infant[MeSH] OR child[MeSH] OR adolescent[MeSH])

For peer review only

Supplementary file 2. Planned covariates to examine.

Characteristics	Variable
Study	Publication year, impact factor of journal, country study conducted, type of control group, bias (sequence generation, allocation concealment, blinding of participants & personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting), type of analysis, funding
Participant	Age, gender, race/ethnicity, maturational stage
Exercise	Type (aerobic, strength, both), length, frequency, intensity, duration, total minutes, total minutes (adjusted for compliance), mode, compliance, exercise supervision, setting, number of sets, number of repetitions, rest between sets, number of exercises, type of resistance, equipment used, fidelity (design, training, delivery, receipt, enactment)
Outcome	Baseline values for primary outcomes (BMI in kg·m <sup>2</sup> , fat mass, percent fat), method used to assess adiposity, i.e., instrumentation

Supplementary file 3. Reference list of excluded studies, including the reasons for exclusion.

1. Notation of Additional Studies. *J Teach Phys Educ*. 1986;6(1):78-89. inappropriate study design
2. Fitness Can and Should Be Fun. *Journal of Sport Psychology*. 1987;9(2):87-88. inappropriate study design
3. Obesity and Cardiovascular Disease Risk Factors in Black and White Girls: The NHLB Growth and Health Study. *American journal of public health*. 1992;82(12):1613-1620. inappropriate study design
4. Health Related Fitness and Blood Pressure in Boys and Girls Ages 10 to 17 Years. *Pediatric exercise science*. 1992;4(2):128-135. inappropriate study design
5. Caltrac Validity for Estimating Caloric Expenditure With Children. *Pediatric exercise science*. 1992;4(2):166-179. inappropriate study design
6. Research Digest. *Pediatric exercise science*. 1992;4(1):5-9. inappropriate study design
7. Program schedule. *American journal of public health*. 1994;84(8):P-7. inappropriate outcomes
8. Two-Year Follow-Up on the Impact of Physical Fitness and Body Fatness on Children's Heart Growth and Rising Blood Pressure: The Muscatine Study. *Pediatric exercise science*. 1995;7(4):364-378. inappropriate study design
9. Children's Ratings of Effort During Cycle Ergometry: An Examination of the Validity of Two Effort Rating Scales. *Pediatric exercise science*. 1995;7(4):407-421. inappropriate outcomes
10. Program Schedule. *American journal of public health*. 1995;85(8):P-9-P-143. inappropriate outcomes
11. Bone Mineral and Muscle Strength Characteristics in Children With Turner Syndrome. *Pediatric exercise science*. 1995;7(1):80-93. inappropriate study design
12. Implementation of treatment protocols in the Diabetes Control and Complications Trial. *Diabetes care*. 1995;18(3):361-376. <http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/332/CN-00118332/frame.html>. inappropriate intervention
13. Is There a Scientific Rationale Supporting the Value of Exercise for the Present and Future Cardiovascular Health of Children? The Pro Argument. *Pediatric exercise science*. 1996;8(4):294-302. inappropriate study design
14. Exercise Regulation During Cycle Ergometry Using the Children's Effort Rating Table (CERT) and Rating of Perceived Exertion (RPE) Scales. *Pediatric exercise science*. 1996;8(4):337-350. inappropriate outcomes
15. Program Schedule. *American journal of public health*. 1996;86(8):P-9-P-176. inappropriate study design
16. Physical Activity, Fitness, and Adiposity of Prepubertal Girls. *Pediatric exercise science*. 1996;8(3):259-267. inappropriate study design
17. Validity and Reliability of the 1/2-Mile Run-Walk as an Indicator of Aerobic Fitness in Children With Mental Retardation. *Pediatric exercise science*. 1996;8(2):130-142. inappropriate outcomes

18. Response to Resistance Training in Pediatric Wheelchair Users. *Pediatric exercise science*. 1996;8(1):6-14. inappropriate study design
19. Conference Proceedings. *Canadian Journal of Applied Physiology*. 1997;22:1P-66P. other
20. Of interest from the journals. *Australian Journal of Nutrition & Dietetics*. 1998;55(4):178-193. other
21. PART IV: PHYSIOLOGY. *Journal of sports sciences*. 1998;16(1):31-68. other
22. PART V: PSYCHOLOGY. *Journal of sports sciences*. 1998;16(1):68-110. other
23. 3rd Baltic bone and cartilage conference. *Acta Orthopaedica Scandinavica*. 1999;70:1. other
24. Of interest from the journals. *Australian Journal of Nutrition & Dietetics*. 2000;57(4):247-247. other
25. Body Attitude, Gender, and Self-Concept: A 30-Year Perspective. *Journal of Psychology*. 2001;135(4):413. inappropriate population
26. Carbohydrate advantage-going the distance in weight management Proceedings of the Kellogg's Nutrition Symposium 2000 Sydney. 8 August 2000. *Australian Journal of Nutrition & Dietetics*. 2001;58(1):S2-S32. other
27. Of interest from the journals. *Nutrition & Dietetics*. 2002;59(4):270-272. other
28. Policy Statements Adopted by the Governing Council of the American Public Health Association, October 24, 2001. *American journal of public health*. 2002;92(3):451-483. other
29. Of interest from the journals. *Nutrition & Dietetics*. 2003;60(3):218. other
30. PART III: KINANTHROPOMETRY. *Journal of sports sciences*. 2003;21(4):293. other
31. Position of the American Dietetic Association, Society for Nutrition Education, and American School Food Service Association: Nutrition Services: An Essential Component of Comprehensive School Health Programs. *Journal of Nutrition Education & Behavior*. 2003;35(2):57. other
32. Using skinfold calipers while teaching body fatness-related concepts: cognitive and affective outcomes. *Journal of science and medicine in sport / Sports Medicine Australia*. 2003. inappropriate outcomes
33. Thursday 12th August 2004. *International Journal of Psychology*. 2004;39(5/6):346-472. inappropriate study design
34. Other Publications. *Pediatric exercise science*. 2004;16(3):296-297. other
35. Abstracts for the International Society for Aging and Physical Activity's 6th World Congress on Aging and Physical Activity: From Research to Action for an Aging Society London, Ontario, Canada, August 3-7, 2004. *Journal of Aging & Physical Activity*. 2004;12(3):246-460. inappropriate study design
36. FREE COMMUNICATIONS. *Journal of sport & exercise psychology*. 2004;26:S25-S206. other
37. Use of air displacement plethysmography in the determination of percentage of fat mass in african american children. *Pediatric research*. 2004. inappropriate study design
38. ABSTRACTS. *Canadian Journal of Applied Physiology*. 2005;30:3-S88. inappropriate study design
39. DataBase Citations Chart. *Am J Health Promot*. 2005;19(6):450-452. other



40. Research Digest. *Pediatric exercise science*. 2005;17(2):201. inappropriate outcomes
41. The following abstracts were presented at the biennial meeting of the North American Society for Pediatric Exercise Medicine, held in St. Andrews, New Brunswick, August 13-16, 2004. *Pediatric exercise science*. 2005;17(1):72. inappropriate study design
42. Efficacy of an internet-based behavioral weight loss program for overweight adolescent African-American girls. *Eating and weight disorders : EWD*. 2005. inappropriate intervention
43. Position of the American Dietetic Association: individual-, family-, school-, and community-based interventions for pediatric overweight. *Journal of the American Dietetic Association*. 2006;106(6):925-945. inappropriate study design
44. Abstracts. *Am J Health Promot*. 2006;21(2):141-144. inappropriate study design
45. Determinants of Physical Activity in an Inclusive Setting. *Adapted Physical Activity Quarterly*. 2006;23(4):390-409. inappropriate study design
46. Abstracts of the 85th Scientific Meeting of the Society for the Study of Human Biology held at University of Westminster, London, 11 May 2006. *Annals of human biology*. 2006;33(5/6):651-661. inappropriate study design
47. Real Men Do Not Read Labels: The Effects of Masculinity and Involvement on College Students' Food Decisions. *Journal of American College Health*. 2006;55(2):91-98. inappropriate study design
48. Weightlifting may help overweight teens reduce risk of diabetes. *O&P Business News*. 2006;15(17):57-57. inappropriate study design
49. Smaller bowls and spoons may curb consumption. *O&P Business News*. 2006;15(17):57-58. inappropriate outcomes
50. Secular Changes in Anaerobic Test Performance in Australasian Children and Adolescents. *Pediatric exercise science*. 2006;18(3):314-328. inappropriate study design
51. Secular Changes in Shuttle-Run Performance: A 23-Year Retrospective Comparison of 9- to 11-Year-Old Children. *Pediatric exercise science*. 2006;18(3):364-373. inappropriate study design
52. Poster Session Abstracts. *Psychophysiology*. 2006;43:S20-S110. inappropriate study design
53. RETRIEVAL AND REVIEW. *J Teach Phys Educ*. 2006;25(3):329-340. other
54. Abstracts of the Canadian Society for Clinical Nutrition's 5th Annual Scientific Meeting with guest societies the Canadian Society for Nutritional Sciences and the Canadian Society for Exercise Physiology / Résumés de la 5e assemblée annuelle de la Société Canadienne de Nutrition Clinique avec les sociétés invitées La Société Canadienne de Sciences de la Nutrition et La Société Canadienne de Physiologie de l'Exercice. *Applied Physiology, Nutrition & Metabolism*. 2006;31(3):331-365. inappropriate study design
55. Speaker Abstracts. *Isokinetics & Exercise Science*. 2006;14(2):111-152. inappropriate study design
56. APAC ACTION: New Executive Director. *Palaestra*. 2006;22(3):8-9. other
57. ECAS 2006 Abstracts and Program. European Cardiac Arrhythmia Society 2nd Annual Congress, April 2-4, 2006, Palais des Congrès, Parc Chanot Marseille,

- France. *Pacing & Clinical Electrophysiology*. 2006;29:S1-S103. inappropriate study design
58. Abstracts – Oral Presentations. *Nutrition & Dietetics*. 2006;63:A1-A24. inappropriate study design
59. Abstracts – Poster Presentations. *Nutrition & Dietetics*. 2006;63:A25-A56. inappropriate study design
60. DIGEST. *Adapted Physical Activity Quarterly*. 2006;23(1):98-101. other
61. Effective dietary interventions for overweight and obese children. *Australian nursing journal (July 1993)*. 2007;14(11):31-34. inappropriate intervention
62. Proceedings of the 2(nd) International Symposia on Lifestyle-related Disease Perspective for Primary Prevention and Treatment in Animal Models and Humans, 21--22 October 2006, Nishinomiya, Japan. *Clinical & Experimental Pharmacology & Physiology*. 2007;34:S1-S97. other
63. Abstracts of the 86th Scientific Meeting of the Society for the Study of Human Biology held at University of Oxford, 31 May 2007. *Annals of human biology*. 2007;34(6):684-696. inappropriate study design
64. THE DIGEST. *Journal of sport & exercise psychology*. 2007;29(5):673-680. inappropriate study design
65. 2007 CSEP Annual Scientific Conference / 2007 Conférence Scientifique Annuel de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2007;32:S1-S98. other
66. Abstracts. *Nutrition & Dietetics*. 2007;64:S77-S97. inappropriate study design
67. Annual conference of the british association of sport and exercise sciences. *Journal of sports sciences*. 2007;25(3):235-369. inappropriate study design
68. Stress reactivity and adiposity of youth. *Obesity*. 2007. inappropriate outcomes
69. Contents / Sommaire. *Applied Physiology, Nutrition & Metabolism*. 2008;33(6):C-1-C-9. other
70. Abstracts. *Psychology & health*. 2008;23:15-278. inappropriate study design
71. 2008 CSEP Annual Scientific Conference / 2008 Conférence scientifique annuelle de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2008;33:S1-S113. inappropriate study design
72. Abstracts of the Canadian Society for Clinical Nutrition's 7th Annual Scientific Meeting: The Road to Excellence in Canadian Nutrition / Résumés de la 7e rencontre scientifique annuelle intitulée « The Road to Excellence in Canadian Nutrition » de la Société canadienne de nutrition clinique. *Applied Physiology, Nutrition & Metabolism*. 2008;33(3):603-640. inappropriate study design
73. Oral program. *Nutrition & Dietetics*. 2008;65:A1-A24. inappropriate study design
74. Posters. *Nutrition & Dietetics*. 2008;65:A25-A48. inappropriate study design
75. APPM MEETING ABSTRACTS. *Pain Medicine*. 2008;9(1):88-141. inappropriate study design
76. Promoting physical activity in middle school girls: Trial of Activity for Adolescent Girls. *American journal of preventive medicine*. 2008. inappropriate population
77. Effects of a classroom-based weight-control intervention on cardiovascular disease in elementary-school obese children. *Acta paediatrica Taiwanica = Taiwan er ke yi xue hui za zhi*. 2008. inappropriate intervention
78. Author and content indices. *International Journal of Food Sciences & Nutrition*. 2009;60(8):728-757. other

79. Changing Health Practitioner's Attitudes to Physical Activity Promotion: Is More Than a Pedometer Needed? *Journal of sport & exercise psychology*. 2009;31(5):675-676. inappropriate outcomes
80. Overweight Adolescents: Don't Blame It on the Television! *Journal of sport & exercise psychology*. 2009;31(5):676-677. inappropriate study design
81. Illness and Medical Bills Linked to Nearly Two-Thirds of All Bankruptcies. *O&P Business News*. 2009;19(18):62-63. other
82. Poster and oral presentations (In alphabetical order by first author). *Psychology & health*. 2009;24:71-419. inappropriate study design
83. Abstracts of the Canadian Society for Clinical Nutrition's 8th Annual Scientific Meeting / Résumés de le 8e rencontre scientifique annuelle intitulée de la Société canadienne de nutrition clinique. *Applied Physiology, Nutrition & Metabolism*. 2009;34(3):495-550. inappropriate study design
84. RESEARCH DIGEST. *Pediatric exercise science*. 2009;21(2):240-246. inappropriate study design
85. Abstracts of the Canadian Obesity Network's 1st National Obesity Summit / Résumés du premier congrès national sur l'obésité du Réseau canadien en obésité. *Applied Physiology, Nutrition & Metabolism*. 2009;34(2):235-305. inappropriate study design
86. Oral Program. *Nutrition & Dietetics*. 2009;66:A1-A24. inappropriate study design
87. Socio-economic differentiation of the growth and the dietary intake of Polish boys aged 7-16 years. *Annals of human biology*. 2009;36(2):199-210. inappropriate study design
88. The Use and Effectiveness of a Teaching Style Centered on Self-Determination Theory in an Exercise Setting. *Journal of sport & exercise psychology*. 2009;31(1):119-120. inappropriate population
89. A Complex Ecological System Is Hindering Youth Weight Management Practices. *Journal of sport & exercise psychology*. 2009;31(1):122-123. inappropriate study design
90. Thin and Happy, or Fat and Sad: Are They Related? *Journal of sport & exercise psychology*. 2009;31(1):123-123. inappropriate study design
91. Abstracts. *Journal of sports sciences*. 2009;27:1-133. inappropriate study design
92. Sixth International Conference on Sport, Leisure and Ergonomics: 14-16 November 2007. *Journal of sports sciences*. 2009;27:1-35. inappropriate study design
93. Psychopharmacological Treatment of Oppositional Defiant Disorder. *CNS Drugs*. 2009;23(1):1-17. inappropriate outcomes
94. The effect of a physical activity intervention on bias in self-reported activity. *Annals of epidemiology*. 2009. inappropriate study design
95. School randomised trial on prevention of excessive weight gain by discouraging students from drinking sodas. *Public health nutrition*. 2009. inappropriate intervention
96. An adolescent weight-loss program integrating family variables reduces energy intake. *Journal of the American Dietetic Association*. 2009. inappropriate outcomes
97. Design of a family-based lifestyle intervention for youth with type 2 diabetes: the

TODAY study. *International journal of obesity* (2005). 2010;34(2):217-226. inappropriate study design

98. Türkiye'de Medulla Spinalis Yaralanması Rehabilitasyonunun Tarihçesi. / The Short History of Spinal Cord Injury Rehabilitation in Turkey. *Turkish Journal of Physical Medicine & Rehabilitation / Türkiye Fiziksel Tıp ve Rehabilitasyon Dergisi*. 2010;56:59-63. other

