



DOSSIER · THERAPY

Lifestyle Programmes

Lifestyle programmes combine nutrition, exercise and behaviour change into a multi-component intervention. Research on this is broad: 467 studies in humans, of which 211 controlled. The areas most studied are metabolism and fatigue; the most cited controlled study concerns PCOS.

668

STUDIES IN
TOTAL

467

IN HUMANS

211

OF WHICH
CONTROLLED

1

IN ANIMALS

0

IN THE LAB

Figures from the IHR study database · Last updated 2026-10-04

How to Read This Dossier

ESTABLISHED

measured in humans, with a comparison group

PLAUSIBLE

supported by mechanism, animal studies or observation

HYPOTHESIS

a likely connection that still needs to be tested

Lifestyle Programme at a Glance

ORIGIN:
A lifestyle programme is not a single measure, but a structured approach that combines nutrition, exercise, weight management and, depending on the target group, sleep, stress management or smoking cessation. In addition, there are usually self-monitoring, goal setting and feedback from professionals or digital applications. Implementation ranges from personal sessions to group meetings to telephone- or internet-supported formats; the duration varies from a few weeks to several years.

EVIDENCE BASE:
668 evaluated studies · 211 controlled human studies · 256 observational studies · 43 review articles · 1 animal study · 0 cell culture studies

- STRONGEST EVIDENCE:**
- Metabolism: In a controlled evaluation, lifestyle participants with a college degree achieved a 68 % risk reduction in diabetes incidence (95 % CI 56 to 77), participants with lower education a 47 % reduction (95 % CI 29 to 61).
 - Metabolism: The meta-analysis on short lifestyle interventions in overweight or obesity evaluated 14 randomised controlled trials; the pooled weight change was -2.59 kg (95 % CI -3.47 to -1.72).
 - Musculoskeletal system: In a randomised study of 83 people with rheumatoid arthritis, a 16-week programme of plant-based nutrition, exercise and stress management led to a 0.9-point greater DAS28 improvement (95 % CI 0.4 to 1.3).
 - Cognition and psyche: The systematic review on whole-diet interventions in depression and anxiety observed significant effects on depression scores in favour of the treatment group in 47 % of the studies.

- LIMITATIONS:**
- The Cochrane review on PCOS leaves open how strong the weight loss is with which form of support.
 - In the study of adolescents with type 2 diabetes, the lifestyle component was always combined with metformin, so no effect of the programme alone can be derived.
 - In the obesity study in adolescents, all participants additionally received lifestyle therapy; the differences between the arms cannot be attributed to the programme.

CLASSIFICATION:
Lifestyle programmes bundle nutrition, exercise and behaviour change; their research is broad, yet which component works and how people stay long-term remains open.

1. What Lifestyle Programmes Are

A lifestyle programme is not a single measure, but a structured approach that addresses several behavioural areas at the same time. Typical are specifications or recommendations on nutrition, physical activity, weight management and – depending on the target group – sleep, stress management or smoking cessation. Implementation ranges from personal sessions to group meetings to telephone- or internet-supported formats. Some programmes are based on established curricula, such as the Diabetes Prevention Program, others are developed for specific groups such as pregnant women, children, older people or people with chronic diseases. The duration varies from a few weeks to several years. The term therefore covers very different interventions, which makes comparison between studies difficult.

2. What the Studies Show in Detail

The key human studies and the most important reviews — by field of application, with population, duration, preparation, measure and result, as the original studies report them. Numbers appear only where the study states them.

Distribution of **controlled human studies** by field of application — the numbers are not additive, as one study may be assigned to several fields:

FIELD OF APPLICATION	CONTROLLED STUDIES
Metabolism	105
Fatigue and stress	57
Heart and circulation	44
Cognition and psyche	41
Safety and tolerability	38
Musculoskeletal system	20
Gut and microbiome	18
Oncology	18

Metabolism

The Cochrane review on lifestyle changes in women with polycystic ovary syndrome pools randomised controlled trials in which nutrition, exercise or behavioural programmes were tested against minimal or no treatment [25]. Reproductive, anthropometric, metabolic and quality-of-life parameters are assessed; PCOS affects 8 % to 13 % of women of reproductive age. It distinguishes interventions in which, after study start, no support, technically mediated support or personal support by counsellors took place. The participants were predominantly white and had a university degree. How strong the weight loss is with which form of support remains the central open question of this evaluation.

