Can a small-changes approach help address the obesity epidemic? A report of the Joint Task Force of the American Society for Nutrition, Institute of Food Technologists, and International Food Information Council

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ABSTRACT

The continued rise in obesity rates in most countries suggests that current programs and initiatives designed to combat obesity have not been successful in reversing the obesity epidemic. Obesity rates are increasing because of a gradual weight gain in most populations. There has been little long-term success in treating established obesity through lifestyle change, perhaps because of the large permanent changes in diet and physical activity required to keep weight off. An alternative strategy to address the obesity epidemic involves not focusing on weight loss but promoting small changes in diet and physical activity to initially prevent further weight gain. With the use of this strategy, obesity rates could first be stabilized in most populations and then, over time, decrease gradually. Supporting data show that small reductions in conscious energy intake and increases in physical activity can reduce excessive weight gain. The opportunity exists to use the small-changes approach to bring different stakeholders together to create a national initiative to address the global epidemic of obesity. The Joint Task Force of the American Society for Nutrition, Institute of Food Technologists, and International Food Information Council believe that a small-changes framework, aimed at helping people make conscious small changes in lifestyle behaviors, in combination with efforts by the private sector to gradually "ratchet down" some of the environmental factors that have contributed to excessive energy intake and the declining rates of physical activity, can be successful in reducing obesity rates. Such an initiative would benefit from the support of educational and social marketing campaigns developed with governmental input and support. Am J Clin Nutr 2009;89:477–84.

INTRODUCTION

Obesity is already recognized as one of the most serious public health issues in the world (1, 2) and will likely get worse because obesity rates are continuing to increase in most countries (3, 4). Moreover, increases in weight appear to affect all populations. A comparison of the US body mass index (BMI; in kg/m²) distribution in 1976–1980 with that in 2005–2006 (Figure 1), indicates that the latter distribution is shifted to the right, which indicates that body weight and BMI are increasing in the entire population (5).

There is little disagreement about the urgent need to address the global epidemic of obesity. However, despite heightened awareness of the problem and many suggestions on how obesity can be reduced (1, 6–8), there has been no real long-term success in tackling this public health problem. This lack of long-term success is due in part to the difficulty many people have in maintaining healthy dietary and physical activity patterns in an environment that discourages physical activity and encourages excessive energy consumption (9–11). In fairness, it is possible that some existing initiatives have had some success over longer periods of time.

On an individual level, treating established obesity through lifestyle modification has proven to be extremely difficult (12), and those few who do succeed have had to make dramatic changes in their diet and physical activity patterns (13). Most people who achieve weight loss through lifestyle modification regain most of the weight lost over time (12, 14).

On a population level, efforts have been directed toward either producing weight loss or preventing those who are not obese from becoming obese. Even though population efforts aim for smaller behavioral changes, there is little indication that these efforts have produced any sustainable changes. Given the complexity of the situation and the many factors promoting weight gain in the population, many consider the situation to be hopeless and predict that most of the population will eventually become obese (15).

In 2003, Hill et al (11) published an article in Science suggesting a paradigm shift in prioritizing strategies to reverse the global epidemic of obesity. These authors suggested that efforts should be focused first on promoting small lifestyle changes and not on producing weight loss or preventing obesity but on eliminating or reducing the gradual excessive weight gain that is occurring in people of all ages. Over time, such efforts can lead to observable reductions in obesity rates. Although previous
efforts at promoting small behavioral changes have been made, this article is the first to suggest that a comprehensive approach involving small changes in both diet and physical activity can be effective at addressing the global epidemic of obesity.

RATIONALE FOR CONSIDERING A SMALL-CHANGES APPROACH TO ADDRESSING OBESITY

A task force consisting of members of the American Society for Nutrition, the Institute of Food Technologists, and the International Food Information Council was established to consider whether a small-changes approach could be useful in addressing obesity. This 17-member task force met in person and by telephone to review data and to evaluate the small-changes approach.