99. Contents / Sommaire. *Applied Physiology, Nutrition & Metabolism*. 2010;35(6):C-1-C-6. inappropriate study design

100. SYMPOSIA SUMMAIRES. *Journal of physical activity & health*. 2010;7:S313-S367. inappropriate study design

101. Physical activity and adolescents: An exploratory randomized controlled trial investigating the influence of affective and instrumental text messages. *British Journal of Health Psychology*. 2010;15(4):825-840. inappropriate intervention

102. To Be Thin: Disordered Eating Among Adolescent Elite Athletes and Non-Athletes. *Journal of sport & exercise psychology*. 2010;32(5):740-741. other

103. Abstracts of the 2010 CSEP General Meeting / Résumés de la 2010 Congrès annuelle de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2010;35(s):S1-S116. inappropriate study design

104. Poster Session Abstracts. *Psychophysiology*. 2010;47:S21-S105. inappropriate study design

105. Abstracts from the 11th International Congress of Behavioral Medicine. *International journal of behavioral medicine*. 2010;17:1-329. inappropriate study design

106. Oral presentations (In alphabetical order by first author). *Psychology & health*. 2010;25:15-100. inappropriate study design

107. Symposia (In alphabetical order by convenor). *Psychology & health*. 2010;25:101-131. inappropriate study design

108. Poster presentations (In alphabetical order by first author). *Psychology & health*. 2010;25:137-376. inappropriate study design

109. Dr. Karola Messner Foundation. *Scandinavian journal of medicine & science in sports*. 2010;20(4):706-707. other

110. Abstracts of the Canadian Nutrition Society's 9th Annual Scientific Meeting / Résumés de la 9e rencontre scientifique annuelle intitulée de la Société canadienne de nutrition. *Applied Physiology, Nutrition & Metabolism*. 2010;35(3):365-437. inappropriate study design

111. Poster Program: Programs are listed alphabetically by first author. *Nutrition & Dietetics*. 2010;67:22-68. inappropriate study design

112. Programs are listed alphabetically by first author. *Nutrition & Dietetics*. 2010;67:xiv-xxiii. inappropriate study design

113. Abstracts of the 51st Symposium of the Society for the Study of Human Biology, 18–20 June 2009, Rome, Italy. *Annals of human biology*. 2010;37(3):451-474. inappropriate study design

114. On Avoiding Rejection, Revisited. *Pediatric exercise science*. 2010;22(2):173-175. other

115. DIFFERENCES BETWEEN BOYS AND GIRLS IN TERMS OF PHYSICAL ACTIVITY. / RAZLIKE IZMEĐU DJEČAKA I DJEVOJČICA U FIZIČKOJ



- AKTIVNOSTI. *Facta Universitatis: Series Physical Education & Sport*. 2010;8(1):1-7. inappropriate study design
116. Vitamin D status in female military personnel during combat training. *Journal of the International Society of Sports Nutrition*. 2010;7:38-42. inappropriate population
  117. A randomized controlled trial of culturally tailored dance and reducing screen time to prevent weight gain in low-income African American girls: Stanford GEMS. *Archives of pediatrics & adolescent medicine*. 2010. inappropriate population
  118. Serving of free school lunch to secondary-school pupils - a pilot study with health implications. *Public health nutrition*. 2010. inappropriate intervention
  119. Abstracts. *Drug & Alcohol Review*. 2011;30:2-92. inappropriate study design
  120. RESUMO. *Motricidade*. 2011;7:5-80. inappropriate study design
  121. Abstracts of the 2011 CSEP General Meeting / Résumés de la 2011 Congrès annuelle de la SCPE. *Applied Physiology, Nutrition & Metabolism*. 2011;36:S299-S360. inappropriate study design
  122. A. Oral presentations. *Psychology & health*. 2011;26:6-72. inappropriate study design
  123. B. Interactive poster presentations. *Psychology & health*. 2011;26:73-253. inappropriate study design
  124. D. Symposium. *Psychology & health*. 2011;26:281-338. inappropriate study design
  125. Poster Session Abstracts. *Psychophysiology*. 2011;48(S1):S21-S119. inappropriate study design
  126. Poster und Freie Mitteilungen. *Schweizerische Zeitschrift für Sportmedizin & Sporttraumatologie*. 2011;2011(3):137-140. inappropriate study design
  127. The use of silhouette to determine body distortion and body dissatisfaction in African American and Caucasian college age females. *International Journal of Fitness*. 2011;7(2):1-8. inappropriate population
  128. Dietitians Association of Australia 29. *Nutrition & Dietetics*. 2011;68:1-22. inappropriate study design
  129. Backward walking training improves balance in school-aged boys. *SMARTT: Sports Medicine, Arthroscopy, Rehabilitation, Therapy & Technology*. 2011;3(1):24-30. inappropriate outcomes
  130. Australian and New Zealand Obesity Society Annual Scientific Meeting 2011. *Obesity research & clinical practice*. 2011;5.  
<http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/813/CN-01003813/frame.html>. inappropriate study design
  131. Abstracts of the 18th European Congress on Obesity, ECO 2011. *Obes Rev*. 2011;12. <http://onlinelibrary.wiley.com/o/cochrane/clcentral/articles/422/CN-01003422/frame.html>. inappropriate study design
  132. Cardiometabolic biomarkers in young black girls: relations to body fatness and aerobic fitness, and effects of a randomized physical activity trial. *International journal of pediatrics*. 2011. inappropriate population
  133. A 10-month physical activity intervention improves body composition in young black boys. *Journal of obesity*. 2011. inappropriate population



134. The Effect of Dietary Fish Oil in addition to Lifestyle Counselling on Lipid Oxidation and Body Composition in Slightly Overweight Teenage Boys. *Journal of nutrition and metabolism*. 2011. inappropriate intervention

135. The 'Healthy Dads, Healthy Kids' randomized controlled trial: efficacy of a healthy lifestyle program for overweight fathers and their children. *EvidenceUpdates*. 2011. inappropriate intervention

136. Impact of intensive school-based nutrition education and lifestyle interventions on insulin resistance,  $\beta$ -cell function, disposition index, and subclinical inflammation among Asian Indian adolescents: a controlled intervention study. *Metabolic syndrome and related disorders*. 2011. inappropriate intervention

137. Pilot evaluation of the HELENA (Healthy Lifestyle in Europe by Nutrition in Adolescence) Food-O-Meter, a computer-tailored nutrition advice for adolescents: a study in six European cities. *Public health nutrition*. 2011. inappropriate intervention

138. UP1 HomeStyles: Shaping Home Environments and Lifestyle Practices to Prevent Childhood Obesity: A Randomized Controlled Trial. *Journal of Nutrition Education & Behavior*. 2012;44(4S1):S81-S81. inappropriate study design

139. UP6 Healthy Caregivers-Healthy Children (HC2): A Childcare Center-based Obesity Prevention Program. *Journal of Nutrition Education & Behavior*. 2012;44(4S1):S82-S82. inappropriate study design

140. Serum leptin is not correlated with body fat in severe food restriction. *Applied Physiology, Nutrition & Metabolism*. 2012;37(6):1063-1071. inappropriate population

141. Physical activity, energy intake, and obesity prevalence among urban and rural schoolchildren aged 11-12 years in Japan. *Applied Physiology, Nutrition & Metabolism*. 2012;37(6):1189-1199. inappropriate study design

142. Abstracts of XVIIth FINA World Sports Medicine Congress. *Journal of Sports Science & Medicine*. 2012;11(4):775-791. inappropriate study design

143. Beverage patterns among Canadian children and relationship to overweight and obesity. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):900-906. inappropriate study design

144. Discussion of 'Overweight and obese boys reduce food intake in response to a glucose drink but fail to increase intake in response to exercise of short duration'. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):1014-1015. inappropriate study design

145. Reply to the discussion of 'Overweight and obese boys reduce food intake in response to a glucose drink but fail to increase intake in response to exercise of short duration'. *Applied Physiology, Nutrition & Metabolism*. 2012;37(5):1016-1017. inappropriate study design

146. Abstracts from the ICBM 2012 Meeting. *International journal of behavioral medicine*. 2012;19:1-341. inappropriate study design

147. Conference Day 1 - Wednesday 5 September 2012. *Nutrition & Dietetics*. 2012;69:2-20. inappropriate study design

148. Conference Day 2 - Thursday 6 September 2012. *Nutrition & Dietetics*. 2012;69:20-47. inappropriate study design

149. Conference Day 3 - Friday 7 September 2012. *Nutrition & Dietetics*. 2012;69:47-

70. inappropriate study design
150. Final Session - Saturday 8 September 2012. *Nutrition & Dietetics*. 2012;69:70-71. inappropriate study design
151. Poster Session Abstracts. *Psychophysiology*. 2012;49(S1):S24-S121. inappropriate study design
152. Abstracts of 53rd Symposium of the Society for the Study of Human Biology celebrating the Human Biology of Jim Tanner held at Corpus Christi College, Cambridge, 13-15 December 2011. *Annals of human biology*. 2012;39(5):448-458. inappropriate study design
153. Cardiorespiratory and metabolic responses associated with children's physical activity during self-paced games. *Canadian Journal of Physiology & Pharmacology*. 2012;90(9):1269-1276. inappropriate study design
154. SYMPOSIA. *Journal of sport & exercise psychology*. 2012:S5-S63. inappropriate study design
155. Free Papers. *Knee Surgery, Sports Traumatology, Arthroscopy*. 2012;20:5-100. inappropriate study design
156. Posters. *Knee Surgery, Sports Traumatology, Arthroscopy*. 2012;20:101-370. inappropriate study design
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Supplementary file 4. Study characteristics.

Study	Year	Country	N	Age (yrs) ( $\bar{X} \pm SD$ ) or Range	Sex	Overweight/Obesity Criteria
Ackel-D'Elia et al.[13]*	2014	Brazil	AE = 24 AE+ST = 24	AE, AE+ST = 16.5 $\pm$ 1.5	MF	All classified as obese (BMI $\geq$ 95th percentile) based on 2000 CDC BMI charts
Alberga et al.[14]	2013	Canada	AE+ST = 12 CON = 7	AE+ST = 10.0 $\pm$ 1.0 CON = 10.0 $\pm$ 2.0	MF	All classified as obese (BMI $\geq$ 95th percentile) based on 2000 CDC BMI charts
Alves et al.[15]	2008	Brazil	AE = 39 CON = 39	AE = 8.0 $\pm$ 1.8 CON = 7.9 $\pm$ 1.5	MF	BMI $\geq$ 85 percentile
Andre & Beguier[16]	2015	France	AE = 8 CON = 8	AE, CON 14.4 $\pm$ 1.5	MF	NA ( $\bar{X}$ BMI = 37.7 kg·m <sup>2</sup> )
Ben Ounis et al.[17]	2010	Tunisia	AE = 16 CON = 16	AE = 13.4 $\pm$ 0.4 CON = 13.2 $\pm$ 0.6	MF	All classified as obese (BMI $\geq$ 97 <sup>th</sup> percentile)



Berntsen et al.[18]	2010	Norway	ST = 32	ST, CON = 12.1	MF	All classified as obese (BMI >97.5 percentile)
			CON =			
			16			
Cao et al.[19]	2012	China	AE = 20	AE = NA	M	All classified as obese (BMI $\geq$ 25 kg·m <sup>2</sup> )
			CON =	CON = NA		
			20			
Chang et al.[20]	2008	China	AE+ST =	AE+ST = 12.6 $\pm$	MF	All classified as obese (BMIs $\geq$ 95th percentile for sex-specific age
			25	0.8		group Chinese children aged 7–18 years)
			CON =	CON = 12.2 $\pm$		
			24	0.1		
Chen et al.[21]	2015	China	AE =15	AE = 14.1 $\pm$ 3.1	NA	All classified as obese (BMI $\geq$ 25 kg·m <sup>2</sup> )
			ST = 15	ST = 13.9 $\pm$ 2.2		
			AE+ST =	AE+ST = 14.2 $\pm$		
			15	3.8		
			CON =	CON = 14.4 $\pm$		
			15	3.2		
Chen et al.[22]	2016	Taiwan	AE = 25	AE = 12.6 $\pm$ 0.7	MF	All classified as obese (BMI >24 kg·m <sup>2</sup> ), equivalent to the 95th
			CON =	CON = 12.8 $\pm$		percentile for Taiwan growth charts
			25	0.8		

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3	Cheng et al.[23]	2012	China	AE+ST =	AE+ST, CON =	M	All classified as obese (BMI ≥ 25 kg.m <sup>2</sup> )
4				30	13.0 to 14.0		
5							
6				CON =			
7							
8				30			
9							
10	Davis et al.[24]	2012	US	AE (LD)	AE (LD) = 9.3 ±	MF	BMI ≥ 85th percentile based on 2000 CDC growth charts
11				= 71	0.9		
12							
13				AE (HD)	AE (HD) = 9.4 ±		
14							
15				= 73	1.2		
16							
17				CON =	CON = 9.4 ± 1.1		
18							
19				78			
20							
21							
22	Elloumi et al.[25]	2011	Tunisia	AE = 7	AE = 13.1 ± 1.0	M	All classified as obese (> 97th percentile)
23							
24				CON = 8	CON = 13.2 ±		
25							
26					0.2		
27							
28	Farpour-Lambert et	2009	Switzerland	AE+ST =	AE+ST = 9.1 ±	MF	All classified as obese (BMI > 97th percentile based on age and
29							
30	al.[26]			22	1.4		sex)
31							
32				CON =	CON = 8.8 ± 1.6		
33							
34				22			
35							
36	Fazelifar et al.[27]	2013	Iran	AE+ST =	AE+ST, CON =	M	All classified as obese (BMI > 28 kg.m <sup>2</sup> )
37							
38				12	11-13		
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				CON =			
				12			
Fiorilli et al.[28]	2017	Italy	AE = 12	AE, ST(MI),	MF	Overweight or obese (BMI >85th percentile and body fat $\geq$ 25% for	
			ST(MI) =	ST(HI) = 12-15		boys and $\geq$ 30% for girls)	
			15				
			ST(HI) =				
			14				
Ghorbanian et	2013	Iran	AE = 15	AE = $17.4 \pm 1.1$	M	NA, but all classified overweight or obese by authors (BMI ( $\bar{X} \pm SD$ )	
al.[29]			CON =	CON = $16.9 \pm$		was $28.41 \pm 2.36 \text{ kg}\cdot\text{m}^{-2}$ )	
			15	1.2			
Gutin et al.[30]	1997	US	AE = 17	AE = $9.6 \pm 0.8$	MF	NA, but all classified as obese by authors ( $\bar{X}$ BMI was $31.4 \text{ kg}\cdot\text{m}^{-2}$ in	
			CON =	CON = $9.5 \pm 1.3$		exercise group and $28.8 \text{ kg}\cdot\text{m}^{-2}$ in control group)	
			18				
Hagstromer et	2009	Sweden	AE+ST =	AE+ST = $13.7 \pm$	MF	All classified as obese according to International of Obesity Task	
al.[31]			16	2.0		Force cutpoints	
			CON =	CON = $13.6 \pm$			
			15	2.2			
Hay et al.[32]	2016	Canada	AE(MI) =	AE(MI) = $15.1 \pm$	MF	Overweight or obese based on age- and sex-specific BMI standards	
			32	1.8			

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				AE(HI) =	AE(HI) = 15.3 ±		
				38	1.7		
				CON =	CON = 15.2 ±		
				33	1.7		
Karacabey[33]	2009	Turkey	AE = 20	AE = 11.8 ± 0.5	M	All classified as obese (BMI ≥ 30.0 kg.m <sup>2</sup> )	
			CON =	CON = 11.2 ±			
			20	0.2			
Kelly et al.[34]	2004	US	AE = 10	AE = 11.0 ± 2.0	MF	Overweight or obese (BMI ≥ 85 <sup>th</sup> percentile)	
			CON =	CON = 11.0 ±			
			10	2.3			
Kelly et al.[35]	2015	US	ST = 13	ST = 15.2 ± 0.9	MF	All classified as obese (BMI ≥ 95 <sup>th</sup> percentile) based on 2000 CDC	
			CON =	CON = 15.5 ±		BMI charts	
			13	0.9			
Kim et al. [36]	2007	SK	AE = 14	AE = 17 ± 0.4	M	NA, but classified as obese ( $\bar{X} \pm SD$ BMI in group was, 29.5 ± 2.2	
			CON =	CON = 17.0 ±		kg.m <sup>2</sup> )	
			12	0.4			
Kim et al. [37]	2008	SK	AE+ST =	AE+ST, CON =	M	Overweight or obese (BMI ≥ 85 <sup>th</sup> percentile based 1999 growth	
			8	NA		charts for Korean children and adolescents aged 2–18 years)	
			CON = 9				