Compared with placebo, lifestyle participants with a college degree achieved a 68 % risk reduction in diabetes incidence (95 % CI 56 to 77), participants with lower education a 47 % reduction (95 % CI 29 to 61). Under metformin the relative risk reduction was 49 % (95 % CI 33 to 62) versus 23 % (95 % CI 1 to 41). The interaction between education and treatment was statistically significant at $p=0.03$.

In the randomised 'Plants for Joints' study of 83 people with rheumatoid arthritis, of whom 77 completed the study, a 16-week programme of fully plant-based nutrition, exercise and stress management led to a 0.9-point greater improvement in DAS28 compared with usual care (95 % CI 0.4 to 1.3; $P<0.0001$) [35]. In addition, body weight (-3.9 kg), fat mass (-2.8 kg), waist circumference (-3 cm), HbA1c (-1.3 mmol/mol) and LDL (-0.32 mmol/l) decreased. In a three-arm study of 283 people with metabolic syndrome, its prevalence decreased by 16.9 % under lifestyle counselling, by 20.2 % under counselling plus linseed (30 g/day) and by 16.0 % plus walnuts (30 g/day) [31]. The regression rate of central obesity was higher in the group receiving counselling plus linseed (19.2 %; $P=0.008$) and in the group receiving counselling plus walnuts (16.0 %; $P=0.04$) than under counselling alone (6.3 %); the regression rate of the metabolic syndrome itself did not differ between the groups (21.1 %, 26.6 % and 25.5 %).

In the TODAY study, 234 adolescents with type 2 diabetes were assigned to a lifestyle programme; the participation rate was approximately 60 % of the planned sessions [36]. Adolescents with at least 75 % session participation did not differ in blood glucose control, but showed a greater reduction in percentage overweight than those with lower participation. The eHealth pilot study 'Body Balance Beyond' randomised 42 women with previous gestational diabetes (mean age 33.5 ± 4.0 years, BMI 32.4 ± 4.3 kg/m²), of whom 30 (71 %) completed the study; the retention rates after six months were 80 %, 54 % and 79 % [38]. In the CKD study, 83 patients with chronic kidney disease stage 3 to 4 were randomised, the exercise programme comprised eight weeks of supervised training and ten months of home training [28]. In the obesity study in adolescents, all participants additionally received lifestyle therapy, so the reported differences between the arms cannot be attributed to the lifestyle programme [27].

Gut and Microbiome

The randomised phase-2 study examined whether intensive lifestyle changes influence the course of mild cognitive impairment or early dementia in Alzheimer's disease [29]. Fifty-one patients aged 45 to 90 years with a Montreal Cognitive Assessment of at least 18 were included; the mean age was 73.5 years. Over 20 weeks the study compared an intensive multidomain lifestyle programme with a wait-list control group. Primary endpoints were clinical assessments of cognition and function; secondary endpoints included the plasma A β 42/40 ratio and further biomarkers. All participants had an A β 42/40 ratio below 0.0672 at baseline, supporting the Alzheimer diagnosis; only two persons dropped out. How strongly the scales change under the programme is the question that remains to be clarified.

A joint advisory from several professional societies classifies nutrition and other lifestyle factors around GLP-1 therapy for obesity [45]. In studies, GLP-1 receptor agonists lower body weight by 5 % to 18 %, with somewhat smaller effects in routine care. The panel identifies challenges including side effects, mainly gastrointestinal, nutrient deficiencies due to calorie reduction, loss of muscle and bone mass, low long-term adherence with subsequent weight regain, and high costs. Several practice guidelines recommend multicomponent, evidence-based nutrition and behavioural therapy; their use together with GLP-1 preparations has not yet become widespread.

The programmes were frequently delivered via internet-based routes. The work classifies components, reach, utilisation, evaluation and implementation of such offers for this target group and serves as orientation for development and research. Which components have the greatest effect on health behaviour must be clarified further.

Further Investigations

PROVEN

The meta-analysis of short lifestyle interventions in adults with overweight or obesity evaluated 14 randomised controlled trials lasting at most six months [4]. Half lasted shorter than 13 weeks, half 13 to 26 weeks; seven were conducted remotely, four in person and three combined. The pooled mean difference in weight change was -2.59 kg (95 % CI -3.47 to -1.72). By intervention duration the values were -2.70 kg (95 % CI -3.69 to -1.71) for programmes under 13 weeks and -2.40 kg (95 % CI -4.44 to -0.37) for 13 to 26 weeks. Recruiting and retaining participants over long periods remains the open task.