There are several reasons why a small-changes approach might be an effective way to address the obesity epidemic.

1) Small changes are more feasible to achieve and maintain than are large changes. Hill et al (11) argued that given human biology and the external food and physical activity environment in the United States, it is difficult to sustain the large behavioral changes required to achieve reductions in body weight by those who were already overweight or obese. The authors argued that small lifestyle changes, such as 2000 more steps of walking (which would burn ≈100 kcal) and simple food substitutions, such as a diet soda for a regular soda [saving ≈150 kcal per 12-oz (340.2 g) serving] would be more sustainable than efforts to achieve the larger changes in diet and physical activity required for permanent weight-loss maintenance. This is not to say that small lifestyle changes will have a greater impact on body weight than will smaller ones but rather that small sustainable changes are better than larger ones that cannot be sustained.

2) Even small changes can have an important impact on body weight regulation. Small changes in diet and/or in physical activity, which might still fall short of optimal diet and physical activity recommendations, might be sufficient to stop the gradual weight gain of individuals and populations. Hill et al (11) made this argument based on their analysis showing that most of the US adult population gradually gains weight over time because of, on average, a very slight average daily discrepancy between energy intake and energy expenditure. This “energy gap” could be eliminated with very small daily behavioral changes resulting in increases in energy expenditure and decreases in energy intake of ≈100 kcal/d. The energy gap was estimated from the average weight gain in US adults, which was determined, using longitudinal and cross-sectional weight data, to be ≈0.4–0.9 kg/y. This gain would result from an average accumulation of body energy of ≈15 kcal/d. The authors assumed that excess energy intake is stored with 50% efficiency (a very conservative assumption), so that the average energy gap in the population is 30 kcal/d. The average accumulation of excess energy at the 90th percentile for weight gain was 50 kcal, producing an energy gap of 100 kcal/d.

3) Achieving small lifestyle changes could lead to increased self-efficacy and could stimulate people to make additional small changes. Thus, the small-changes approach could be the start of a process that could ultimately lead to larger changes.

4) The small-changes approach can be applied to reduce environmental forces that promote increases in energy intake and decreases in physical activity. The environmental situation thought to promote obesity did not develop overnight and will not be reversed immediately. A small-changes approach could be used to lessen, over time, the environmental pressures toward obesity.

5) The small-changes approach could be a unifying platform to allow the public and private sectors to work together to address obesity. This platform would not focus on blaming existing forces, but rather would provide credit for making positive changes, regardless of the starting point. For example, a food company would not be evaluated on the “healthiness” of their current products but rather would be given credit for positive changes in their product offerings.

Since the publication of the Science article, the small-changes approach has been widely embraced. For example, the US Department of Health and Human Services launched a small-changes initiative that included television and radio commercials and a website (www.smallstep.gov; accessed 13 October 2008). The small changes message was promoted by the US Surgeon General (www.surgeongeneral.gov/priorities/prevention; accessed 1 December 2008). A nonprofit initiative, America On the Move (www.americathemove.org; accessed 13 October 2008), was formed to promote the small-changes approach to modifying diet and physical activity. Through its Partner with My Pyramid Corporate Challenge, the US Department of Agriculture enlisted 81 companies to make product, packaging, and promotion changes to help consumers make small changes consistent with the Dietary Guidelines (www.MyPyramid.gov; accessed 2 December 2008). Groups such as the American Diabetes Association, the American Heart Association, and the American Cancer Society recommend the small-changes approach, as do many other public health organizations.

The food industry has embraced the small-changes approach by addressing portion size. Offering snacks in 100-kcal packages has become extremely popular and is based on research showing slightly higher energy intakes when food is presented in large rather than small portions, although the impact of packaging snacks in smaller portions on energy intake of the population is yet unclear. In short, the small-changes strategy is increasingly being embraced by many of those interested in addressing the obesity epidemic. The purpose of this article is to evaluate the scientific evidence supporting the feasibility and effectiveness of this strategy for addressing the global epidemic of obesity. An additional intent is to consider how this approach could be used in modifying environmental determinants of energy intake and physical activity. In this review, we consider the following specific questions:

1) Can the energy gap help in developing strategies to address obesity?