Lau et al.[110]	2015	China	AE(LI) = 21	AE(LI) = $9.9 \pm 0.9$	MF	Overweight according to age-specific BMI cut-off values (boys >20.20 kg·m <sup>2</sup> and girls >20.29 kg·m <sup>2</sup> )
			AE(HI) = 15	AE(HI) = $11.0 \pm 0.6$		
			CON = 12	CON = $10.6 \pm 0.6$		
Lee et al.[39]	2012	US	AE = 16	AE = $15.2 \pm 0.9$	M	All classified as obese (BMI $\geq$ 95th percentile) based on 2000 CDC BMI charts
			ST = 16	ST = $14.6 \pm 1.5$		
			CON = 13	CON = $14.8 \pm 1.4$		
Lee et al.[40]	2013	US	AE = 16	AE = $14.6 \pm 1.9$	F	All classified as obese (BMI $\geq$ 95th percentile) based on 2000 CDC BMI charts
			ST = 16	ST = $14.8 \pm 1.9$		
			CON = 12	CON = $15.0 \pm 2.2$		
Li et al.[111]	2014	China	AE = 20	AE = $15.4 \pm 2.6$	M	All classified as obese (BMI $\geq$ 25 kg·m <sup>2</sup> )
			CON = 20	CON = $14.6 \pm 3.5$		
Maddison et al.[42]	2011	NZ	AE = 160	AE, CON = $11.6 \pm 1.1$	MF	Overweight or obese according to International Obesity Task Force international cutoffs for child obesity
			CON = 162			

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3	McNarry et al.[43]	2015	UK	AE = 15	AE, CON = 9.3	MF	Obese, defined as BMI $\geq$ 95 <sup>th</sup> percentile
4				CON =	$\pm$ 0.9		
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6							
7				11			
8							
9	Meyer et al.[44]	2006	Germany	AE = 33	AE = 13.7 $\pm$ 2.1	MF	Obese, defined as > 95 <sup>th</sup> percentile for German pediatric population
10				CON =	CON = 14.1 $\pm$		
11							
12				34	2.4		
13							
14	Monteiro et al.[45]	2015	Brazil	AE = 11	AE = 11.0 $\pm$ 1.0	MF	Obese according to BMI
15				AE+ST =	AE+ST = 11.0 $\pm$		
16							
17				14	1.3		
18							
19							
20	Murphy et al.[46]	2009	US	AE = 23	AE = 10.3 $\pm$ 1.9	MF	Overweight (BMI $\geq$ 85 <sup>th</sup> percentile)
21				CON =12	CON = 10.0 $\pm$		
22							
23					1.3		
24							
25							
26	Nobre et al.[47]	2017	Brazil	AE = 40	AE = 9.8 $\pm$ 5.7	M	Overweight (BMI = 85th to 95th percentile) and obese BMI $\geq$ 95th
27				CON =	CON = 9.9 $\pm$ 4.8		percentile)
28							
29				19			
30							
31							
32	Owens et al.[48]	1999	US	AE = 35	AE = 9.5 $\pm$ 1.2	MF	Obese, classified as a triceps skinfold greater than the 85th
33				CON =	CON = 9.4 $\pm$ 1.3		percentile for gender, age, and ethnicity
34							
35				39			
36							
37	Park et al.[49]	2012	SK	AE+ST =	AE+ST = 12.1 $\pm$	MF	BMI $\geq$ 85th percentile for age and gender according to WHO cut-off
38				15	0.4		points
39							
40							
41							
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Author	Year	Country	Intervention	Control	Sex	Outcome
Racil et al.[50]	2013	Tunisia	CON = 14	CON = 12.2 ± 0.4	F	BMI >97th percentile according to French standards
			AE(MI) = 11	AE(MI) = 16.3 ± 0.5		
			AE(HI) = 11	AE(HI) = 15.6 ± 0.7		
			CON = 12	CON = 15.9 ± 1.2		
Racil et al.[51]	2016	Tunisia	AE = 23	AE = 16.6 ± 0.9	F	Obese according to CDC growth charts
			AE+ST = 26	AE+ST = 16.5 ± 1.2		
			CON = 19	CON = 16.9 ± 1.0		
Rooney et al.[52]	2005	US	AE = 26	AE = 8.9 ± 2.2	MF	Overweight or obese (BMI ≥ 84.5 percentile)
			CON = 33	CON = 8.6 ± 2.1		
Saygin & Ozturk [53]	2011	Turkey	AE = 20	AE, CON = 10.0	F	NA, but authors classified all participants as obese (baseline BMI $\bar{X} \pm SD = 25.9 \pm 2.1$ in exercise group and $26.1 \pm 1.4$ in control group)
			CON = 19	to 12.0		

1							
2							
3	Schranz et al.[54]	2014	Australia	ST = 26	ST = 14.9 ± 1.4	M	Overweight or obese according to Cole et al. BMI cutpoints
4				CON =	CON = 15.1 ±		
5							
6				23	1.6		
7							
8	Seo et al.[55]	2012	SK	AE = 10	AE = 14.7 ± 1.5	M	Obese, defined as BMI >95th percentile based on French population
9				CON =	CON = 14.6 ±		standards
10							
11				10	3.0		
12							
13	Shaibi et al.[56]	2006	US	ST = 11	ST = 15.1 ± 1.7	M	Overweight or obese (BMI ≥ 85 <sup>th</sup> percentile based on 2000 CDC
14				CON =	CON = 15.6 ±		growth charts)
15							
16				11	1.7		
17							
18	Sigal et al.[57]	2014	Canada	AE = 75	AE = 15.5 ± 1.4	MF	Obese (BMI ≥ 95th percentile for age and sex)
19				ST = 78	ST = 15.9 ± 1.5		
20				AE+ST =	AE+ST = 15.5 ±		
21							
22				75	1.3		
23				CON =	CON = 15.6 ±		
24							
25				76	1.3		
26							
27	Silva et al.[58]	2012	Brazil	AE = 9	AE, CON = 13	MF	Overweight or obese according to Cole et al. BMI cutpoints
28				CON = 5	to 17 yrs		
29							
30	Song et al.[59]	2012	SK	AE = 12	AE = 12.7 ± 0.7	M	Obese (> 30% body fat)
31				CON =	CON = 12.6 ±		
32							
33				10	0.6		
34							
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Staiano et al.[60]	2017	US	AE = 20	AE = $15.3 \pm 1.2$	F	Overweight or obese (BMI $\geq$ 85 <sup>th</sup> percentile)
			CON =	CON = $16.1 \pm$		
			18	1.4		
Sun et al.[61]	2011	China	AE = 25	AE, CON $13.6 \pm$	MF	Overweight or obese (>85 <sup>th</sup> percentile) based on China Obesity
			CON =	0.7		Task Force Recommendations
			17			
Tan et al.[62]	2010	China	AE = 30	AE = $9.4 \pm 0.5$	MF	Obese (body mass greater than 20% of standard body-mass-for
			CON =	CON = $9.5 \pm 0.5$		height of Chinese children)
			30			
Vasconcellos et	2016	Brazil	AE = 10	AE = $14.1 \pm 1.3$	MF	Obese (BMI >2 standard deviations above age and sex specific
al.[63]			CON =	CON = $14.8 \pm$		WHO reference medians)
			10	1.5		
Watts et al.[64]	2004	Australia	AE+ST =	AE+ST, CON =	MF	Obese according to Cole et al. BMI cutpoints
			19	$14.3 \pm 1.5$		
			CON =			
			19			
Watts et al.[65]	2004	Australia	AE = 14	AE, CON = 8.9	MF	Obese according to Cole et al. BMI cutpoints
			CON =	$\pm 1.6$		
			14			

1							
2							
3	Weintraub et	2008	US	AE = 9	AE = 9.5 ± 0.6	MF	Overweight or obese (BMI ≥ 85th percentile based on 2000 CDC
4							
5	al.[66]			CON =	CON = 10.3 ±		BMI growth charts)
6							
7				12	0.8		
8							
9	Wong et al.[67]	2008	Singapore	AE+ST =	AE+ST = 13.8 ±	M	Obese according to Cole et al. BMI cutpoints
10							
11				12	1.1		
12							
13				CON =	CON = 14.3 ±		
14							
15				12	1.5		
16							
17	Youssef et al.[68]	2015	Lebanon	AE = 14	AE = 16.1 ± 1.1	F	Overweight or obese according to Cole's BMI cutpoints
18							
19				CON = 9	CON = 16.3 ±		
20							
21					1.5		
22							
23	Zehsaz et al.[69]	2017	Iran	AE = 16	AE = 10.8 ± 0.9	M	Overweight or obese (BMI ≥ 25 kg·m <sup>2</sup> )
24							
25				CON =	CON = 10.3 ±		
26							
27				16	0.9		

Notes: US, United States; SK, South Korea; NZ, New Zealand; UK, United Kingdom; N, number of participants; yrs, years; AE, aerobic exercise, LPA, leisure physical activity; ST, strength training; CON, control;  $\bar{X} \pm SD$ , mean  $\pm$  standard deviation; LI, lower intensity; MI, moderate-intensity; HI, high-intensity; M, males; F, females; NA, not available; LD, low-dose; HD, high-dose; BMI, body mass index; CDC, Centers for Disease Control and Prevention; WHO, World Health Organization \*, study also included a leisure intervention but was excluded because it didn't meet our eligibility criteria.

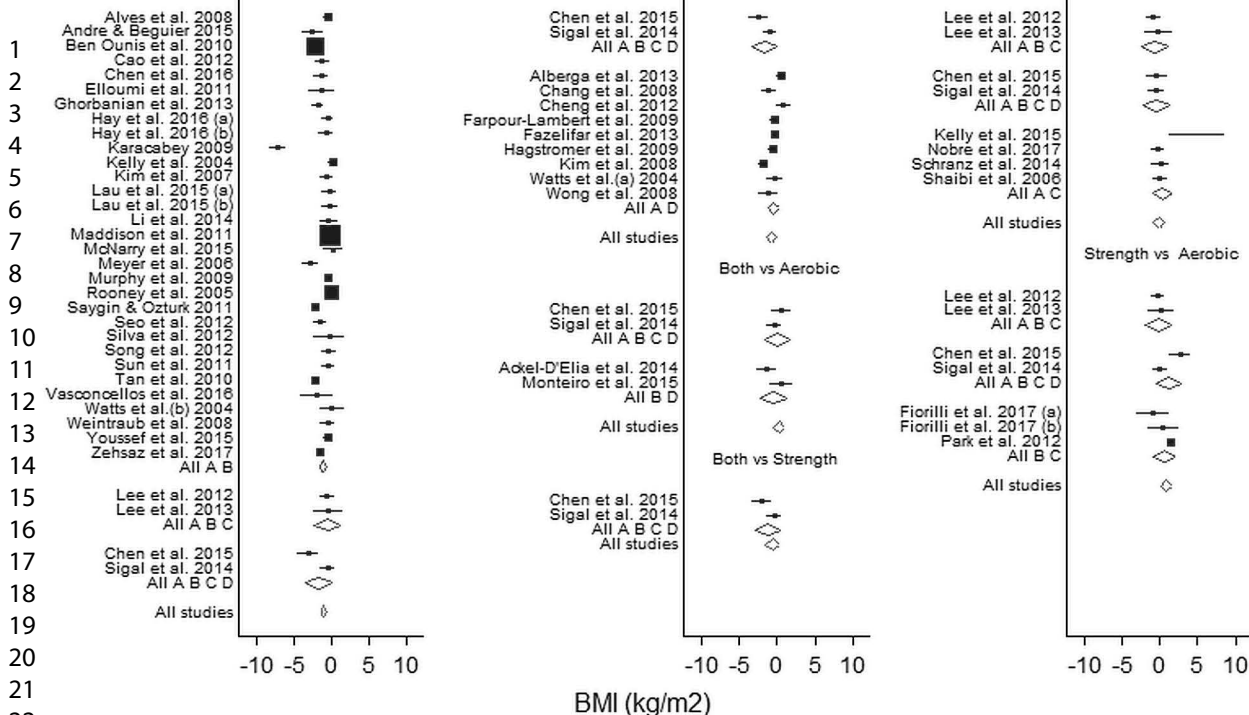
## Supplementary file 5. Study-level risk of bias assessment results.

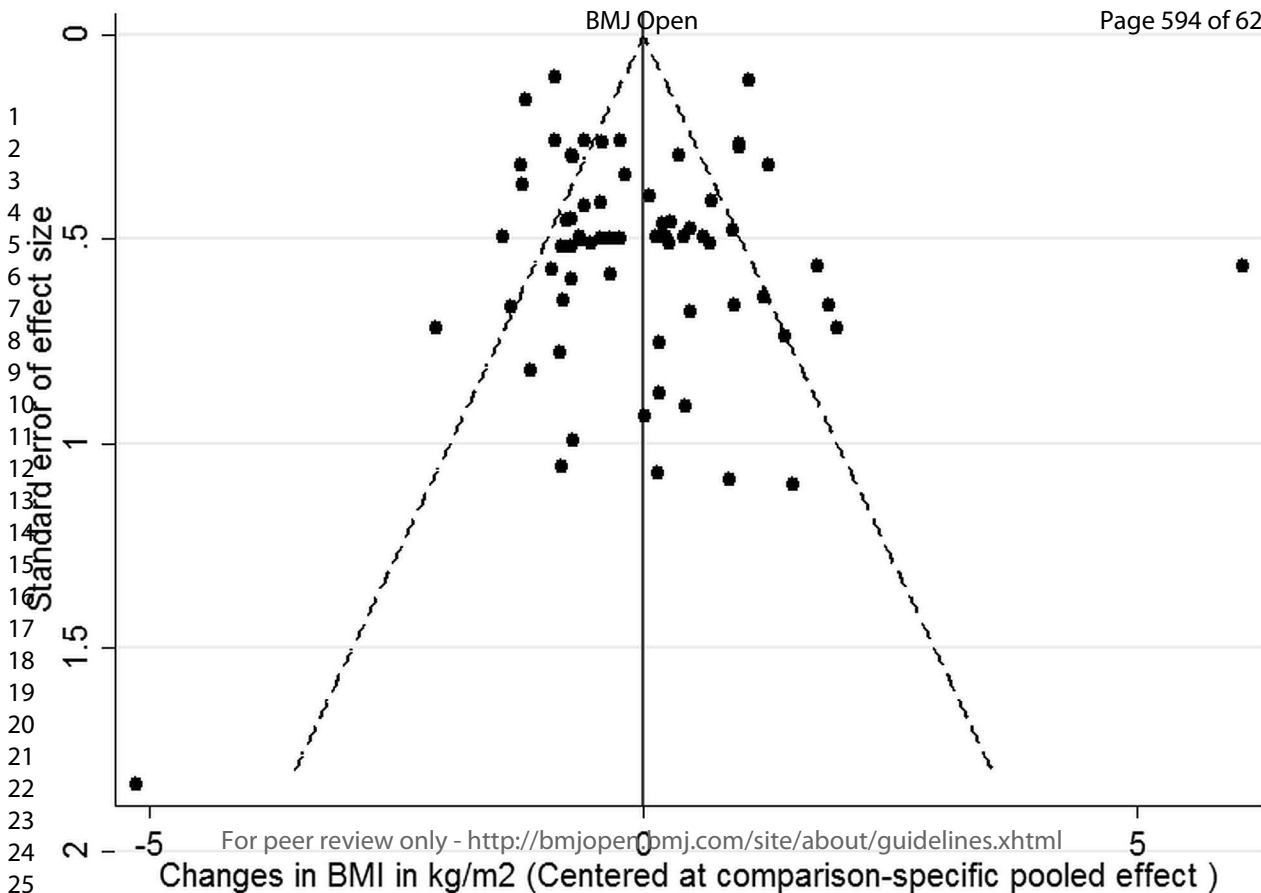
Study	Random sequence generation	Allocation concealment	Blinding (participants & personnel)	Blinding (outcome assessors)	Incomplete outcome data	Selective reporting	Physically inactive
Ackel-D'Elia et al.*	low	unclear	high	unclear	unclear	low	unclear
Alberga et al.	low	low	high	unclear	high	unclear	unclear
Alves et al.	low	unclear	high	unclear	low	unclear	unclear
Andre & Beguier	low	unclear	high	unclear	unclear	unclear	unclear
Ben Ounis et al.	low	unclear	high	unclear	unclear	unclear	low
Berntsen et al.	low	unclear	high	unclear	low	unclear	unclear
Cao et al.	low	unclear	high	unclear	unclear	unclear	unclear
Chang et al.	high	unclear	high	unclear	unclear	unclear	unclear
Chen et al.	low	unclear	high	unclear	unclear	unclear	unclear
Chen et al.	low	unclear	high	unclear	high	unclear	unclear
Cheng et al.	low	unclear	high	unclear	unclear	unclear	unclear
Davis et al.	low	low	high	high	low	low	low
Elloumi et al.	low	unclear	high	unclear	unclear	unclear	high
Farpour-Lambert et al.	low	low	high	low	low	low	low
Fazelifar et al.	low	unclear	high	unclear	low	unclear	low
Fiorilli et al.	low	unclear	high	unclear	low	unclear	low
Ghorbanian et al.	low	unclear	high	unclear	unclear	unclear	low
Gutin et al.	low	unclear	high	unclear	low	unclear	unclear
Hagstromer et al.	low	unclear	high	unclear	high	low	high
Hay et al.	low	low	high	low	low	low	unclear

