Table 2

Description of the intervention studies included in the review for Salud Pública de México

Study	Aim and design	Setting and Sample	Intervention description (including control group activities)	Outcomes measures	Results
Bazzano et al.[22] USA	Evaluation of impact on: weight status, dietary habits, exercise, self-efficacy; access to health care, life-satisfaction, and community capacity. Pre-test post-test one group design	**Setting**: Sessions held at service agency N = 68 began study, 2 dropped out. 'Higher functioning' adults with IDD who were overweight (BMI ≥ 25) and had 1+ additional risk factors for diabetes or metabolic syndrome	**Program name**: The Healthy Lifestyle Change Program **Intervention target:** Persons with ID **Duration:** PA and education, 2x 2hr/week for 7 months **Components:** (1) client peer mentoring; (2) interactive health education; (3) supervised physical activity; (4) behavioural modification; (5) one-on-one health management education and advocacy; (6) clinical support; and (7) a supportive social network. Each class included 50 minutes of interactive health education, a 10-minute healthy snack break, and 1-hour of supervised physical activity.	BMI, WC, self-report PA frequency and duration in min/week (no details of how this was done), eating habits, knowledge and self-efficacy toward exercise, healthy eating and making doctor's appointment	Significant improvement in BMI (pre-test = 33.3, post-test = 32.8) and WC (pre-test = 41.3in, post-test = 40.4in), PA frequency (pre-test = 3.2x/wk, post-test = 3.9x/wk) and duration (pre-test = 133 min/wk, post-test = 206min/wk), most eating habits, self-efficacy toward exercise, and making doctor's appointment. Mixed findings for self-efficacy toward healthy eating and healthy eating knowledge.
Bergström et al.[25] Sweden	Impact of a novel three-component programme on physical activity and dietary habits Cluster RCT, randomization unit was the residence (group homes [GH] and supported living [SL])	**Setting**: Sessions for adults with IDD held in their home N = 130 persons; Intervention: residences n = 14 (10 GH, 4 SL); participants, n = 64; women = 57.8%; mean age = 36.2y ± 10.1; control residences: n = 16 (11 GH, 5 SL) participants, n = 66; women = 56.1%, mean age = 39.4y ± 11.3.	**Program name**: Hälsokörkortet (Driver's licence for health) **Intervention target:** Persons with ID and caregivers collectively **Duration:** 12 – 16 months. Caregivers: health ambassador, 6 x 3hr meetings; peer education study circle, 10 x 90 min. Persons with ID: 10 x 90 min. **Components:** intervention based on social cognitive theory. Components: (1) appointment of a health ambassador in each community residence; (2) a peer education study circle focusing on health for caregivers; and (3) a health course for the residents. See Elinder et al. [29] for study circle and health course details.	Primary outcome: PA via pedometer steps per day; secondary outcomes: BMI, waist circumference (WC), dietary quality, satisfaction with life, and work routines	Baseline steps/day for intervention group = 8042 (± 5524) and control group = 6296 (± 4167). Controlling for baseline values, clustering, and type of residence, regression analysis revealed a significant effect for PA (b =1608 steps/day, p = .045). A significant effect for total work routines (p = .016), domains of general health promotion work (p = .010), and PA (p = .043). No significant effect on BMI, WC, dietary quality, or satisfaction with life.