2) Is there evidence to suggest that a small-changes approach can be effective at reducing or stabilizing obesity rates?
3) Has the small-changes approach been used successfully to reduce or prevent excessive weight gain?
4) Can the small-changes approach be used to change environmental determinants of obesity?
5) Can the small-changes approach serve as the foundation for a national campaign to address obesity?

CAN THE ENERGY GAP HELP IN DEVELOPING STRATEGIES TO ADDRESS OBESITY?

Hill et al (11) defined the energy gap for preventing weight gain as the average difference between energy intake and energy expenditure of the population or of an individual that leads to weight gain over time. This energy gap is the level of energy intake above energy expenditure that is causing weight gain. For example, an extra 15 kcal/d will not lead to continued weight gain over time, whereas an extra 15 kcal/d above energy expenditure will. This energy gap is small (median: ≈15 kcal/d) and is in contrast with the energy gap that is created by cumulative weight gain leading to obesity. The energy gap provides an estimate of the degree of behavioral change that would be required to achieve a specific weight outcome. For example, the energy gap required for an obese individual to return to a healthy BMI would be large (16). This is because there is a cumulative increase in body weight as obesity progresses, which leads to increased energy costs. The energy gap for preventing weight gain is small because it estimates the degree of behavioral change required to not gain any additional weight, regardless of whether the person is lean, overweight, or obese.

The energy gap for weight loss can also be estimated. Energy requirements are higher in the obese, but decline with weight loss because of declines in resting energy expenditure and reductions in the energy cost of physical activity (17). The energy gap required to produce and maintain weight loss would be significantly larger than the energy gap required to prevent weight gain. We used data obtained in a whole-room calorimeter (JO Hill, HR Wyatt, unpublished observations, June 2007) to estimate that the energy gap to maintain a 9–14-kg weight loss in obese subjects would be ≈175–250 kcal/d and that the energy gap to maintain an 18–27-kg weight loss would be 325–480 kcal/d (Figure 2). This large energy gap created by weight loss illustrates why large behavioral changes are required to achieve and maintain reductions in body weight in obese individuals. It is important to emphasize that these values are applicable to the obese population and should not be extrapolated to whole populations because there may be some metabolic adaptations to established obesity.

Alternatively, regardless of someone’s current weight or BMI, further weight gain can be prevented by small decreases in energy intake and/or increases in physical activity. This concept is illustrated in Figure 3 for adults and children.

The fact that there is a small energy gap underlying global increases in body weight and obesity is supported by several other investigators in other populations. The studies in which the energy gap was estimated or could be estimated from the data collected are listed in Table 1. In addition to Hill et al (11), Brown et al (18) determined the energy gap in middle-aged Australian women and reported that the average weight gain was ≈0.5 kg/y over 5 y and resulted in the daily accumulation of energy of ≈10 kcal/d. More recently, Zhai et al (19) estimated the energy gap in the Chinese population to be 45 kcal/d. Wang et al (20) estimated the energy gap to be 110–165 kcal/d among children by investigating the difference between the actual and optimal trajectory of weight gain. In a longitudinal study that compared growth in children of 2 lean parents with growth in children of 2 obese parents, Goran et al (21) found that the average excess accumulation of body energy between groups was ≈25 kcal/d, or ≈50 kcal/d, based on the assumptions of Hill et al concerning energy storage.