1	Karacabey	low	unclear	high	unclear	unclear	unclear	low
2								
3	Kelly et al.	low	unclear	high	unclear	unclear	low	unclear
4								
5	Kelly et al.	low	low	high	unclear	low	unclear	unclear
6								
7								
8	Kim et al.	low	unclear	high	unclear	unclear	unclear	low
9								
10								
11	Kim et al.	low	unclear	high	unclear	high	unclear	unclear
12								
13								
14	Lau et al.	low	unclear	high	unclear	unclear	unclear	unclear
15								
16								
17	Lee et al.	low	low	high	unclear	low	unclear	low
18								
19	Lee et al.	low	low	high	unclear	low	unclear	low
20								
21								
22	Li et al.	low	unclear	high	unclear	low	unclear	unclear
23								
24								
25	Maddison et al.	low	low	high	high	low	low	high
26								
27								
28	McNarry et al.	low	low	high	unclear	unclear	high	unclear
29								
30	Meyer et al.	low	unclear	high	unclear	high	low	low
31								
32								
33	Monteiro et al.	low	unclear	high	unclear	unclear	low	unclear
34								
35								
36	Murphy et al.	low	unclear	high	unclear	unclear	low	unclear
37								
38								
39	Nobre et al.	low	unclear	high	unclear	unclear	unclear	unclear
40								
41	Owens et al.	low	unclear	high	unclear	low	unclear	unclear
42								
43								
44	Park et al.	low	unclear	high	unclear	low	low	unclear
45								
46								
47	Racil et al.	low	unclear	high	unclear	unclear	unclear	low
48								
49								
50	Racil et al.	low	unclear	high	unclear	unclear	unclear	low
51								
52								
53	Rooney et al.	low	unclear	high	unclear	low	low	unclear
54								
55	Saygin & Ozturk	low	unclear	high	unclear	unclear	unclear	unclear
56								
57								
58								
59								
60								



1	Schranz et al.	low	unclear	high	high	low	low	unclear
2								
3	Seo et al.	low	unclear	high	unclear	high	unclear	unclear
4								
5	Shaibi et al.	low	unclear	high	unclear	high	low	unclear
6								
7								
8	Sigal et al.	low	low	high	unclear	low	unclear	low
9								
10								
11	Silva et al.	low	unclear	high	unclear	high	unclear	unclear
12								
13								
14	Song et al.	low	unclear	high	low	high	unclear	low
15								
16	Staiano et al.	low	low	high	low	low	low	unclear
17								
18								
19	Sun et al.	low	unclear	high	unclear	low	unclear	unclear
20								
21								
22	Tan et al.	high	high	high	unclear	low	unclear	unclear
23								
24								
25	Vasconcellos et al.	low	low	high	low	high	low	low
26								
27	Watts et al.	low	unclear	high	unclear	unclear	unclear	unclear
28								
29								
30	Watts et al.	low	unclear	high	unclear	unclear	unclear	unclear
31								
32								
33	Weintraub et al.	low	unclear	high	high	low	low	unclear
34								
35								
36	Wong et al.	low	unclear	high	unclear	low	unclear	unclear
37								
38								
39	Youssef et al.	low	low	high	unclear	unclear	unclear	low
40								
41	Zehsaz et al.	low	unclear	high	unclear	unclear	unclear	unclear
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Supplementary file 8. Simple meta-regression results for changes in BMI (kg.m²).

Variable	Aerobic			Strength			Both		
	$\beta_1$			$\beta_1$			$\beta_1$		
	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI
<i>Study characteristics</i>									
- Year	0.02±0.56	0.32(.75)	-0.9,0.1	- 0.007±0.13	-0.06(.95)	-0.3,0.2	-0.02 ± .10	-0.17(.87)	-0.2,0.18
- Impact factor	0.07±0.09	0.85(.39)	-0.1,0.2	-0.18±0.14	-1.30(.19)	-0.5,.0.1	0.001±0.09	0.02(.99)	-1.7,1.7
- Country (other vs USA)	<b>-1.06±0.51</b>	<b>-2.1(.04)*</b>	<b>-2.1,-0.05</b>	-0.36±0.79	0.46(.64)	-1.9,1.2	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.81±0.46	-1.8(.08)	-1.7,0.09	-0.07±0.78	-.08(.93)	-1.6,1.5	-0.69±0.73	-0.95(.34)	-2.1,0.7
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	0.44±1.1	0.42(.68)	-1.6,2.5	ID	ID	ID	ID	ID	ID
-- Unclear	-0.32±0.69	-0.48(.63)	-2.9,2.3	-0.30±1.3	-0.22(.82)	-2.9,2.3	-0.41± 1.2	-0.34(.74)	-2.8,2.0
- Incomplete data (ref = low)									
-- High	-0.93±0.63	-1.5(.14)	-2.2,0.3	0.01±1.3	0.01(.99)	-2.6, 2.6	0.004±0.88	0(1.0)	-1.7,1.7
-- Unclear	-0.84±0.44	-1.9(.06)	-1.7,0.03	0.28±0.95	0.29(0.77)	-1.6,2.1	-0.39±0.77	-0.51(.61)	-1.9,1.1
- Selective reporting	-0.58±0.44	-1.3(0.18)	-1.4,0.3	-0.70±0.83	-0.85(0.4)	-2.3,0.9	-0.02±0.73	-0.02(.98)	-1.5,1.4



(unclear vs. low)

- Inactive (ref = low)

-- High	1.0±0.93	1.1(0.28)	-0.8,2.8	ID	ID	ID	0.35±1.3	0.27(.78)	-2.2,2.9
-- Unclear	0.81±0.43	1.9(.06)	-0.04,1.7	<b>1.83±0.77</b>	<b>2.4(.02)*</b>	<b>0.3,3.3</b>	0.02±0.73	0.02(.98)	-1.4,1.5
- Funding (yes vs no)	<b>1.06±0.40</b>	<b>2.6(.008)*</b>	<b>0.3,1.8</b>	0.56±0.89	0.63(.53)	-1.2,2.3	-0.09±0.72	-0.13(.90)	-1.5,1.3
- Matching	-0.76±0.64	1.2(.23)	-0.5,2.0	0.39±0.98	0.40(.69)	-1.5,2.3	-0.26±0.80	-0.32(.75)	-1.8,1.3
- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Control type (other vs none)	0.41±0.53	0.76(.44)	-0.6,1.4	-0.82±1.13	-0.72(.47)	-3.5,1.4	-0.81±0.75	-1.07(.28)	-2.3,0.7
- Analysis type (abp vs itt)	-0.51±0.43	-1.2(.22)	-1.3,0.3	0.34±0.78	0.43(.66)	-1.2,1.9	-0.27±0.77	-0.35(.73)	-1.8,0.8
- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (enactment)	-0.22±0.64	-0.35(.73)	-1.5,1.0	-0.10±0.73	-0.13(.90)	1.5,1.3	0.92±0.79	1.2(.24)	-0.6,2.5

(yes vs no)

*Participant*

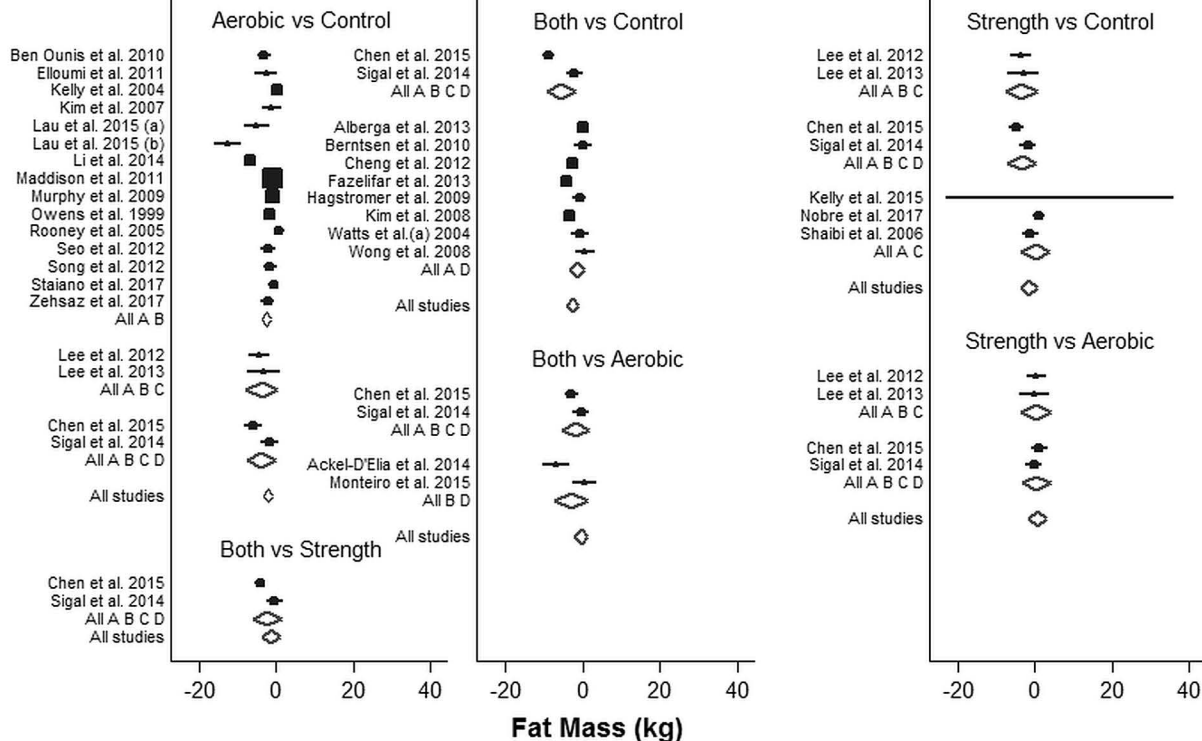
*characteristics*

- Age (years)	-0.04±0.08	-0.51(.61)	-0.2, 0.1	-0.06±0.23	-0.26(.79)	-0.5,0.4	-0.20±0.17	-1.2(.23)	-0.5,0.1
- Gender (females vs males)	-0.51±0.98	0.52(.60)	-1.4,2.4	-0.55±1.6	-0.34(.74)	-3.8,2.7	-0.45±0.48	-0.92(.35)	-1.4,0.5

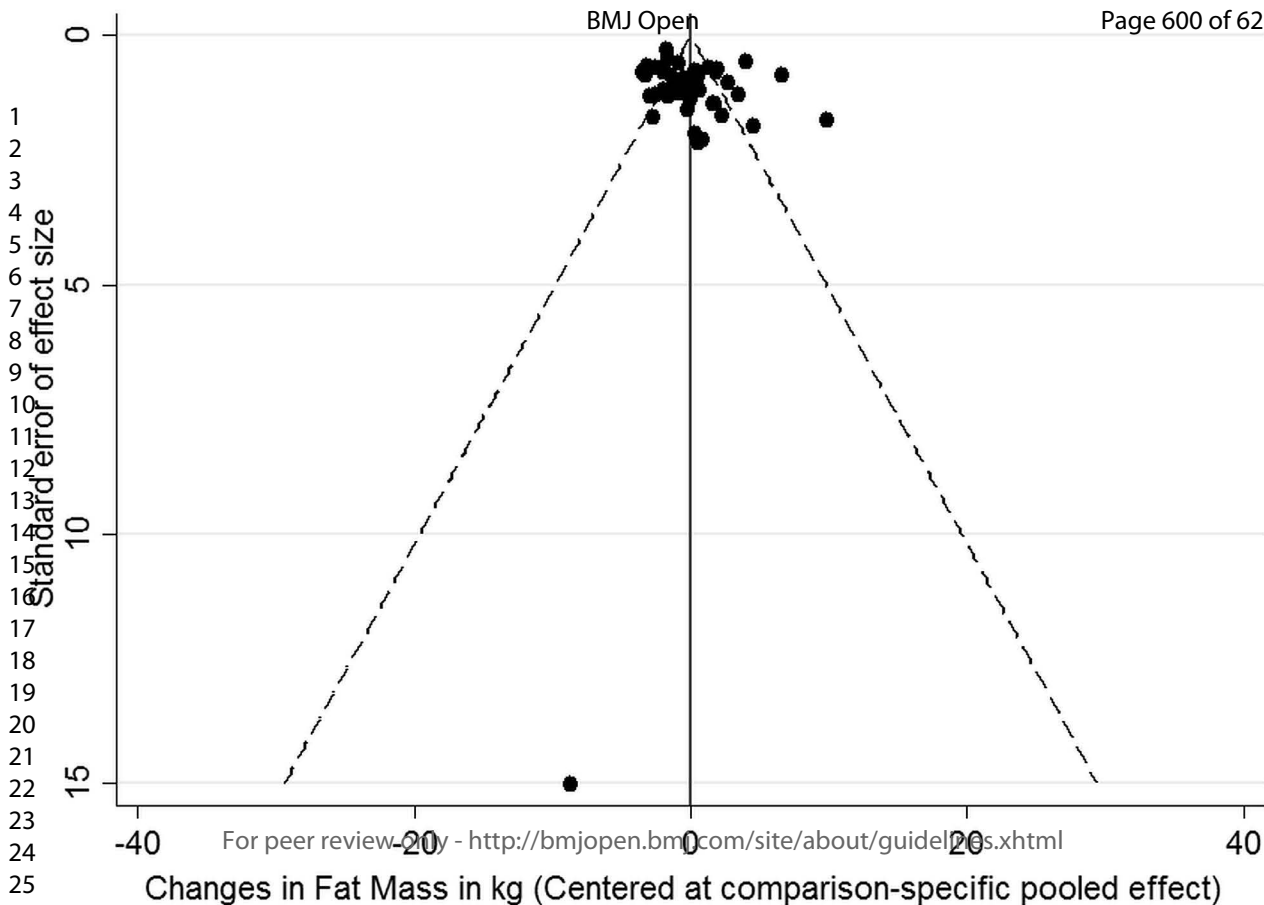
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3	- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
4	- Maturational stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
5										
6	<i>Exercise</i>									
7										
8	<i>characteristics</i>									
9										
10	- Length (weeks)	-0.02±0.03	0.77(0.44)	-0.04,0.09	-0.03±0.07	-0.39(.70)	-0.2,0.1	-0.03±0.04	-0.77(.44)	-0.1, 0.05
11	- Frequency	-0.18±0.17	1.06(.29)	-0.1,0.5	-0.67±0.63	-1.06(.29)	-1.9,0.6	-0.31±0.37	-0.84(.40)	-1.0,0.4
12										
13	(days/week)									
14										
15	- Intensity (high vs	-0.88±0.45	-1.9(.05)	-1.8,0.01	ID	ID	ID	ID	ID	ID
16										
17	moderate)									
18										
19	- Duration	-0.01±0.01	-1.8(.07)	-0.03,0.001	-0.01±0.02	-0.53(.59)	-	-0.01±0.02	-	-
20										
21	(min/session)						0.05,0.03		0.67(0.50)	0.06,0.03
22										
23	- Compliance (%)	<b>-0.02±0.01</b>	<b>-2.1(.03)*</b>	<b>-.04,-.002*</b>	-	-0.25(.80)	-	0.03±0.06	0.46(.64)	-0.08,0.1
24										
25					0.008±0.03		0.08,0.06			
26										
27	- Minutes per week	<b>-0.01±.002</b>	<b>-2.6(.01)*</b>	<b>-.009,-.001</b>	NA	NA	NA	NA	NA	NA
28										
29	(total) <sup>a</sup>									
30										
31	- Minutes per week	<b>-.01±.0004</b>	<b>13.3(&lt;0.001)*</b>	<b>-0.007,-</b>	NA	NA	NA	NA	NA	NA
32										
33	(adjusted total) <sup>a</sup>			<b>0.005</b>						
34										
35	- Sets <sup>b</sup>	NA	NA	NA	-0.03±0.05	-0.55(.58)	-0.1,0.07	NA	NA	NA
36										
37	- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
38										
39	- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
40										
41	- Number of exercises <sup>b</sup>	NA	NA	NA	-0.21±0.80	-0.27(.79)	-1.8,1.3	NA	NA	NA
42										
43	- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
44										

- Type of strength program <sup>b</sup> (c vs t)	NA	NA	NA	0.01±0.75	0.01(.99)	-2.2,2.2	NA	NA	NA
- Type of strength equipment <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Supervision (no vs yes)	0.94±0.67	1.4(.16)	-0.4,2.3	<b>5.1±2.2</b>	<b>2.4(.02)*</b>	<b>0.9,9.4</b>	ID	ID	ID
- Location (home versus facility)	-0.77±0.44	1.7(.08)	-0.1,1.6	<b>5.1±2.0</b>	<b>2.6(.01)*</b>	<b>1.2,9.0</b>	ID	ID	ID
<i>Outcome characteristics</i>									
- Baseline BMI (kg·m <sup>2</sup> )	-0.08±0.05	-1.7(.10)	-0.2,0.01	-0.09±0.0	-0.99(.32)	-0.3,.08	-0.07±0.10	-0.67(.50)	-0.3,0.1
- Assessment method	NA	NA	NA	NA	NA	NA	NA	NA	NA

Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; BMI, body mass index; c vs t, circuit versus traditional; **boldface** items indicate statistically significant findings; \*, statistically significant (two-tailed  $p \leq 0.05$ ); total number of observations for statistically significant results from multivariate models were 53 for country, 53 for funding, 16 for compliance, 32 for total minutes per week of exercise, 12 for compliance-adjusted minutes per week of exercise, 51 for supervision, and 51 for location.