Bodde et al.[26] USA	Effectiveness of health education curriculum on PA knowledge, skills, and participation. Pre-post delayed treatment design (quasi-experimental)	**Setting**: Sessions held at service agency N = 44 began study, 2 dropped out. Ambulatory adults with mild-moderate ID Gender, age, BMI not reported although no difference between groups on these variables	**Program name**: Promoting Health through Physical Activity Knowledge and Skills (PHPAKS) **Intervention target:** Persons with ID **Duration:** 8 x 30 min. **Components:** Video instruction, pictorial memory tools, and interactive class activities. See Bodde et al.'s [23] formative evaluation for lesson content.	Physical activity knowledge (Physical Activity Recommendations Assessment, PARA; adapted Nutrition Activity Knowledge Scale, NAKS) and 7-day accelerometry (Actigraph)	Significant pre-test to post-test increases in knowledge (both NAKS and PARA); but only knowledge of PA recommendations significantly improved in relation to the control condition. Compliance with accelerometer wear time criteria was 59%. Minutes of moderate-vigorous physical activity did not change from pre-test (M = 7.0 min, SD = 21.6) to post-test (M = 7.7 min, SD = 31.5), p = .41. 2 participants withdrew after pre-test
McDermott et al.[24] USA	Test the efficacy of the health promotion intervention to prevent increase in BMI and to increase physical activity RCT	**Setting**: Sessions held at service agency N = 443 at baseline 18 – 65 years, women = 225. Dropout: 115 at 9 weeks, + 70 at 6 months, + 51 at 12 months	**Program name:** Steps to Your Health **Intervention target:** Persons with ID **Duration:** 1x 90 min/week for 8 weeks **Components:** Sessions focused on nutrition education, exercise, stress management, behaviour change. Each session delivered by health educator experienced working with adults with ID. Each session followed by an optional brisk walk. Control group participated in same length hygiene and safety classes.	MVPA (via accelerometer at 3 METs) and BMI	At baseline 20% of entire sample overweight and 59% obese, no difference between groups. No significant change in BMI at 12m and no between group differences. At baseline 16.9% of entire sample accumulated 150 minutes MVPA/week. No significant change in MVPA at 12m and no between group differences.

Stanish et al.[18] USA	To facilitate MVPA in the workplace B-A-B-A reversal design	**Setting**: Sessions held at service agency (sheltered workshop) N = 17 sheltered workshop employees; women = 29.4%; mean age = 42.6y	**Program name:** No specific name **Intervention target:** Persons with ID **Duration:** 3 x 15-17 min/week for 10 weeks **Components:** To promote MVPA at work two exercise conditions were tested: 1) live exercise leader plus aerobic dance exercise video, and 2) exercise video as the only source of instruction and verbal promotion. Weeks 1 – 6: condition 1 for 2w, then condition 2 for 2w, then condition 1 for 2w. Weeks 7 – 10, condition 2 only. Five different videos were developed for each condition.	MVPA was measured using observations every 20 seconds using the System for Observing Fitness Instruction Time (SOFIT) during the 15 – 17 min exercise sessions.	82% of employees engaged in in the program up to 3 days per week. The removal of the exercise leader only reduced the level of group engagement in MVPA by 7%. Verbal praise and encouragement seemed to be adequate to maintain the interest of most participants. 7 participants adhered to the program in the follow-up period.
VanSwearingen et al.[28] USA	Compare two interventions: 1) the task-oriented, motor sequence learning exercise (TO) to 2) the impairment oriented, multi-component exercise (IO) on activity and participation Single-blind RCT	**Setting**: Sessions held at clinical research training centre N=50 at baseline, 3 dropped out. TO group: n = 23 and mean age = 76.5y ± 5.5; IO group: n = 24 and mean age = 78.4y ± 5.5. 65% of overall sample were Women.	**Program name:** Task-oriented, motor sequence learning exercise (TO) **Intervention target:** Persons with ID **Duration:** Both programs, 2 x 20-30 min/week for 12 weeks **Components:** Led by a physical therapist in small groups. TO program. Based in principles of motor sequence learning, participants engaged in increasingly complex walking patterns and treadmill walking to promote regular timing. IO program. Based on current [sic] standards of physical therapy for gait and balance retraining; including: strength, balance, and endurance training.	Mobility performance (gait speed and variability, gait efficacy, lower extremity functioning, disability limitations, energy cost of walking, and PA via accelerometer counts per minute.	Physical activity did not change for either group from pre-test to post-test. Gait speed improved for both groups. In addition the TO group improved the energy cost of walking, gait efficacy, and lower extremity functioning. Compared to OI, the TO group also showed significantly greater gains in gait efficacy, energy cost of walking, and physical function. However, change in gait efficiency did not mediate change in activity or participation outcomes.

Note. MVPA = Moderate-Vigorous Physical Activity, NR = Not Reported, PA = Physical Activity