Several other studies did not calculate the energy gap but reported rates of weight gain over time in populations that would be consistent with a small energy gap. For example, Tataranni et al (22) examined the Pima Indians, a largely obese population in southwestern Arizona. An average weight gain comparable with an accumulation of body energy of 30–40 kcal/d was found. Sheehan et al (23) found that Americans gain weight at a steady rate until ≈60 y of age. From 1971 to 1992, the average weight gain of those aged <60 y ranged from 0.25 to 0.54 kg/y. Ebrahimi-Mameghani et al (24) followed a Scottish population for a total of 9 y and found that only 20% of the population remained at a stable weight. Approximately 42.2% of the population gained >5 kg, and 17.6% of the population gained >10 kg.
TABLE I

<table>
<thead>
<tr>
<th>Population</th>
<th>Energy accumulation</th>
<th>Energy gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>US adults (9)</td>
<td>15 kcal/d; 59 kcal/d for 90th percentile</td>
<td>30 kcal/d; 100 kcal/d for 90th percentile</td>
</tr>
<tr>
<td>US children (20)</td>
<td>—</td>
<td>110–165 kcal/d</td>
</tr>
<tr>
<td>US children (21)</td>
<td>25 kcal/d</td>
<td>50 kcal/d</td>
</tr>
<tr>
<td>Australian women (18)</td>
<td>10.5 kcal/d</td>
<td>21 kcal/d</td>
</tr>
<tr>
<td>Chinese adults (19)</td>
<td>22.5 kcal/d</td>
<td>45 kcal/d</td>
</tr>
<tr>
<td>Adult Pima Indians (22)</td>
<td>30.6 kcal/d</td>
<td>61.2 kcal/d</td>
</tr>
<tr>
<td>Scottish adults (24)</td>
<td>11.5 kcal/d in 42.2% of population;</td>
<td>23 kcal/d for 42.2% of population;</td>
</tr>
<tr>
<td></td>
<td>23 kcal/d in 17.6% of population</td>
<td>46 kcal/d for 17% of population</td>
</tr>
<tr>
<td>Swedish adults (25)</td>
<td>4.1 kcal/d for men; 6.2 kcal/d for women</td>
<td>8.2 kcal/d for men; 12.4 kcal/d for women</td>
</tr>
<tr>
<td>Chilean women aged 40–53 y (26)</td>
<td>16.8 kcal/d</td>
<td>33.6 kcal/d</td>
</tr>
</tbody>
</table>

During the 9-y study period, Berg et al (25) examined a population of men and women in Sweden and found a mean body weight increase of 3.3 kg for women and 5 kg for men over the 17-y study period. A study in Chilean women aged 40–53 y found an average weight gain of 3.8 kg over 5 y (26).

Several studies have shown that some groups are gaining weight at a much higher rate than the general population. In these populations, the energy gap is >100 kcal/d. Levitsky et al (27) followed a sample of students during their first semester in college. The results showed a mean weight gain of almost 2 kg in the first 12 wk of college, which constituted an energy gap of 367 kcal/d. A study conducted by Butte et al (28), which followed a large cohort of Hispanic children (4–19 y of age) for 1 y, found that the mean weight gain was significantly higher in overweight children (7.5 kg/y) than in nonoverweight children (4.4 kg/y). The energy gap was ≈130 kcal/d more for overweight Hispanic children than for nonoverweight Hispanic children.

In summary, the available data suggest that many populations are gradually gaining weight, which is being fueled by a relatively small difference between energy intake and energy expenditure. Put simply, on average, most people are consuming only slightly more calories than they are expending and, consequently, are gradually gaining weight at an average of 0.5–1 kg/y.

IS THERE EVIDENCE TO SUGGEST THAT A SMALL-CHANGES APPROACH CAN BE EFFECTIVE AT REDUCING OR STABILIZING OBESITY RATES?