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Supplementary file 11. Simple meta-regression results for changes in fat mass (kg).

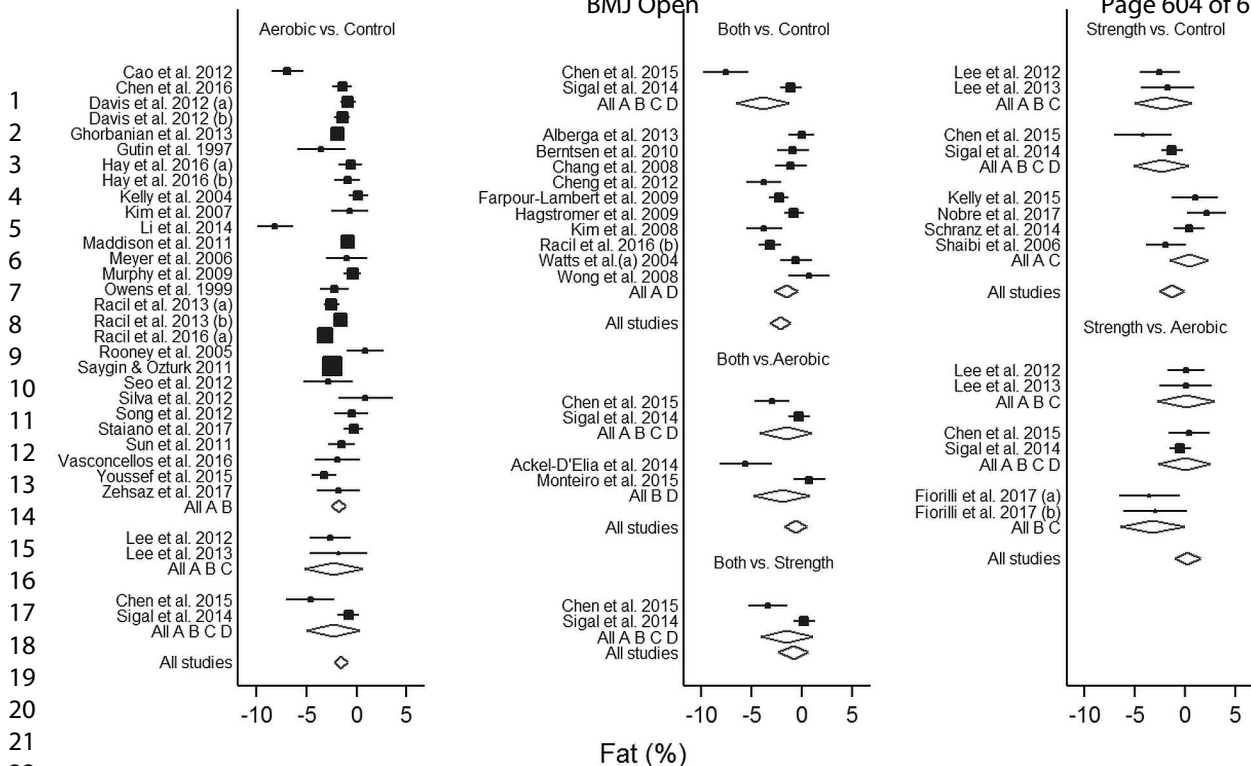
Variable	Aerobic			Strength			Both		
	$\beta_1$			$\beta_1$			$\beta_1$		
	( $\bar{X} \pm SE$ )	z(p)	95% CI	( $\bar{X} \pm SE$ )	z(p)	95% CI	( $\bar{X} \pm SE$ )	z(p)	95% CI
<i>Study characteristics</i>									
- Year	-0.23±0.1	-1.9(.06)	-0.5,0.01	0.09±0.30	0.31(.76)	-0.5,0.7	<b>0.48±0.22</b>	<b>-2.1(.03)*</b>	<b>-0.9,-0.4</b>
- Impact factor	0.16±0.27	0.58(.56)	-0.4,0.7	-0.12±0.35	-0.35(.73)	-0.8,0.6	0.25±0.28	0.91(.36)	-0.3,0.8
- Country (other vs usa)	-1.7±1.2	-1.4(.17)	-4.1,0.7	0.54±2.1	0.26(.79)	-3.5,4.6	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.66±1.4	-0.46(.64)	-3.5,2.1	1.3±2.2	0.60(.55)	-2.9,5.5	-1.8±2.0	-0.92(.35)	-5.7,2.1
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	ID	ID	ID	ID	ID	ID	ID	ID	ID
-- Unclear	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Incomplete data (ref = low)									
-- High	0.37±2.2	0.17(.87)	-4.0,4.7	1.0±3.3	0.31(.76)	-5.4,7.4	0.22±2.1	0.11(.91)	-3.9,4.3
-- Unclear	-0.69±1.3	-0.52(.61)	-3.3,1.9	1.3±2.4	.056(.58)	-3.3,6.0	-2.8±1.9	-1.5(.13)	-6.5,0.9
- Selective reporting (unclear vs. low)	<b>-3.2±1.2</b>	<b>-2.6(.009)*</b>	<b>-5.7,-0.8</b>	-0.68±2.8	-0.24(.81)	-6.2,4.9	-0.40±1.9	-0.21(.83)	-4.1,3.3
- Inactive (ref = low)									
-- High	0.93±2.4	0.39(.69)	-3.7,5.6	ID	ID	ID	2.4±3.4	0.72(.47)	-4.2,9.1
-- Unclear	0.15±1.5	0.10(.92)	-2.7,3.0	2.1±2.2	0.94(.35)	-2.3,6.5	0.62±2.1	0.30(.77)	-3.5,4.7
- Funding (yes vs no)	2.5±1.5	1.7(.09)	-0.4,5.5	1.7±2.4	0.69(.49)	-3.0,6.4	<b>3.6±1.6</b>	<b>2.3(.02)*</b>	<b>0.5,6.8</b>
- Matching	2.3±1.4	1.67(.09)	-0.4,4.9	-0.20±2.7	-0.08(.94)	-5.4,5.0	-0.47±2.0	-0.23(.82)	-4.4,3.5
- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID

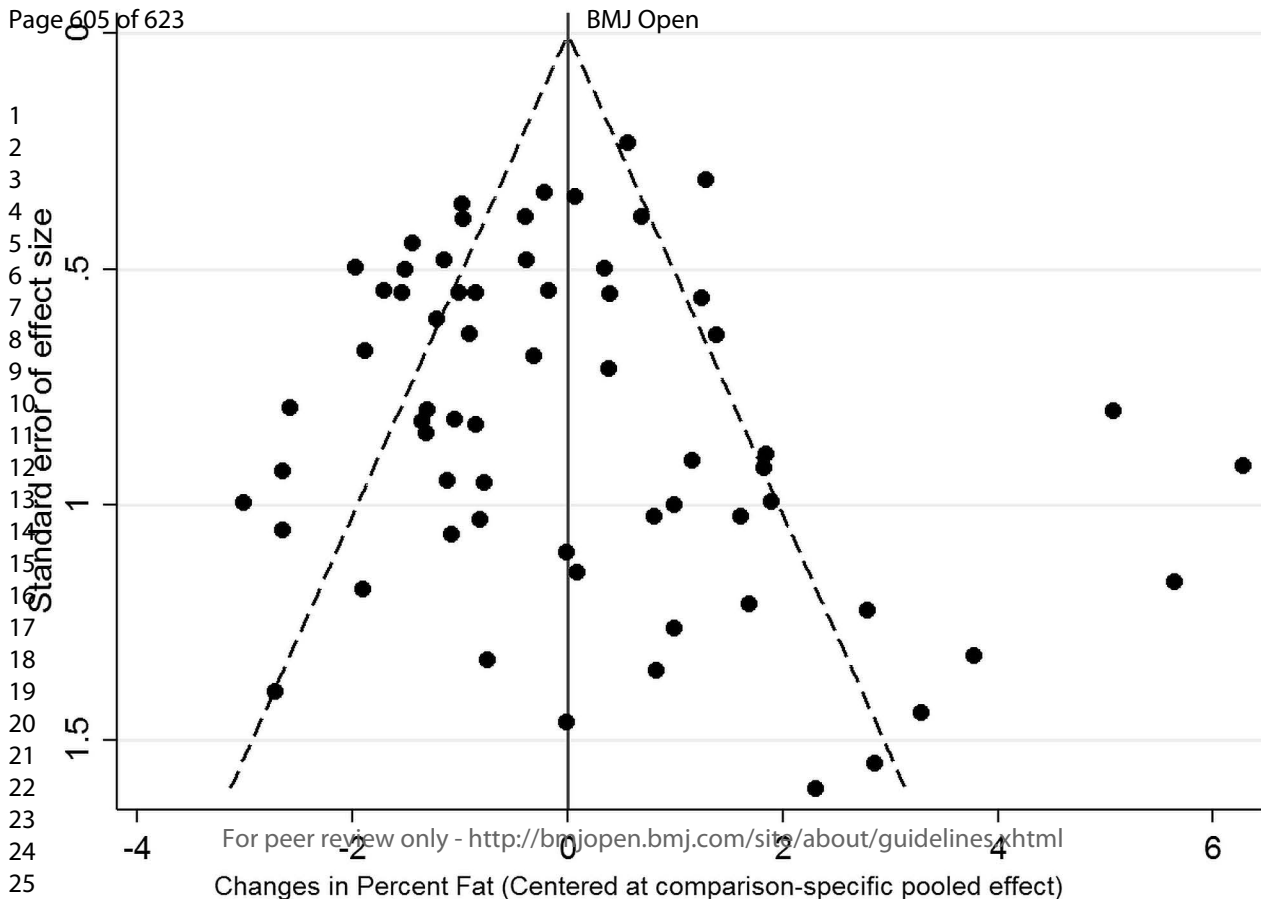
- Control type (other vs none)	2.6±1.9	1.4(.16)	-1.0,6.3	0.45±2.8	0.16(.87)	-5.0,5.9	1.4±1.8	0.79(.43)	-2.2,5.0
- Analysis type (abp vs itt)	0.63±1.3	0.47(.64)	-2.0,3.2	1.9±2.1	0.91(.36)	-2.3,6.2	-1.3±1.9	-0.69(.49)	-5.0,2.4
- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Fidelity (enactment) (yes vs no)	-1.2±1.0	-1.2(.25)	-3.2,0.8	-1.2±1.7	-0.74(.46)	-4.5,2.0	ID	ID	ID
<i>Participant characteristics</i>									
- Age (years)	-0.02±0.26	-0.10(.92)	-0.5,0.5	-0.62±0.54	-1.1(.25)	-1.7,0.4	-0.67±0.44	-1.5(.13)	-1.5,0.2
- Gender (females vs males)	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Maturation stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
<i>Exercise characteristics</i>									
- Length (weeks)	<b>0.26±0.11</b>	<b>2.3(.02)*</b>	<b>0.04,0.48</b>	0.07±0.22	0.33(.74)	-0.4,0.5	0.13±0.15	0.83(.41)	-0.2,0.4
- Frequency (days/week)	0.54±0.44	1.2(.22)	-0.3,1.4	-1.7±1.5	-1.2(.24)	-4.6,1.1	-1.6±0.96	-1.7(.09)	-3.5,0.2
- Intensity (high vs moderate)	<b>-4.9±1.7</b>	<b>-2.9(.003)*</b>	<b>-8.2,1.6</b>	ID	ID	ID	ID	ID	ID
- Duration (min/session)	0.02±0.03	0.86(.39)	-0.03,0.09	-0.02±0.06	-0.39(.69)	-0.1,.1	0.09±0.06	1.6(.11)	-0.02,0.2
- Compliance (%)	<b>-0.07±0.02</b>	<b>-3.9(&lt;0.001)*</b>	<b>-0.1,-0.03</b>	-0.26±0.37	-0.72(.47)	-1.0,0.4	0.002±.03	0.06(.95)	-0.07,.07
- Minutes per week (total) <sup>a</sup>	0.007±0.01	0.69(.49)	-0.01,0.03	NA	NA	NA	NA	NA	NA
- Minutes per week (adjusted total) <sup>a</sup>	<b>-0.006±.003</b>	<b>-2.1(.03)*</b>	<b>-0.01,-0.0006</b>	NA	NA	NA	NA	NA	NA
- Sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Number of exercises <sup>b</sup>	NA	NA	NA	0.10±1.2	0.08(.93)	-2.3,2.5	NA	NA	NA
- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA

1										
2										
3	- Type of strength program <sup>b</sup> (c vs t)	NA	NA	NA	-0.85±1.3	-0.65(.52)	-3.4,1.7	NA	NA	NA
4	- Type of strength equipment <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
5										
6	- Supervision (no vs yes)	2.3±1.7	1.3(.18)	-1.1,5.6	8.1±15.3	0.53(.59)	-21.8,38.1	ID	ID	ID
7										
8	- Location	2.2±1.6	1.4(.17)	-0.9,5.3	8.3±15.2	054(.59)	-21.6,38.1	ID	ID	ID
9										
10	<i>Outcome characteristics</i>									
11	- Baseline fat mass (kg)	-0.09±0.05	-1.8(.07)	-0.2,0.007	-0.10±0.08	-1.3(.18)	-0.3,05	-0.01±0.08	-.17(.86)	-0.2,0.1
12										
13	- Assessment method (ref = DEXA)									
14										
15	-- MRI	-2.5±2.1	-1.2(.22)	-6.7,1.6	-1.9±3.2	-0.59(.56)	-8.1,4.3	-1.3±2.6	-0.51(.61)	-6.4,3.8
16										
17	-- BI	-2.2±1.7	-1.3(.20)	-5.6,1.2	ID	ID	ID	-2.7±2.7	-0.98(.33)	-8.1,2.7
18										
19	-- Skinfolks	-3.1±1.7	-1.8(.07)	-6.4,0.3	2.1±3.7	0.55(.58)	-5.3,9.4	0.65±2.8	0.23(.82)	-4.8,6.1

20 Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct  
21 analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; c vs t, circuit versus  
22 traditional; DEXA, dual-energy x-ray absorptiometry; MRI, magnet resonance imaging; BI, bioelectrical impedance; **boldface** items indicate statistically  
23 significant findings; \*, statistically significant (two-tailed p ≤ 0.05); total number of observations for statistically significant findings from multivariate models  
24 were 32 for year of publication, selective reporting, funding, length of training and intensity of training, 10 for compliance, and 8 for adjusted minutes per  
25 week of exercise.  
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## Supplementary file 14. Simple meta-regression results for changes in percent body fat.