The mHealth programme TXT2BFIT was tested in a two-arm, blinded randomised controlled trial in 250 adults aged 18 to 35 years at increased risk of weight gain [30]. Included were persons with a BMI of 23.0 to 24.9 kg/m² and at least 2 kg weight gain in the preceding twelve months or with a BMI of 25.0 to 31.9 kg/m². In the twelve-week intervention the programme group received eight text messages per week, one email per week, five personal coaching calls, a nutrition booklet and access to internet-based resources; the control group received only four text messages and printed guidelines. Body weight and height were measured at baseline and after twelve weeks. The size of the effect achieved is the central question this study was intended to clarify.

The process evaluation of TXT2BFIT examined how participants used and perceived the individual programme components [33]. Over 80 % completed the survey after the three-month intensive phase (programme group $n=110$, control group $n=104$). Frequency of use of the components, delivered dose, engagement and difficulties encountered were recorded. The study-protocol report describes the design as a nine-month two-arm study with a twelve-week intensive phase and a subsequent maintenance phase in which the programme group continued to receive text messages, among other things [34]. Which component most strongly influences the weight trajectory has therefore not yet been decided.

Cognition and Psyche

PLAUSIBLE

The systematic review of whole-diet interventions and their effects on depression and anxiety evaluated randomised controlled trials published between April 1971 and May 2014 [47]. All reported depression scores; ten reported anxiety scores or overall mood. Compared with the control condition, 47 % of the studies observed significant effects on depression scores in favour of the treatment group; the remainder reported no effect.

Effective interventions were based on a single delivery route, involved a nutrition professional and less frequently recommended a reduction in meat consumption. Under which conditions the finding can be transferred to other cultures remains open.

In a randomised controlled trial with older adults, 15 senior centres in Arkansas were randomly assigned to a lifestyle programme or an attention-control group (cognitive training) [32]. The 228 participants were obese (BMI 34.5 ± 4.9) and had a mean age of 71.2 ± 6.6 years; the programme consisted of twelve sessions delivered in groups by trained lay health advisors. After four months, follow-up data were available for 93 % of the original group. Body weight was measured with a digital scale, together with percentage weight loss and the proportion achieving at least 5 % and at least 7 % weight loss. Which advisor and centre characteristics support success requires further clarification.

An exploratory randomised controlled trial with wait-list control examined a six-week mindfulness-based lifestyle programme in adults with Parkinson's disease whose disability corresponded to H&Y stage 2 [11]. Included were 18- to 75-year-olds who could attend at least four of the six sessions; the study ran from 2012 to 2013 and included a qualitative component. The primary aim was change in function and well-being after the programme and its stability after six months. All participants in the wait-list control group received the intervention later. Whether the observed changes are sustained over six months remains the open question.

The randomised controlled trial Time2bHealthy tested a parent-focused, internet-based healthy lifestyle programme for preschool children in Australia [10]. Participants were parents or caregivers of children aged two to five years who were overweight or at least on the 50th percentile of BMI for age and sex. The programme group received an eleven-week internet-based programme followed by fortnightly emails for three months; it set goals, received individual feedback from a nutrition professional and access to a closed Facebook group. The primary endpoint was the objectively measured BMI of the child. The extent to which BMI changes is the question this study is intended to answer.

Oncology

The ENRICH trial examined whether the constructs of social cognitive theory used in the programme mediate change in exercise behaviour [37]. 174 cancer patients and caregivers were surveyed at baseline, after eight weeks and after 20 weeks and were randomly assigned to a six-part in-person lifestyle programme or a wait-list control group. An earlier analysis of the trial had shown a significant effect on the primary step-count outcome after eight and after 20 weeks.

After eight weeks a significant effect of the intervention on the behavioural target was observed ($A=9.12$) [37]. Self-efficacy, behavioural goal, outcome expectations, barriers and social expectations were examined as putative mediators. Which of these factors actually explains the increase in physical activity is the question that further analyses must clarify.

Inflammation

The TODAY study followed lipids and inflammatory markers over 36 months in 699 adolescents with newly diagnosed type 2 diabetes and compared three arms: metformin alone, metformin plus rosiglitazone and metformin plus intensive lifestyle programme [44]. LDL, apolipoprotein B, triglycerides and non-HDL cholesterol rose over twelve months and stabilised in the following 24 months. The proportion with LDL ≥ 130 mg/dL or on LDL-lowering therapy increased from 4.5 % to 10.7 % over 36 months, while 55.9 % remained in the target range below 100 mg/dL. The treatment group did not influence LDL, apolipoprotein B or non-HDL. Because the lifestyle component was always combined with metformin, no effect of the lifestyle programme alone can be inferred from these comparisons. Whether the programme makes an independent contribution to the inflammatory markers remains open.