Effects of large compared with small changes on increases in physical activity

Several government bodies and scientific organizations have issued guidelines for physical activity. Many of these guidelines (29, 30) recommend 30 min/d of moderate-intensity physical activity most days. Some guidelines recommend 60 min/d of moderate-intensity physical activity to prevent weight gain and 60–90 min/d of physical activity to maintain weight loss and prevent weight regain (31, 32). Meeting these recommendations requires large changes for most people. Brownson et al (32) reviewed population data on physical activity trends among US adults. In 2000, only ≈26% of this population met even the 30-min/d physical activity level recommendation. Moreover, this number has not changed over the past decade. It is clear that guidelines that set large behavioral goals for physical activity have not been successful.

Alternatively, Hill et al (11) estimated that an extra 2000 steps/d would be sufficient to increase energy expenditure by ≈100 kcal/d and that this simple change could stop weight gain in most adults. These authors further suggested that pedometers could be used as tools to allow people to set and monitor physical activity in steps/d. Before 2003, several studies had been published that used pedometers to measure physical activity, but a Medline search found that only 4 of these studies used an increase in the number of steps per day as a physical activity intervention. Since 2003, >30 studies that used an increase in the number of steps per day as a physical activity intervention have been conducted. A review by Ogilvie et al (33) provides the details and outcomes of these interventions. Bravata et al (34) reviewed 26 studies (n = 2767 subjects) in which pedometers were used as tools to increase physical activity. Pedometers work because they provide physical activity goals that are simple and measurable. The average increase in steps per day was 2491, which represented a 26.9% increase in physical activity over baseline. Most people can obtain this type of increase by walking for ≈20–25 min. Such an increase would be effective for most people to achieve the recommended physical activity level of 30 min/d. Moreover, this increase of 2491 steps/d, or ≈20 min/d of walking, was associated with a slight decline in BMI (0.38). The main point is that 20 min of walking is a small behavioral change that was achieved and was sufficient to prevent weight gain.

Other small-changes approaches to increasing physical activity have been shown to be effective. Dolan et al (35) evaluated the impact of prompts to take the stairs instead of the escalator. These researchers reviewed 8 studies and found that the mean (± SD) increase in stair usage was 2.8% ± 2.4%. It was projected that a 2.8% increase in stair usage could result in the prevention of a weight gain of 300 g/person per year in new stair users. The authors concluded that this strategy could have a slight impact on reducing the national prevalence of obesity. However, it should be noted that if the impact of the environment worsens, additional changes might be required to avoid weight gain.

Another small-changes approach is the Take 10! Program, which is aimed at integrating increased energy expenditure into academic curricula. Caloric expenditure with this intervention ranges from 25 to 37 kcal/10-min session (36). Participating in 5–10 Take 10! sessions per week would burn an additional 150–300 kcal during this period. This small change could have a big impact on energy balance and weight maintenance in the school-aged population.
Effects of large compared with small changes on improvements in diet

Efforts to achieve large changes in the diets of Americans have not been widely successful. The More Matters program (formerly known as the 5-a-Day program) has promoted the consumption of 5 servings of fruit and vegetables/d since 1991, with only modest success. The percentage of Americans who know that they should eat ≥5 servings of fruit and vegetables/d has increased from ≈8% to ≈20%, but the consumption of fruit and vegetables changed little from 1994 to 2005 (37).

Americans were told to make big reductions in dietary fat intake in 1980 and in the early 1990s (38, 39). Although much was made of the resulting decline in the percentage of calories from fat eaten, the total fat consumed (in g/d) declined very slightly in the mid-1980s but actually began increasing in the late 1980s (40). The percentage of calories consumed from fat declined because of an increase in total energy intake (40). Additionally, efforts to promote big reductions in dietary carbohydrate during the late 1990s and early 2000s were not sustainable, as evidenced by a decline in several formerly very popular low-carbohydrate diets.

Some big changes in diet have been successful. One such change has been an increase in the consumption of reduced-fat milk; however, this change has occurred over 35 y (41). Another successful big dietary change has been recent efforts to eliminate most synthetic trans fatty acids from the US diet. This change may be working largely because it does not require major behavioral changes on the part of the consumer. The changes are being done by the food manufacturers and by restaurants, which have reduced their use of partially hydrogenated fats. Consumers who seek to eliminate trans fatty acids can do it with little or no sacrifice of taste or convenience.