Variable	Aerobic			Strength			Both		
	$\beta_1$			$\beta_1$			$\beta_1$		
	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI	$(\bar{X} \pm SE)$	z(p)	95% CI
<i>Study characteristics</i>									
- Year	-0.003±0.07	-0.04(.97)	-0.1,0.1	0.03±0.20	0.16(.87)	-0.38,0.44	-0.26±0.15	-1.8(.08)	-0.6, 0.03
- Impact factor	0.04±0.05	0.86(.39)	-0.05,0.1	-0.07±0.22	-0.34(.73)	-0.5,0.4	0.12±0.14	0.83(.41)	-0.2,0.4
- Country (other vs usa)	-0.68±0.72	-0.94(.35)	-2.1,0.74	-0.34±1.3	-0.27(.79)	-2.8,2.2	ID	ID	ID
- Sequence generation	ID	ID	ID	ID	ID	ID	ID	ID	ID
- Allocation conceal (unclear vs low)	-0.43±0.70	-0.62(.54)	-1.8,0.9	-0.24±1.3	-0.19(.85)	-2.7,2.2	-1.3±1.2	-1.1(.27)	-2.7,2.2
- Blinding (P & P)	NA	NA	NA	NA	NA	NA	NA	NA	NA
- Blinding (OA) (ref = low)									
-- High	-0.23±1.4	-0.17(.87)	-2.9,2.5	ID	ID	ID	ID	ID	ID
-- Unclear	-0.97±0.96	-1.0(.31)	-2.8,0.91	-2.0±2.1	-0.96(.34)	-6.1,2.1	0.06±1.9	0.03(.98)	-3.8,3.9
- Incomplete data (ref = low)									
-- High	0.21±0.96	0.22(.83)	-1.7,2.1	-0.31±2.1	-0.14(.88)	-4.5,3.9	-0.35±1.4	-0.25(.80)	-3.1,2.4
-- Unclear	-0.66±0.71	-0.93(.35)	-2.0,0.7	1.6±1.5	1.07(.28)	-1.4,4.6	-0.35(1.4)	-0.25(.80)	-3.1,2.4
- Selective reporting (unclear vs. low)	<b>-1.6±0.66</b>	<b>-2.4(.01)*</b>	<b>-2.9,-0.30</b>	-1.0±1.5	-0.66(.51)	-4.0,2.0	-0.19±1.1	-0.17(.86)	-2.4,2.0
- Inactive (ref = low)									
-- High	0.82±1.9	0.44(.66)	-2.8,4.5	ID	ID	ID	1.6±2.1	0.75(.45)	-2.5,5.6
-- Unclear	-0.04±0.67	-0.07(.95)	-1.4,1.3	<b>2.7±1.3</b>	<b>2.2(.03)*</b>	<b>0.25,5.2</b>	0.05±1.2	0.75(.45)	-2.5,5.6
- Funding (yes vs no)	<b>2.1±0.70</b>	<b>3.0(0.003)*</b>	<b>0.7,3.5</b>	<b>4.1±1.3</b>	<b>3.07(.002)*</b>	<b>1.5,6.8</b>	<b>4.4±1.2</b>	<b>3.6(&lt;0.001)*</b>	<b>2.0,6.8</b>

1										
2	- Matching	1.1±0.77	1.4(.16)	-0.4,2.6	-0.21±1.7	-0.12(.90)	-3.6,3.2	0.41±1.2	0.34(.73)	-1.9,2.7
3										
4	- Crossover trial	ID	ID	ID	ID	ID	ID	ID	ID	ID
5										
6	- Control type (other vs none)	-0.03±0.82	-0.03(.97)	-1.6,1.6	-1.2±1.7	-0.72(.47)	-4.6,2.1	0.78±1.1	0.71(.48)	-1.4,2.9
7										
8	- Analysis type (abp vs itt)	0.22±0.70	0.32(.75)	-1.1,1.6	0.09±1.3	0.07(.94)	-2.4,2.6	-1.1±1.1	-1.02(.31)	-3.3,1.1
9										
10	- Fidelity (design)	ID	ID	ID	ID	ID	ID	ID	ID	ID
11										
12	- Fidelity (training)	ID	ID	ID	ID	ID	ID	ID	ID	ID
13										
14	- Fidelity (delivery)	ID	ID	ID	ID	ID	ID	ID	ID	ID
15										
16	- Fidelity (receipt)	ID	ID	ID	ID	ID	ID	ID	ID	ID
17										
18	- Fidelity (enactment) (yes vs no)	-0.59±0.43	-1.4(.17)	-1.4,0.26	-1.5±0.84	-1.7(.08)	-3.1,0.17	-0.78±0.87	-0.89(.37)	-2.5,0.93
19										
20	<i>Participant characteristics</i>									
21										
22	- Age (years)	-0.12±0.11	-1.05(.29)	-0.34,0.10	-0.64±0.35	-1.83(.07)	-1.3,0.05	-0.31±0.2	-1.5(.12)	-0.7,0.08
23										
24	- Gender (females vs males)	0.51±0.98	0.52(.60)	-1.4,2.4	-0.55±1.6	-0.34(.74)	-3.8,2.7	ID	ID	ID
25										
26	- Race ethnicity	ID	ID	ID	ID	ID	ID	ID	ID	ID
27										
28	- Maturation stage	ID	ID	ID	ID	ID	ID	ID	ID	ID
29										
30	<i>Exercise characteristics</i>									
31										
32	- Length (weeks)	<b>0.13±0.06</b>	<b>2.2(.03)*</b>	<b>0.01,0.25</b>	0.03±0.11	0.29(0.77)	-0.19,0.26	0.07±0.07	1.0(.31)	-0.06,0.20
33										
34	- Frequency (days/week)	0.20±0.28	0.73(.47)	-0.3,0.7	-1.4,0.96	-1.5(.14)	-3.3,0.5	-0.40±0.58	-0.70(.49)	-1.5,0.7
35										
36	- Intensity (high vs moderate)	0.33±0.81	0.41(.68)	-1.3,1.9	ID	ID	ID	-1.3±2.0	-0.62(.53)	-5.3,2.7
37										
38	- Duration (min/session)	-0.006±0.01	-0.47(.64)	-0.03,0.02	-0.06±0.04	-1.6(.12)	-0.14,0.02	0.03±0.02	1.06(.29)	-0.02,0.07
39										
40	- Compliance (%)	-0.03±0.02	-1.7(.10)	-0.07,0.006	-0.05±0.05	-0.92(.36)	-0.16,0.06	0.03±0.04	0.91(.36)	-0.04,0.1
41										
42	- Minutes per week (total) <sup>a</sup>	-0.002±0.004	-0.48(.63)	-0.01,0.006	NA	NA	NA	NA	NA	NA
43										
44	- Minutes per week (adjusted total) <sup>a</sup>	-0.005±0.004	-1.1(.26)	-0.01,0.003	NA	NA	NA	NA	NA	NA
45										
46										
47										



- Sets <sup>b</sup>	NA	NA	NA	0.13±0.09	1.3(.18)	-0.06,0.31	NA	NA	NA
- Repetitions <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Rest between sets <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Number of exercises <sup>b</sup>	NA	NA	NA	0.03±0.97	0.03(.97)	-1.9,1.9	NA	NA	NA
- Type of resistance <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Type of strength program <sup>b</sup> (c vs t)	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Type of strength equipment <sup>b</sup>	NA	NA	NA	ID	ID	ID	NA	NA	NA
- Supervision (no vs yes)	1.5±1.2	1.3(.18)	-0.7,3.8	2.5±2.3	1.1(.27)	-1.9,7.0	ID	ID	ID
- Location	1.5±1.1	1.4(.17)	-0.67,3.7	2.6±2.2	1.2(.24)	-1.7,6.9	ID	ID	ID
<i>Outcome characteristics</i>									
- Baseline percent fat	0.06±0.05	1.3(.21)	-0.03,0.16	0.03±0.08	.39(.69)	-0.13,0.19	0.12±0.07	1.7(.08)	-0.02,0.27
- Assessment method (ref = DEXA)	NA	NA	NA	NA	NA	NA	NA	NA	NA
-- MRI	-0.38±1.2	-0.31(.76)	-2.8,2.1	-1.5±1.5	-0.99(.32)	-4.4,1.4	0.42±1.7	0.24(.81)	-3.0,3.8
-- BI	-1.2±0.73	-1.7(.09)	-2.7,0.2	ID	ID	ID	-0.22±1.5	-0.15(.88)	-3.1,2.6
-- Skinfolds	0.65±1.1	0.61(.54)	-1.4,2.7	-1.1±1.7	-0.67(.51)	-4.4,2.2	1.2±1.9	0.62(.53)	-2.5,4.9
-- Plethysmography	1.3±316.2	0.00(1.0)	-618,621	ID	ID	ID	-3.6±316	-0.01(.99)	-623,616

Notes: <sup>a</sup>, limited to aerobic exercise studies; <sup>b</sup>, limited to studies that included only strength training; NA, not applicable; ID, insufficient data to conduct analysis; P & P, participants and personnel; OA, outcome assessment; abp vs. itt, analysis-by-protocol vs intention-to-treat; BMI, body mass index; c vs t, circuit versus traditional; DEXA, dual-energy x-ray absorptiometry; MRI, magnet resonance imaging; BI, bioelectrical impedance; **boldface** items indicate statistically significant findings; \*, statistically significant (two-tailed  $p \leq 0.05$ ); total number of observations for statistically significant results for multivariate models were 50 for selective reporting, being physically inactive, funding, and length of training.

Supplementary file 15. Changes in secondary outcomes.

Variable	Aerobic				Strength				Both			
	ES/P	$\beta_1$			ES/P	$\beta_1$			ES/P	$\beta_1$		
	(#)	$(\bar{X} \pm SE)$	z(p)	95% CI	(#)	$(\bar{X} \pm SE)$	z(p)	95% CI	(#)	$(\bar{X} \pm SE)$	z(p)	95% CI
Body weight (kg)	35/1478	<b>-1.9±0.34</b>	<b>-5.4(&lt;0.001)*</b>	<b>-2.5,-1.2</b>	8/331	0.28±0.71	0.39(.70)	-1.1,1.7	13/510	<b>-1.4± 0.50</b>	<b>-2.8(0.004)*</b>	<b>-2.4,-0.4</b>
Fat-free mass (kg)	16/177	0.07±0.40	0.18(.86)	-0.72,0.86	7/305	0.82±0.62	1.3(.19)	-0.40,2.0	11/431	<b>1.3±0.46</b>	<b>2.8(0.006)*</b>	<b>0.4,2.2</b>
WC (cm)	19/973	<b>-1.9±0.62</b>	<b>-3.1(.002)*</b>	<b>-3.1,-0.7</b>	5/195	-0.34±1.1	-0.32(.75)	-2.5,1.8	4/223	-2.2±1.3	-1.7(.08)	-4.6,0.3
VO <sub>2</sub> max (ml·kg <sup>-1</sup> ·min <sup>-1</sup> )	22/1167	<b>3.1±0.50</b>	<b>6.1(&lt;0.001)*</b>	<b>2.1,4.1</b>	6/248	1.2±0.84	1.4(.15)	-0.45,2.9	8/366	<b>3.0±0.82</b>	<b>3.6(&lt;0.001)*</b>	<b>1.4,4.6</b>
SBP (mmHg)	12/489	<b>-4.4±1.5</b>	<b>-2.9(.004)*</b>	<b>-7.5,-1.4</b>	3/151	-2.9±2.6	-1.1(.26)	-8.1,2.2	5/255	-2.3±2.3	-0.97(.33)	-6.9,2.3
DBP (mmHg)	11/421	<b>-2.5±1.1</b>	<b>-2.2(.03)*</b>	<b>-4.6,-0.3</b>	3/151	-1.5±1.8	-0.84(.40)	-5.0,2.0	5/255	-2.3±1.6	-1.4(.16)	-5.5,0.9
TC (mg/dl)	14/463	<b>-5.3±2.5</b>	<b>-2.1(.03)*</b>	<b>-10.2, -0.4</b>	2/125	0.07±5.5	0.01(.99)	-10.8,10.9	7/326	-3.5±3.6	-0.96(.34)	-10.5,3.6
HDL (mg/dl)	17/602	<b>3.3±0.89</b>	<b>3.7(&lt;0.001)*</b>	<b>1.6,5.1</b>	2/125	0.82±2.2	0.38(.71)	-3.5,5.1	7/326	0.95±1.4	0.67(.50)	-1.8,3.7
LDL (mg/dl)	16/570	<b>-6.2±2.3</b>	<b>-2.7(.006)*</b>	<b>-10.7,1.8</b>	2/125	-1.2±5.4	-0.23(.82)	-11.8,9.3	7/326	-4.8±3.3	-1.4(.15)	-11.4,1.7
TG (mg/dl)	16/560	<b>-14.8±3.4</b>	<b>-4.3(&lt;0.001)*</b>	<b>-21.4,-8.1</b>	2/125	-8.4±9.4	-0.90(.37)	-26.9,10	7/326	<b>-11.1±4.9</b>	<b>-2.2(.02)*</b>	<b>-20.8,1.4</b>
Fasting glucose (mg/dl)	19/753	-1.9±1.0	-1.9(.06)	-3.9,.08	5/195	0.06±1.8	0.03(.97)	-3.4,3.6	7/346	<b>-4.8±1.7</b>	<b>-2.82(.005)*</b>	<b>-8.2,-1.5</b>
Fasting insulin (uU/ml )	17/725	<b>-2.9±0.6</b>	<b>-4.6(&lt;0.001)*</b>	<b>-4.3,-1.7</b>	4/167	<b>-3.2±1.4</b>	<b>-2.2(.03)*</b>	<b>-6.0,-0.3</b>	5/240	<b>-3.6±1.1</b>	<b>-3.2(.002)*</b>	<b>-5.8,-1.4</b>

Notes: #ES/P, number of effect sizes and number of participants (exercise plus control); ID, insufficient data available to conduct meta-analysis; \*, **boldface** items statistically significant; \*, statistically significant (two-tailed p ≤ 0.05).

Supplementary file 16. Original published protocol for study. See below.

For peer review only

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Protocol

# BMJ Open Exercise and adiposity in overweight and obese children and adolescents: protocol for a systematic review and network meta-analysis of randomised trials

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## ABSTRACT

**Introduction** Overweight and obesity is a worldwide public health problem among children and adolescents. However, the magnitude of effect, as well as hierarchy of exercise interventions (aerobic, strength training or both), on selected measures of adiposity is not well established despite numerous trials on this issue. The primary purposes of this study are to use the network meta-analytical approach to determine the effects and hierarchy of exercise interventions on selected measures of adiposity in overweight and obese children and adolescents.

**Methods and analysis** Randomised exercise intervention trials >4 weeks, available in any language up to 31 August 2017 and which include direct and/or indirect evidence, will be included. Studies will be located by searching seven electronic databases, cross-referencing and expert review. Dual selection and abstraction of data will occur. The primary outcomes will be changes in body mass index (in kg/m<sup>2</sup>), fat mass and percent body fat. Risk of bias will be assessed using the Cochrane Risk of Bias assessment instrument while confidence in the cumulative evidence will be assessed using the Grading of Recommendations Assessment, Development and Evaluation instrument for network meta-analysis. Network meta-analysis will be performed using multivariate random-effects meta-regression models. The surface under the cumulative ranking curve will be used to provide a hierarchy of exercise treatments (aerobic, strength or both).

**Ethics and dissemination** This study does not require ethics approval. Findings will be presented at a professional conference and published in a peer-reviewed journal.