A review article classifies the role of nutrition in the development and prevention of non-alcoholic fatty liver disease [49]. Accompanying factors listed include insulin resistance, elevated free fatty acids, hepatic inflammation, oxidative stress and an imbalance of pro-inflammatory cytokines as well as genetic and epigenetic pathways, physical inactivity, sleep and dietary composition. Macro- and micronutrients are discussed as triggering factors and as possible starting points for prevention. Which concrete dietary pattern most strongly influences the course has therefore not yet been decided.

Heart and Circulation

PROVEN The systematic review with meta-analysis of dietary patterns and blood pressure evaluated 17 randomised controlled trials [46]. Healthy dietary patterns such as the DASH diet, the Nordic diet and the Mediterranean diet lowered systolic blood pressure by 4.26 mm Hg and diastolic blood pressure by 2.38 mm Hg. These patterns are rich in fruit, vegetables, whole grains, legumes, seeds, nuts, fish and dairy products and low in meat, sweets and alcohol. Physical activity and weight loss in combination with dietary change can lower blood pressure further.

The work explicitly concludes that further research is needed to clarify the effect of dietary patterns on blood pressure in cultures other than those described. The study was registered with PROSPERO. Whether the observed reductions occur in the same magnitude across different population groups is therefore the central open question.

Musculoskeletal System

A review of lifestyle interventions with nutrition, exercise and dietary supplements in non-alcoholic fatty liver disease in childhood summarises the data available at the time [50]. Studies of nutrition alone focused on sugar and carbohydrates without any dietary pattern proving superior; in obese children with fatty liver, weight loss can be beneficial independently of the diet used. Exercise is considered plausibly beneficial because physical inactivity, low aerobic fitness and low muscle mass are risk factors for the disease.

The review explicitly states that at the time of its preparation no randomised controlled trials on exercise as a treatment for fatty liver in children were available. Combinations of nutrition and exercise showed a possible reduction in alanine aminotransferase activity and the liver fat fraction determined by magnetic resonance. Findings on vitamin E, fish oil and probiotics were inconsistent in children. Exercise as a standalone treatment in children with fatty liver thus remains the open research question.

Overall Picture

Individual studies such as 'Plants for Joints' [35], the linseed and walnut study [31] or the web intervention for women with gestational diabetes [26] each show their own directions and magnitudes, but as individual works they do not carry the same evidentiary weight.

Several of the supporting works demonstrate a change in weight, but not an independent effect of the programme on the respective disease; the CKD study [28], the PCOS review [25] and the Alzheimer study [29] leave their endpoints open. Where complex programmes consist of multiple components, the works predominantly determine the overall effect of the programme, not the contribution of individual components [33]. Thus the question of the active ingredient and the effective dose of lifestyle programmes remains at the beginning.

Methodology of the Evidence Base

The controlled works are predominantly randomised controlled trials, partly with wait-list control [11] [29], partly open controls [32], supplemented by systematic reviews and meta-analyses [4] [25] [46] [47] [48] as well as statements from professional societies [40] [45]. Study duration ranges from six weeks [11] through twelve weeks [30] [31] to 56 weeks [27] and 36 months of follow-up [44]. Endpoints are body weight and BMI, anthropometric and metabolic parameters, blood pressure, cognition, exercise behaviour and process measures of implementation. Feasibility and retention [38] frequently serve as primary endpoints, while clinically hard endpoints are rarer. Systematic comparisons of individual components, uniform dose specifications and information on the origin of the respective funding are lacking.

The Heterogeneity of the Programmes Limits Transferability

The central difficulty lies in the definition. What constitutes a lifestyle programme is defined differently from study to study: number and type of components, intensity, duration, form of supervision and target group vary considerably. As a result, findings can only be transferred to other programmes to a limited extent. A finding on an internet-supported programme for young adults says little about a group-based programme for older people. Although the reviews bundle several studies, they often have to forgo pooled estimates or consider subgroups separately because of this diversity. For practice this means: the question is not whether lifestyle programmes work, but which components make a difference in which group under which conditions.