The small-changes approach as a single strategy to reducing energy intake in populations has not been directly tested. However, a great deal of research suggests that small changes in specific components of the diet could produce small but important changes in energy intake without the need for conscious energy restriction. For example, Donahoo et al (42) found that energy intake will decrease by ≈20 kcal/d with each 1% decrease in the percentage of fat in the diet. Perhaps small changes in dietary fat would be more sustainable than larger ones. Similarly, small reductions in portion size can produce reductions in energy intake without stimulating hunger (43–46). Consumption of sugar-sweetened beverages in the United States has increased from an average of 222 to 458 kcal/d over the past 25 y (47). Reducing the consumption of caloric beverages has been found to decrease total energy intake (48), so there may be merit in recommending small reductions in the consumption of these products. Studies have also shown that fiber supplementation can reduce energy intake by 15–20% (49).

Reducing the energy density of certain foods is a strategy that can be achieved with reductions in fat or sugar intake (provided these macronutrients are replaced by ingredients with fewer calories, such as protein or carbohydrate in the case of fat) or with increases in fiber, water, or air. The advantage of this approach is that calorie intake can be reduced without a decrease in serving size. Prentice and Jebb (50) reviewed the published data on energy density and energy intake and concluded that the evidence is clear that energy intake increases directly with increases in energy density. Rolls et al (51) consistently found that reducing energy density produces small reductions in energy intake in short-term experiments. They estimated that a reduction of 0.1 kcal/g in the energy density of the diet produces reductions in energy intake of 110 kcal/d in men and of 82 kcal/d in women. The strategy of reducing energy density seems to reduce energy intake in children as well. Leahy et al (52) found that reducing the energy density of an entrée served to children reduced energy intake from that entrée by 25% and total intake from the meal by 18%.

HAS THE SMALL-CHANGES APPROACH BEEN USED SUCCESSFULLY TO REDUCE OR PREVENT EXCESSIVE WEIGHT GAIN?

A substantial amount of research suggests the feasibility of changing energy intake and total physical activity through a small-changes approach. Another important question is whether the small-changes approach can be shown to be effective at reducing excessive weight gain, as suggested by Hill et al (11).

The most direct evidence for the ability of the small-changes approach to reduce or prevent excessive weight gain comes from Rodearmel et al (53, 54), who used a family-based small-changes intervention in families with at least one child who was overweight or at risk of overweight. These researchers tested the efficacy of the America On the Move initiative, which advocates an increase in walking by 2000 steps/d and reducing energy intake by 100 kcal/d. In one study (53), the intervention families were asked to make 2 small changes: 1) to consume cereal for breakfast and 2) to increase physical activity by 2000 steps/d over baseline. After 14 wk, the increase in BMI-for-age in the target children was significantly less in the intervention group than in the control group. Mothers in the intervention group also experienced a favorable change in BMI.

In a second study conducted by Rodearmel et al (54), the intervention consisted of 1) reducing energy intake by ≈100 kcal/d by replacing sugar or sugar-containing beverages with noncaloric sweeteners or products containing noncaloric sweeteners, and 2) increasing walking by 2000 steps/d over baseline. After 6 mo, significantly more children in the intervention group than in the control group maintained or decreased their BMI-for-age (Figure 4).