**PROSPERO registration number** CRD42017073103.

## INTRODUCTION

### Rationale

Overweight and obesity in children and adolescents is a major public health problem worldwide. Between 1980 and 2013, the worldwide prevalence of overweight and obesity in children and adolescents increased by 6.9%, from 16.9% to 23.8%, in boys and by 6.4%, from 16.2% to 22.6%, in girls from

## Strengths and limitations of this study

- To the best of the investigative team's knowledge, this is the first systematic review to use the network meta-analytical approach to determine the effects as well as hierarchy of exercise interventions (aerobic, strength training or both) on body mass index in kg/m<sup>2</sup>, fat mass and percent body fat in overweight and obese children and adolescents.
- The results of this systematic review with network meta-analysis should be useful to practitioners and policy-makers for making informed decisions about exercise in the treatment of overweight and obesity in children and adolescents.
- The results of this systematic review with network meta-analysis should be useful to researchers with respect to the conduct and reporting of future research on this topic.
- Common to most meta-analyses, the results may yield significant heterogeneity which cannot be explained.
- Like any aggregate data meta-analysis, the possibility of ecological fallacy exists, that is, that group averages are not reflective of an individual's values.

developed countries.<sup>1</sup> For developing countries, increases of 4.8%, from 8.1% to 12.9% for boys and 5%, from 8.4% to 13.4% in girls, were reported.<sup>1</sup>

The negative outcomes associated with obesity in children and adolescents are both immediate and long term.<sup>2</sup> For immediacy, a population-based study of children and adolescents 5–17 years of age found that approximately 70% of obese youth had a minimum of one cardiovascular disease risk factor (high cholesterol, high blood pressure, etc).<sup>3</sup> Obese children and adolescents are also more likely to be diagnosed with prediabetes,<sup>4</sup> as well as being at an increased risk for bone and joint difficulties, sleep apnoea,



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and social and psychological issues such as stigmatisation, poor self-esteem and poorer health-related quality of life.<sup>5 6</sup> Long-term, childhood and adolescent overweight and obesity has been demonstrated to track into adulthood,<sup>7–11</sup> thus placing overweight and/or obese adults at a greater risk for cardiovascular disease, type 2 diabetes, stroke, several types of cancer and osteoarthritis.<sup>2</sup>

One promising intervention in the treatment of overweight and obesity is exercise. However, previous randomised trials that were limited to or included overweight and obese children and adolescents have led to conflicting results,<sup>12–58</sup> with some reporting statistically significant reductions in adiposity (body mass index (BMI)) as a primary outcome<sup>12 13 16 17 22 27 28 31 41 51–56 59–63</sup> and others reporting no change.<sup>14 15 18–21 23–26 29 30 32–40 42–50 57 58 62 64 65</sup> When limited to overweight and obese male and female children and adolescents,<sup>12 14 17–20 22–26 28 31 33 36 38–41 45–57</sup> only 18 (45.0%) have reported statistically significant reductions in BMI.<sup>12 17 22 28 31 41 50–58</sup> While this may lead one to the general conclusion that exercise does little to reduce BMI in overweight and obese children and adolescents, this would be short-sighted since it relies on the vote-counting approach,<sup>66</sup> an approach that has been shown to be less valid than the meta-analytical approach.<sup>66 67</sup>

Previous systematic reviews with meta-analyses that have focused on the effects of exercise as an independent intervention on BMI as a primary outcome in male and female children and adolescents have reported conflicting findings with five reporting a significant improvement in BMI<sup>68–72</sup> and five others reporting no statistically significant improvement.<sup>73–77</sup> However, 9 of the 10 suffer from one or more of the following limitations: (1) inclusion of a small number of studies with exercise as the only intervention,<sup>71 73–75</sup> (2) inclusion of non-randomised trials,<sup>68 74</sup> (3) inclusion of children and adolescents who were not overweight or obese.<sup>70 72 74 76 77</sup> Relevant to this study, all 10 suffer from reliance on pairwise versus network meta-analyses, the latter of which incorporates both direct and indirect evidence. In addition, there was an absence of an established hierarchy for determining which types of exercise (aerobic, strength training or both) might be best for improving BMI based on both direct and indirect evidence.<sup>68–77</sup> To partially address this issue as well as demonstrate feasibility, the investigative team has recently used the network meta-analytical approach to examine the effects of exercise (aerobic, strength training or both) on BMI z-score in overweight and obese children and adolescents.<sup>78 79</sup> Statistically significant reductions in BMI z-score were found for aerobic exercise and combined aerobic and strength exercise, but not strength training alone (mean, 95% CI, aerobic, –0.10, –0.15 to –0.05; aerobic and strength, –0.11, –0.19 to –0.03; strength, 0.04, –0.07 to 0.15).<sup>79</sup> Combined aerobic and strength training was ranked best, followed by aerobic exercise and then strength training.<sup>79</sup> Consistency in evidence and risk of bias did not differ between direct and indirect studies.<sup>79</sup> It was concluded that combined aerobic exercise

and strength training as well as aerobic exercise alone are associated with reductions in BMI z-score.<sup>79</sup> The lack of effect on BMI z-score in the strength training studies may have been the result of increases in lean muscle mass. However, since BMI in kg/m<sup>2</sup> continues to be the most frequently assessed and reported measure of adiposity in both the clinical and public health setting, such an examination using the network meta-analytical approach is needed. In addition, since all types of BMI measures as well as body weight do not capture changes in body composition (fat mass, percent body fat, etc), the inclusion of such outcomes, as previously suggested,<sup>79</sup> is also necessary.

## Objectives

The primary objectives of the current study are to conduct a systematic review with network meta-analysis of randomised trials to (1) determine the effects of exercise (aerobic, strength training or both) on adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents, and (2) establish a hierarchy of exercise interventions (aerobic, strength training or both) for treating adiposity (BMI in kg/m<sup>2</sup>, fat mass, percent body fat) in overweight and obese children and adolescents.

## METHODS

### Overview

This study will follow the guidelines from the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension statement for network meta-analyses of healthcare interventions.<sup>80</sup>

### Eligibility criteria

The inclusion criteria for this proposed network meta-analysis will be as follows: (1) direct evidence from randomised trials that compare two or more exercise interventions (aerobic, strength training, both) or indirect evidence from randomised controlled trials that compare an exercise intervention group to a comparative control group (non-intervention, attention control, usual care, wait-list control, placebo), (2) exercise-only intervention (aerobic, strength training or both), (3) studies lasting ≥4 weeks, (4) male and/or female children and adolescents 2–18 years of age, (5) participants overweight or obese, as defined by the authors, (6) studies published in any language up to 31 August 2017, (7) data available for BMI in kg/m<sup>2</sup>, fat mass or percent body fat.

Studies will be limited to randomised trials because it is the only way to control for confounders that are not known or measured as well as the observation that non-randomised controlled trials tend to overestimate the effects of healthcare interventions.<sup>81 82</sup> Indirect evidence studies will be limited to randomised controlled trials with at least one exercise arm that participates in either aerobic, strength training, or a combination of aerobic and strength training exercise. Direct evidence



studies will be limited to randomised trials that include at least two of the following exercise arms: (1) aerobic, (2) strength training, (3) aerobic and strength training exercise.

For the purposes of this study, exercise, aerobic exercise and strength training will be defined according to the 2008 Physical Activity Guidelines for Americans,<sup>83</sup> that is, movement which is 'planned, structured, and repetitive and purposive in the sense that the improvement or maintenance of one or more components of physical fitness is the objective',<sup>83 84</sup> aerobic exercise as 'exercise that primarily uses the aerobic energy-producing systems, can improve the capacity and efficiency of these systems, and is effective for improving cardiorespiratory endurance',<sup>83</sup> and strength training as 'exercise training primarily designed to increase skeletal muscle strength, power, endurance, and mass'.<sup>83</sup> Four weeks was chosen as the lower cut point for intervention length based on previous research demonstrating improvements in adiposity over this period of time in 11-year-olds.<sup>21</sup>

Participants will be limited to overweight and obese children and adolescents, as defined by the original study authors, because it has been shown that this population is at an increased risk for premature morbidity and mortality throughout their lifetime.<sup>85</sup>

While some research has suggested that studies yielding statistically significant and positive results are more likely to be published in English-language versus non-English-language journals,<sup>86</sup> other research has shown this to not be the case.<sup>87</sup> Given the former, studies from both English-language and non-English-language articles will be included with the latter translated into English by the second author using the freely available web-based Babelfish and Bing translators. For those studies that cannot be translated using Babelfish and/or Bing, professional translation services will be used.

BMI in kg/m<sup>2</sup> was included as one of the three primary adiposity outcomes because it is the most commonly used and understood variable by practitioners as well as others and can be easily measured from body weight and height. However, because BMI is an indirect measure of adiposity, fat mass and percent body fat will be included because they are more direct measures of adiposity. The inclusion of fat mass and percent body fat may be especially relevant for studies that include strength training given that decreases in adiposity as measured by BMI may be offset by increases in muscle mass, a secondary outcome that will be included.

Information sources

The following seven electronic databases will be searched: (1) PubMed, (2) Web of Science, (3) Cochrane Central Register of Controlled Trials, (4) Cumulative Index to Nursing and Allied Health Literature, (5) Sport Discus, (6) Translating Research into Practice and (7) ProQuest Dissertations and Theses. In addition to electronic database searches, cross-referencing will be conducted by examining the reference lists of previous review articles as

well as each included study for potential articles that meet the inclusion criteria. On completion of initial searches, the third author will examine the reference list for thoroughness and completeness. Suggested studies will then be retrieved to see if they meet all inclusion criteria.

Search strategy

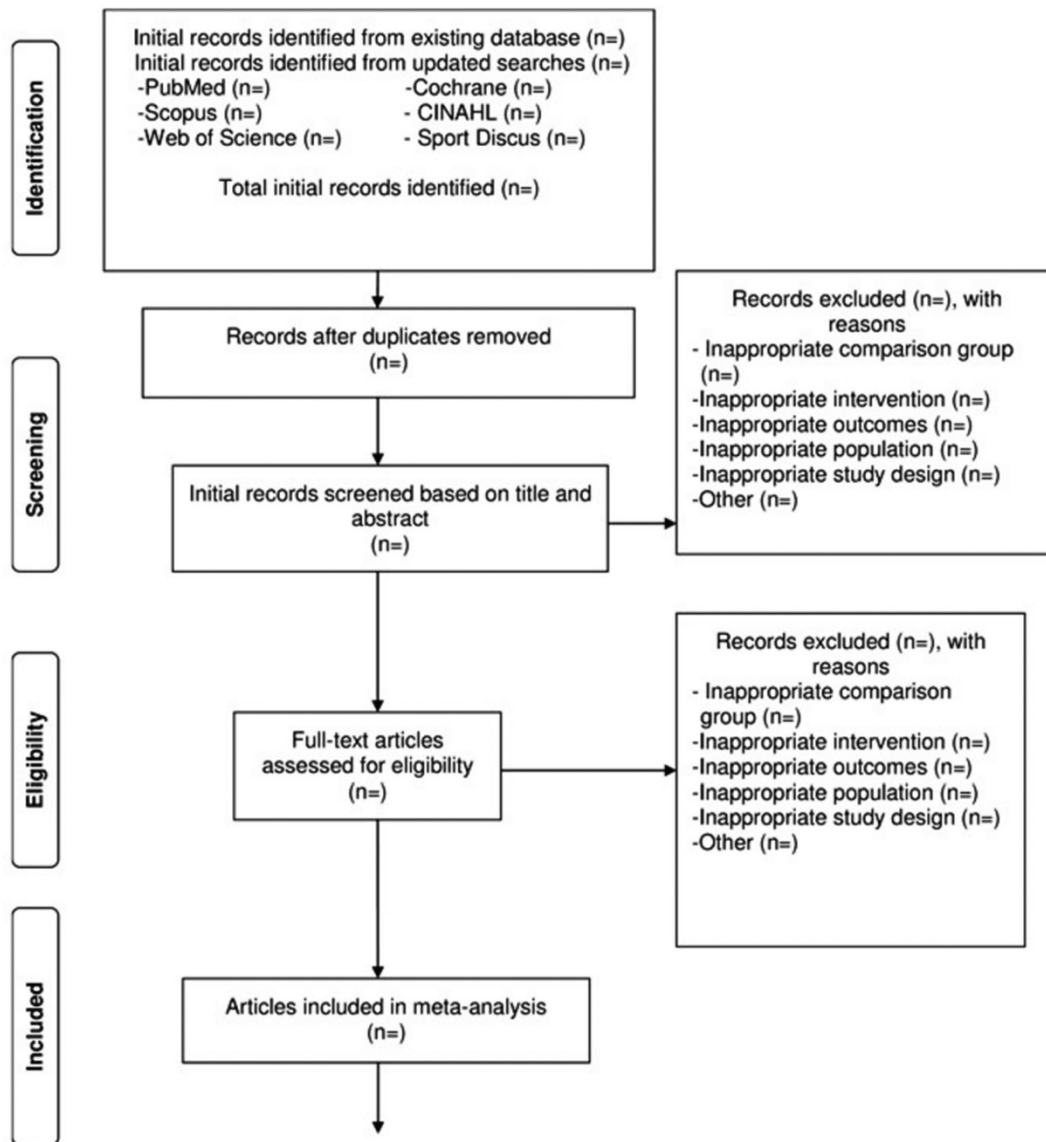
Search strategies specific to each database will be developed by the investigative team. Major keywords, or forms of keywords to include will be 'random', 'children', 'adolescents', 'overweight', 'obese', 'exercise', 'physical fitness', 'body composition', 'fat mass', 'body fat', 'body composition', 'body mass index', 'adiposity'. A copy of a preliminary search strategy using PubMed, including limits, can be found in the online supplementary file. This search strategy will be adapted for other database searches. All database searches and article retrieval will be conducted by the second author with oversight from the first author.

Study records

Study selection

All studies to be screened will be imported into EndNote (V.X8; Thomson-Reuters; 2016, New York, USA) and duplicates removed electronically and then manually by the second author. A copy of the database will then be provided to the first author for duplicate screening. To minimise selection bias, the first and second authors will select all studies, independent of each other. They will then review their selections for accuracy and consistency. The full report for each article will be retrieved for all titles and abstracts that appear to meet the inclusion criteria as well as those where uncertainty exists. Multiple reports for the same study will be addressed by including the most recently published article and drawing from prior reports, assuming the same methods and sample sizes are reported. Based on previous research suggesting neither a clinically nor statistically significant effect on results, blinding to journal titles, study authors or institutions of the authors will not be employed during the screening and data abstraction processes.<sup>88</sup> Reasons for excluded studies will be recorded using the following categories: (1) inappropriate population, (2) inappropriate intervention, (3) inappropriate comparison(s), (4) inappropriate outcome(s), (5) inappropriate study design, (6) other. On the conclusion of screening, the first and second authors will meet and review their selections. Cohen's  $\kappa$  statistic will be used to measure inter-selection agreement.<sup>89</sup> Any discrepancies will be resolved by consensus. If consensus cannot be reached, the third author will serve as an arbitrator. After selecting the final number of studies to include, the overall precision of the searches will be computed by dividing the number of included studies by the total number of studies screened after removing duplicates.<sup>90</sup> The number needed-to-read (NNR) will then be calculated as the reciprocal of the precision.<sup>90</sup> A flow diagram that describes the search procedure will be included as well as supplementary file

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**Figure 1** Proposed flow diagram to depict the search process.

a reference list of all excluded studies, including the reason(s) for exclusion. **Figure 1** illustrates the proposed structure for the flow diagram.

#### Data abstraction

For this project, Microsoft Excel (V.2016; Microsoft Corporation, Redmond, Washington, USA) will be used to develop comprehensive electronic codebooks that will define the coding process for each of the variables coded. The codebook will be created by the first two authors with feedback from the third author. Consequently, the abstraction of data from the studies in this proposed project should require little subjective judgement on the part of the coder. The major groups of variables to code will include (1) study characteristics (author, journal, year of publication, etc), (2) participant characteristics (age, gender, height, body weight, etc) and (3) data for

primary and secondary outcomes (sample sizes, baseline and postexercise means and SD, etc). **Table 1** contains a preliminary list of variables that will be coded. Based on previous research by the investigative team,<sup>79</sup> a codebook capable of including at least 242 items from each study is expected. To avoid data abstraction bias, the first two authors will independently code (dual-coding) all studies to ensure accuracy and consistency. Inter-rater agreement will be assessed using Cohen's  $\kappa$ .<sup>89</sup> Any disagreement in the items coded will be discussed until mutual agreement is reached. If agreement cannot be reached, the third author will serve as an arbitrator.