3. How Robust the Research Is

The 668 evaluated works are distributed across 467 human studies, of which 256 are observational and 211 controlled, as well as 157 basic research and 43 review or mechanism works. One animal finding is included. The controlled studies focus on metabolism (105), fatigue (57), cardiovascular (44), cognition (41) and safety (38); smaller fields are musculoskeletal (20), gut (18), oncology (18), bone (10) and inflammation (10). The most cited controlled works concern polycystic ovary syndrome, gestational diabetes, adolescent obesity, chronic kidney disease, mild cognitive impairment, weight prevention in young adults and metabolic syndrome. Reviews with high citation frequency exist on blood pressure, depression and anxiety as well as on eHealth formats of the Diabetes Prevention Program.

4. What Is Frequently Claimed — and What the Data Provide

STATEMENT	EVIDENCE BASE
Lifestyle programmes sustainably lower body weight.	The database contains numerous controlled studies on weight management, yet the programmes differ greatly. Most investigations show short-term effects; the
Lifestyle programmes improve cognitive performance in dementia.	The most cited controlled study from 2024 investigated intensive lifestyle changes in mild cognitive impairment or early Alzheimer's dementia. Individual contr
Digital programmes are equivalent to personal meetings.	Review articles on eHealth formats of the Diabetes Prevention Program are available. However, comparability with personally conducted programmes is limited,

STATEMENT	EVIDENCE BASE
Lifestyle programmes are suitable for all chronic diseases.	The controlled studies cover metabolism, cardiovascular system, exhaustion and some further areas. For many conditions, further controlled investigations star

5. The Most Robust Works

Ordered by evidentiary strength, not by familiarity: reviews and studies with many participants first. The complete evaluation comprises considerably more works; the most robust are listed here.

Controlled Human Studies

- ¹ The role of bariatric surgery in hypertension control: a systematic review and meta-analysis with extended benefits on metabolic factors (2025) — Review, 2,548 participants
- ² A Comparison Between Lifestyle Interventions and Usual Care Among Indian Adults With Hypertension: A Systematic Review and Meta-Analysis (2026) — Review, 1,547 participants
- ³ Effects of lifestyle education interventions on quality of life and fbg in women with gestational diabetes: a systematic review and meta-analysis (2026) — Review, 4,777 participants
- ⁴ Weight Loss in Short-Term Interventions for Physical Activity and Nutrition Among Adults With Overweight or Obesity: A Systematic Review and ... (2024) — Review
- ⁵ Lifestyle interventions improving health-related quality of life: A systematic review and meta-analysis of randomized control trials (2024) — Review
- ⁶ The Effect of Lifestyle Interventions on Anxiety, Depression and Stress: A Systematic Review and Meta-Analysis of Randomized Clinical Trials (2024) — Review
- ⁷ Metformin's Overall Effectiveness and Combined Action with Lifestyle Interventions in Preventing Type-2 Diabetes Mellitus in High-Risk ... (2025) — Review article
- ⁸ Type 2 diabetes prevention programs at the community and municipal level: a scoping review of controlled intervention studies (2026) — Review article
- ⁹ Systematic review of influence of ethnicity on efficacy and safety of pharmacotherapy for childhood and adolescent obesity (2026) — Review article
- ¹⁰ An Internet-Based Childhood Obesity Prevention Program (Time2bHealthy) for Parents of Preschool-Aged Children: Randomized Controlled Trial (2019) — 2,017 participants
- ¹¹ The effects of a mindfulness-based lifestyle program for adults with Parkinson's disease: a mixed methods, wait list controlled randomised control ... (2016) — 2,013 participants
- ¹² Association of Intensive Lifestyle and Metformin Interventions With Frailty in the Diabetes Prevention Program Outcomes Study (2021) — 2,385 participants
- ¹³ Evaluation of a Community-Based Diabetes Prevention Program in Thailand: A Cluster Randomized Controlled Trial (2019) — 1,903 participants
- ¹⁴ Evaluation of an adapted version of the Diabetes Prevention Program for low- and middle-income countries: A cluster randomized trial to evaluate ... (2022) — 2,019,782 participants
- ¹⁵ The intervention process in the European Fans in Training (EuroFIT) trial: a mixed method protocol for evaluation (2017) — 500 participants
- ¹⁶ Long-term effects and effect heterogeneity of lifestyle and metformin interventions on type 2 diabetes incidence over 21 years in the US Diabetes ... (2025) — 3,234 participants
- ¹⁷ Effectiveness of a blended mobile-based lifestyle intervention in women with glucose intolerance after a recent history of gestational diabetes ... (2024) — 2,022,240 participants
- ¹⁸ Enhancing Lifestyles in the Metabolic syndrome (ELM) multisite behavioral efficacy trial. Design and baseline cohort (2024) — 618 participants
- ¹⁹ Testosterone Treatment, Weight Loss, and Health-related Quality of Life and Psychosocial Function in Men: A 2-year Randomized Controlled Trial (2024) — 1,007 participants
- ²⁰ Lifestyle Intervention for Sustained Remission of Metabolic Syndrome: A Randomized Clinical Trial (2026) — 618 participants
- ²¹ Long-term Outcomes of Testosterone Treatment in Men: A T4DM Postrandomization Observational Follow-up Study (2023) — 1,007 participants
- ²² Lifestyle Intervention for Cardiovascular Disease Risk Factors in Jeddah, Saudi Arabia (2020) — 2,015 participants
- ²³ Prevalence of Distal Symmetrical Polyneuropathy by Diabetes Prevention Program Treatment Group, Diabetes Status, Duration of Diabetes, and Cumulative ... (2024) — 3,234 participants
- ²⁴ Clinical and cost-effectiveness of remote-delivered, online lifestyle therapy versus psychotherapy for reducing depression: results from the CALM ... (2024) — 2,022,182 participants