**FIGURE 4.** Percentage of target children in the America On the Move (AOM) and Self-Monitoring (SM) groups who maintained/reduced or increased their percentage BMI-for-age over 6 mo (54). Significantly more AOM children than SM children maintained or reduced their percentage BMI-for-age (P < 0.05). Significantly fewer AOM children than SM children increased their percentage BMI-for-age (P < 0.05).
Several studies that used pedometers to increase physical activity showed reductions in weight. Chan et al. (55) used pedometers in a 12-wk work-site intervention in 106 sedentary workers and achieved slight decreases in both BMI and waist circumference. Toole et al. (56) conducted a self-reported pedometer-walking program in which participants increased their walking by 2000 steps/d and experienced a decrease in BMI. Clarke et al. (57) used pedometers to measure increases in physical activity in low-income mothers. They found that the use of pedometers was associated with increased physical activity and with reductions in body weight, percentage body fat, and waist circumference.

Fewer studies have been conducted to evaluate the impact of a small-changes approach to reducing energy intake alone on obesity rates. James et al. (58) reported initial success in a school-based intervention aimed at reducing the consumption of carbonated soft drinks by children. The percentage of overweight children increased by 7.6% in the control group and decreased by 0.2% in the intervention group. The difference in energy intake due to the intervention was $\sim 35–40$ kcal/d. However, the impact of the intervention was not sustained over 3 y (59). This illustrates the potential of a relatively modest decrease in energy intake to affect anthropometric variables but also emphasizes the difficulty of sustaining even small behavioral changes.

The available data strongly suggest that excessive weight gain in most of the population is due to a slight degree of positive energy balance and that small lifestyle changes can reduce the energy gap. The small-changes approach has been shown to be effective at increasing total physical activity, decreasing total energy intake, and preventing or reducing excessive weight gain. Given the lack of success with other approaches to lifestyle changes, the small-changes approach deserves serious attention. The small-changes approach might, at a minimum, help prevent obesity and manage obesity rates. James et al. (58) reported initial success in a school-based intervention aimed at reducing the consumption of carbonated soft drinks by children. The percentage of overweight children increased by 7.6% in the control group and decreased by 0.2% in the intervention group. The difference in energy intake due to the intervention was $\sim 35–40$ kcal/d. However, the impact of the intervention was not sustained over 3 y (59). This illustrates the potential of a relatively modest decrease in energy intake to affect anthropometric variables but also emphasizes the difficulty of sustaining even small behavioral changes.

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campaign to address obesity. The historic record clearly demonstrates remarkable advances in the application of nutrition and food science research to benefit health (60). Given the gravity of the obesity epidemic and the ensuing public health consequences, there is a pressing need to implement the small-changes approach. As presented, a small-changes initiative aimed at affecting the food supply could result in a landmark discovery in nutrition and food science that dramatically benefits public health and could lead to a national initiative to address obesity around the world. This task force believes that a small-changes framework aimed at helping people make conscious small changes in lifestyle behaviors in combination with efforts by the private sector to gradually “ratchet down” some of the environmental factors that have contributed to excessive energy intake and to the declining rates in physical activity could be successful in reducing obesity rates. This initiative could be supported by educational and social marketing campaigns driven by or influenced by the many government agencies addressing this problem.

The manuscript was reviewed by all members of the Joint Task Force: Susan Borra (International Food Information Council); Roger Clemens (ET Horn Company); Fergus Clydesdale (University of Massachusetts, Amherst); John Courtney (American Society for Nutrition); Sarah Davis (Institute of Food Technologists); John Erdman (University of Illinois, Urbana-Champaign); Mary Christ-Erwin, Porter-Novelli, and Shelley Goldberg (International Food Information Council); Penny Kris-Etherton (Pennsylvania State University); Gil Leveille (Wrigley Science Institute); James Hill (University of Colorado, Denver); Lori Hoolihan (Dairy Council of California); Guy Johnson (McCormick Science Institute); Penny Kris-Etherton (Pennsylvania State University); Gil Leveille (Wrigley Science Institute); Daryl Lund (Emeritus, University of Wisconsin, Madison); Indra Mehrotra (General Mills Bell Institute of Health and Nutrition); Keith Singletary (University of Illinois, Urbana-Champaign); and Connie Weaver (Purdue University).

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