#### Outcomes and prioritisation

The primary outcomes in this study will be changes in BMI in  $\text{kg}/\text{m}^2$ , fat mass, and percent body fat in overweight and obese children and adolescents. Secondary





**Table 1** Covariates to examine using simple meta-regression

Characteristics	Variable
Study	Publication year, impact factor of journal, country study conducted, type of control group, bias (sequence generation, allocation concealment, blinding of participants and personnel, blinding of outcome assessors, incomplete outcome data, selective outcome reporting), type of analysis
Participant	Age, gender, race/ethnicity, maturational stage
Exercise	Type (aerobic, strength, both), length, frequency, intensity, duration, total minutes, total minutes (adjusted for compliance), mode, compliance, exercise supervision, setting, number of sets, number of repetitions, rest between sets, number of exercises, type of resistance, equipment used, fidelity (design, training, delivery, receipt, enactment)
Outcome	Baseline values for primary outcomes (BMI in kg/m <sup>2</sup> , fat mass, percent fat), method used to assess adiposity, that is, instrumentation, body weight, lean body mass, waist circumference, waist-to-hip ratio, diet, energy intake, energy expenditure, physical activity level, non-exercise activity, maximum oxygen consumption (relative and absolute), muscular strength, resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin

BMI, body mass index.

outcomes will include body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, physical activity level, maximum oxygen consumption (relative and absolute), muscular strength, resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high-density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin.

**Risk of bias assessment in individual studies**

Risk of bias for included studies will be assessed using the Cochrane Risk of Bias Instrument.<sup>91</sup> Assessment is based on judgements of low, high or unclear risk of bias across six defined domains: (1) sequence generation, (2) allocation sequence concealment, (3) blinding of participants and personnel, (4) blinding of outcome assessors, (5) incomplete outcome data and (6) selective outcome reporting. A seventh domain, whether participants were exercising regularly, as defined by the original study authors, will also be assessed using the same approach as for the other six domains. As previously recommended, study-level results will be reported for each domain according to risk of bias (low, high or unclear) while the percentage of low, high or unclear results across each domain will also be reported.<sup>91</sup> This risk of bias approach has been recommended over the use of study quality rating scales given the lack of empirical evidence to support the latter.<sup>82 92 93</sup> Assessment for risk of bias will be limited to the primary outcomes of interest, that is, changes in BMI in kg/m<sup>2</sup>, fat mass and percent body fat. All studies will be classified as high risk of bias with respect to the category ‘blinding of participants and personnel’ given that it’s virtually impossible to blind participants to group assignment in exercise intervention protocols. Based on previous research, no study will be excluded based on risk of bias results.<sup>94</sup>

**Data synthesis**

**Calculation of effect sizes**

The primary outcomes for this study will be changes in BMI in kg/m<sup>2</sup>, fat mass (kg), and percent body fat using the original metric. Changes for indirect comparisons will be calculated by subtracting the change outcome difference in the exercise group minus the change outcome difference in the control group. Variances will be computed using the pooled SDs of change scores in the exercise and control groups. If change score SDs are not available, they will be calculated from 95% CIs for either change outcome or treatment effect differences as well as pre-SD and post-SD values, the latter according to procedures developed by Follmann *et al.*<sup>95</sup> For direct comparisons, that is, randomised trials with no control group, the same general procedures will be followed except that the control group data will be replaced with one of the exercise interventions as follows: (1) aerobic minus strength training, (2) aerobic and strength training combined minus aerobic training, (3) aerobic and strength training combined minus strength training. Ninety-five percent CI and *z*- $\alpha$  values will be calculated for each outcome from each study. For those studies that include both direct and indirect comparisons, only direct comparison data will be included since a primary purpose of the current meta-analysis is determining which exercise interventions(s) might work best for improving adiposity in children and adolescents. For studies in which adiposity outcomes are assessed at multiple intervention time points, for example, 0 weeks, 8 weeks and 16 weeks, only data from the initial and last assessment will be used. If follow-up data are available, results from such studies will also be analysed separately to determine the sustainability of changes in adiposity. If any cross-over trials are included, treatment effects will be calculated by using all assessments from the intervention and control periods and analysing them similar to a parallel group



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trial.<sup>96</sup> While the possibility of a unit-of-analysis error exists as well as studies being underweighted versus overweighted, this method is believed to be better than alternative approaches, for example, limiting data from the first assessment point or trying to impute SDs, especially given the primary and secondary outcomes included and expected distribution of findings.<sup>96</sup>

Secondary outcomes (body weight, lean body mass, waist circumference, waist-to-hip ratio, energy intake, energy expenditure, maximum oxygen consumption (relative and absolute), resting systolic and diastolic blood pressures, total cholesterol, high-density lipoprotein cholesterol, ratio of total cholesterol to high-density lipoprotein cholesterol, non-high-density lipoprotein cholesterol, low-density lipoprotein cholesterol, triglycerides, glycosylated haemoglobin, fasting and non-fasting glucose and insulin) will be handled using the same approach as for primary outcomes. However, given the different metrics expected and the inability to convert between them, changes in physical activity levels and muscular strength will be calculated using the standardised mean difference effect size, adjusted for small sample sizes.<sup>97</sup>

#### Pooled estimates for changes in outcomes

*Network (geometry) plots* for each outcome will be used to provide a visual representation of the evidence base with nodes (circles) weighted by the number of participants randomised to each treatment and edges (lines) weighted by the number of studies evaluating each pair of treatments.<sup>98 99</sup> *Contribution plots* for each outcome will be used to determine the most dominant comparisons for each network estimate as well as for the entire network.<sup>98</sup> The weights applied will be a function of the variance of the direct treatment effect and the network structure, the result being a percent contribution of each direct comparison to each network estimate.<sup>98</sup>

Network meta-analysis will be performed using *multivariate random-effects meta-regression models* that can be performed within a frequentist setting, allows for the inclusion of potential covariates, and correctly accounts for the correlations from multiarm trials.<sup>100 101</sup> A two-tailed  $\alpha$  value  $\leq 0.05$  and non-overlapping 95% CI will be considered to represent statistically significant changes. Separate network meta-analysis models will be used to examine for changes in each primary and secondary outcome. Potential *covariates* will be examined by (1) conducting simple meta-regression for statistically significant associations between covariates and changes in primary outcomes (BMI in  $\text{kg}/\text{m}^2$ , fat mass, percent fat), (2) examining for multicollinearity between covariates ( $r > 0.80$ ) and (3) building a multiple meta-regression model. A list of potential covariates to examine using simple meta-regression is shown in [table 1](#). While we will include all methods used to assess adiposity, we will also conduct sensitivity analyses to see if results differ according to method of assessment, for example, fat mass assessed using whole body MRI versus bioelectrical impedance. Secondary outcomes (energy intake and expenditure,

physical activity level, muscular strength) will be handled using the same approach. *Transitivity*, that is, similarity in the distribution of potential effect modifiers across the different pairwise comparisons for each outcome<sup>102</sup> will include those listed in [table 1](#). *Inconsistency*, that is differences in effect estimates between direct and indirect results for the same comparison,<sup>103</sup> will be checked by assessing differences in treatment effects between direct and indirect effect estimates as well as differences between trials with different designs, for example, two-arm versus multiarm trials.<sup>101 103 104</sup> However, the probability of inconsistency is considered small given recent research demonstrating that inconsistency was detected in only 2%–14% of tested loops, depending on the effect measure and heterogeneity estimation method.<sup>105 106</sup> Finally, *prediction intervals* will be used to enhance interpretation of results with respect to the magnitude of heterogeneity as well as provide an estimate of expected results in a future study.<sup>107–109</sup> For network meta-analysis, degrees of freedom (*df*) will be set to the number of studies—the number of comparisons–1.<sup>109</sup>

#### Meta-biases

*Small-study effects* (publication bias, etc) will be assessed using comparison-adjusted funnel plots.<sup>98</sup> In the absence of small-study effects, the comparison-adjusted funnel plot should be symmetrical around the zero line.

#### Confidence in cumulative evidence

*Quality analysis* of specific pairwise effect estimates in the network meta-analysis will be evaluated using a recently developed modification of the Grading of Recommendations Assessment, Development and Evaluation for network meta-analysis across five domains: (1) study limitations, (2) indirectness, (3) inconsistency, (4) imprecision and (5) small-study effects.<sup>110</sup> Assessment will be conducted using the same procedures as for study selection and data abstraction.

To establish a hierarchy of exercise interventions for selected outcomes in the current meta-analysis, *ranking analysis*, that is, the ability to rank all interventions for a single outcome under study, for example changes in BMI in  $\text{kg}/\text{m}^2$ , will be used based on probabilities. However, because the ranking of treatments based exclusively on the probability of each treatment being the best should be avoided given that it does not account for the uncertainty in the relative treatment effects and the possibility for assigning higher ranks for treatments in which little evidence is available, separate *rankograms* and *cumulative ranking probability plots* will be used to present ranking probabilities along with their uncertainty for changes in primary and secondary outcomes.<sup>98 111</sup> The surface under the cumulative ranking curve (SUCRA), a transformation of the mean rank, will be used to establish a hierarchy of exercise interventions (aerobic, strength, both) while accounting for the location and variance of all treatment effects.<sup>98 111</sup> Larger SUCRA values indicate better ranks for the treatment.<sup>98 111</sup> Interpretation of all rankings will



be approached from the perspective of absolute and relative treatment effects.<sup>99</sup>

Software used for statistical analysis

All data will be analysed using Stata (V.14.1; Stata/SE for Windows, Stata Corporation, College Station, Texas, USA), Microsoft Excel (V.2016; Microsoft Corporation, Redmond, Washington, USA), and two add-ins for Excel, SSC-Stat (V.2.18; SSC-Stat, V.3.0.; Statistical Services Center; 2007; University of Reading, UK) and EZAnalyze (V.3.0; TA Poynton; 2007).

Amendments to protocol

None to date. If this protocol is amended, the date of each amendment, a description of the change, as well as a rationale for the change, will be provided.

**Contributors** GAK is the guarantor. GAK, KSK and RRP drafted the manuscript. All authors contributed to the development of the data sources to search for relevant literature, including search strategy, selection criteria, data extraction criteria and risk of bias assessment strategy. GAK provided statistical expertise while RRP provided content expertise on exercise and adiposity in overweight and obese children and adolescents. All authors read, provided feedback and approved the final manuscript.

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**PRISMA Network Meta-Analysis (NMA) Checklist**  
**Exercise and Adiposity in Overweight and Obese Children and Adolescents: A Systematic**  
**Review with Network Meta-Analysis of Randomised Trials**

Section/Topic	Item #	Checklist Item	Reported on page #
<b>TITLE</b>			
Title	1	Identify the report as a systematic review <i>incorporating a network meta-analysis (or related form of meta-analysis).</i>	1
<b>ABSTRACT</b>			
Structured summary	2	Provide a structured summary including, as applicable: <b>Background:</b> main objectives <b>Methods:</b> data sources; study eligibility criteria, participants, and interventions; study appraisal; and <i>synthesis methods, such as network meta-analysis.</i> <b>Results:</b> number of studies and participants identified; summary estimates with corresponding confidence/credible intervals; <i>treatment rankings may also be discussed. Authors may choose to summarize pairwise comparisons against a chosen treatment included in their analyses for brevity.</i> <b>Discussion/Conclusions:</b> limitations; conclusions and implications of findings. <b>Other:</b> primary source of funding; systematic review registration number with registry name.	2
<b>INTRODUCTION</b>			
Rationale	3	Describe the rationale for the review in the context of what is already known, <i>including mention of why a network meta-analysis has been conducted.</i>	4-7
Objectives	4	Provide an explicit statement of questions being addressed, with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	7
<b>METHODS</b>			
Protocol and registration	5	Indicate whether a review protocol exists and if and where it can be accessed (e.g., Web address); and, if available, provide registration information, including registration number.	7
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale. <i>Clearly describe eligible treatments included in the treatment network, and note whether any have been clustered or merged into the same node (with justification).</i>	8

Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	8-9
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	9, <i>Supplementary file 1</i>
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	9
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	10
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	10-11
<b>Geometry of the network</b>	<b>S1</b>	Describe methods used to explore the geometry of the treatment network under study and potential biases related to it. This should include how the evidence base has been graphically summarized for presentation, and what characteristics were compiled and used to describe the evidence base to readers.	12
Risk of bias within individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	11
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means). <i>Also describe the use of additional summary measures assessed, such as treatment rankings and surface under the cumulative ranking curve (SUCRA) values, as well as modified approaches used to present summary findings from meta-analyses.</i>	11-12, 14
Planned methods of analysis	14	Describe the methods of handling data and combining results of studies for each network meta-analysis. This should include, but not be limited to: <ul style="list-style-type: none"> <li>• <i>Handling of multi-arm trials;</i></li> <li>• <i>Selection of variance structure;</i></li> <li>• <i>Selection of prior distributions in Bayesian analyses; and</i></li> <li>• <i>Assessment of model fit.</i></li> </ul>	13
<b>Assessment of Inconsistency</b>	<b>S2</b>	Describe the statistical methods used to evaluate the agreement of direct and indirect evidence in the treatment network(s) studied. Describe efforts taken to address its presence when found.	12-13
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	13
Additional analyses	16	Describe methods of additional analyses if done, indicating which were pre-specified. This may include, but not be limited to, the following: <ul style="list-style-type: none"> <li>• Sensitivity or subgroup analyses;</li> </ul>	13-14, <i>Supplementary file 2</i>

- Meta-regression analyses;
- *Alternative formulations of the treatment network; and*
- *Use of alternative prior distributions for Bayesian analyses (if applicable).*

## RESULTS†

Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	<i>15, Figure 1, Supplementary file 3</i>
<b>Presentation of network structure</b>	<b>S3</b>	Provide a network graph of the included studies to enable visualization of the geometry of the treatment network.	<i>Figures 3,5,7</i>
<b>Summary of network geometry</b>	<b>S4</b>	Provide a brief overview of characteristics of the treatment network. This may include commentary on the abundance of trials and randomized patients for the different interventions and pairwise comparisons in the network, gaps of evidence in the treatment network, and potential biases reflected by the network structure.	<i>22, 24, 26</i>
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	<i>15-21, Tables 1 and 2, Supplementary file 4</i>
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment.	<i>Supplementary file 5</i>
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: 1) simple summary data for each intervention group, and 2) effect estimates and confidence intervals. <i>Modified approaches may be needed to deal with information from larger networks.</i>	<i>Supplementary files 6, 9, and 12</i>
Synthesis of results	21	Present results of each meta-analysis done, including confidence/credible intervals. <i>In larger networks, authors may focus on comparisons versus a particular comparator (e.g. placebo or standard care), with full findings presented in an appendix. League tables and forest plots may be considered to summarize pairwise comparisons.</i> If additional summary measures were explored (such as treatment rankings), these should also be presented.	<i>21-37, Figures 4, 6, 8, Table 3, Supplementary file 15</i>
<b>Exploration for inconsistency</b>	<b>S5</b>	Describe results from investigations of inconsistency. This may include such information as measures of model fit to compare consistency and inconsistency models, <i>P</i> values from statistical tests, or summary of inconsistency estimates from different parts of the treatment network.	<i>22-33, Supplementary files 6, 9, and 12</i>

1	Risk of bias across studies	22	Present results of any assessment of risk of bias across studies for the evidence base being studied.	21, Figure 2, Supplementary files 7, 10, 13
2				
3				
4	Results of additional analyses	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression analyses, <i>alternative network geometries studied, alternative choice of prior distributions for Bayesian analyses, and so forth</i> ).	23, 25-28 567-576 Supplementary files 8, 11, and 14
5				
6				
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9				
10				
11	DISCUSSION			
12	Summary of evidence	24	Summarize the main findings, including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy-makers).	33-41
13				
14				
15				
16	Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review level (e.g., incomplete retrieval of identified research, reporting bias). <i>Comment on the validity of the assumptions, such as transitivity and consistency. Comment on any concerns regarding network geometry (e.g., avoidance of certain comparisons).</i>	41-42
17				
18				
19				
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23	Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	42
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28	FUNDING			
29	Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review. This should also include information regarding whether funding has been received from manufacturers of treatments in the network and/or whether some of the authors are content experts with professional conflicts of interest that could affect use of treatments in the network.	43
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PICOS = population, intervention, comparators, outcomes, study design.  
\* Text in italics indicates wording specific to reporting of network meta-analyses that has been added to guidance from the PRISMA statement.† Authors may wish to plan for use of appendices to present all relevant information in full detail for items in this section.