6. Summary

PROVEN

Lifestyle programmes are multi-component interventions comprising nutrition, physical activity, weight management and behavioural elements; the research encompasses 467 human studies, of which 211 are controlled. Metabolism and fatigue are the most extensively investigated. In one controlled analysis, participants with a college degree achieved a 68 % risk reduction in diabetes incidence (95 % CI 56 to 77), while participants with lower educational attainment achieved 47 % (95 % CI 29 to 61); the interaction between education and treatment was significant at $p=0.03$. A meta-analysis of 14 randomised controlled trials on brief interventions in overweight or obesity yielded a pooled weight change of -2.59 kg (95 % CI -3.47 to -1.72).

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That programmes with personal support, goal setting and feedback strengthen behaviour more effectively is a reasonable assumption; the Cochrane review on PCOS distinguishes support formats but leaves open how strongly weight loss varies by format. **Hypothesis:** If education and intensity of support moderate diabetes prevention, low-threshold, linguistically adapted formats could reduce the gap between educational groups. Likewise, the combination of several behavioural domains could explain why brief interventions already produce weight changes, while long-term weight maintenance remains the open task.

Open question: Which component most strongly influences the weight trajectory has not been decided. In the study of adolescents with type 2 diabetes the lifestyle component was always combined with metformin, so no independent contribution to inflammatory markers can be derived. In the obesity study in adolescents all arms additionally received lifestyle therapy, which is why the reported differences cannot be attributed to the programme. A study would therefore need to examine lifestyle programmes with clear controls, defined support format and sufficient duration, and measure which component carries the effect and how participants are retained long-term.

7. What Remains Open

- **Programme fidelity:** How can the implementation of a lifestyle programme be measured in a standardised way so that results become comparable across studies?
- **Long-term effect:** Which controlled studies examine whether the observed changes are maintained over several years?
- **Target Groups:** For which patient groups are controlled studies lacking, and how could such studies be designed?

Frequently Asked Questions

What distinguishes a lifestyle programme from a single nutrition or exercise recommendation?

A lifestyle programme combines several components – usually nutrition, exercise and behaviour change – and typically involves structured delivery with multiple contacts. A single recommendation is limited to one area. In the studies available, the range extends from brief internet-supported programmes to multi-year supervised interventions.

How robust is the overall evidence on lifestyle programmes?

There are 211 controlled studies in humans, plus 256 observational studies and 43 reviews. The reviews pool individual areas, such as blood pressure or depression. Because of the large differences between programmes, pooled statements are possible only to a limited extent. For many applications there are several controlled studies, for others only a few.

What role do digital formats play in the research?

Digital or telephone-supported programmes have been examined in several controlled studies, including for weight prevention in young adults and as eHealth variants of the Diabetes Prevention Program. The 2017 review summarises such eHealth formats. Direct comparison with personally delivered programmes has so far been rare.

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International Health Research

Research, put in context. Every statement leads to the original paper; the decision in the individual case rests with the treating professional.
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