

**Written Comments to the OECD Health Committee**

7 October 2026

Report on Best Practices in Diet and Physical Activity for Non-Communicable Disease Prevention

General Comments Chapter 1

- *Business at OECD* welcomes the combination of nutrition, physical activity, sleep and stress-management guidance with biometric monitoring, personalised feedback and multidisciplinary support in the Reverse Diabetes2 Now (RD2N) intervention, to support self-management of Type 2 Diabetes. This is consistent with WHO's work on physical activity and its role in preventing and managing noncommunicable diseases (NCDs) (WHO, Health topics: Physical activity, 2026). In particular, the WHO affirms that regular physical activity reduces the risk of heart disease and stroke by 19%, diabetes by 17%, and depression and dementia by 28-32%. In response, WHO has launched their Global action plan on physical activity 2018-2030. However, diabetes type 2 is not solely caused by insulin resistance due to overweight, and the initiative appears to give little to no attention to diabetes type 2 where insulin resistance plays a minor, or no role at all.
- It is encouraging to see that the intervention places individuals at the centre of their own health management through education, behaviour change support, self-monitoring, nutrition, physical activity, sleep, stress management, and peer support. This is very consistent with self-care principles that encourage individuals to take an active role in maintaining and improving their health. However, our members caution against the goal of the programme that is communicated as: "Het doel daarvan is te voorkomen dat je diabetesmedicatie moet gebruiken. Gebruik je momenteel metformine? Dan werken we, als dit mogelijk is, aan het afbouwen of stoppen daarvan." (The goal of this is to prevent you from having to use diabetes medication. Are you currently using metformin? Then, if possible, we will work on tapering off or stopping it.). Rather, we encourage OECD to emphasise, that the goal should be overall Health and Quality of Life of people living with diabetes.
- Evidence-based pharmacological interventions also play an important preventive role, particularly for individuals with established disease or elevated cardiovascular and metabolic risk, by reducing the likelihood of serious complications and acute events. A comprehensive prevention framework should therefore integrate population-level policies, lifestyle interventions, early diagnosis, appropriate medical treatment, and sustained access to medicines.
- We are pleased to see that the RD2N intervention more directly applies and supports the principles of self-care compared to the others, such as the Regulation of Food Marketing to Children, which is much more indirect with respect to self-care. For example, through the RD2N intervention, participants track many health metrics themselves and receive biometric feedback and personalised advice. This strengthens individual capability and informed decision-making.
- The RD2N intervention also highlights the importance of building health literacy through its

focus on education on nutrition, understanding processed foods, glycaemic carbohydrates, mediterranean diet patterns, food labels, physiology, and behaviour change. These are critical competencies as they improve people's ability to make informed health decisions. However, we suggest that the Best Practice framework also assess interventions that combine lifestyle change with pharmacological management, biomarker-based screening, and vaccination, reflecting the integrated care pathways used in real-world clinical practice even include type 1 diabetes.

- We particularly welcome the inclusion of monitoring tools in the intervention so that participants can measure and report blood glucose levels themselves and receive rapid feedback. This is relevant to connected monitoring devices and digitally supported self-management.
- We also suggest taking a broader metabolic-health perspective when considering the outcomes and transferability of lifestyle interventions. Type 2 diabetes, obesity, cardiovascular disease and steatotic liver disease share important modifiable drivers, including unhealthy diet, physical inactivity and excess weight. The 2026 World Health Assembly resolution on steatotic liver disease and the second EASL-Lancet Commission on liver health in Europe reinforce the case for integrating liver health into wider NCD prevention strategies.
- We also invite OECD to recognize screening, diagnosis and immunization as co-equal pillars of NCD prevention, not just diet and physical activity. The document frames NCD prevention almost exclusively through behavioral modification. We would encourage OECD to explicitly acknowledge that early diagnosis, structured screening programs, and immunization are equally validated, complementary prevention levers, consistent with OECD's own prior work (including "The Health and Economic Benefits of Tackling Non-Communicable Diseases," 2026) and with the fact that many NCDs, such as type 1 diabetes and respiratory disease, are not primarily lifestyle-driven.
- We invite avoiding implying that lifestyle change can substitute for medication use or adherence. The RD2N case study's emphasis on "reducing medication use" and "diabetes reversal" risks being read as positioning lifestyle interventions as an alternative to pharmacological treatment. We would recommend balanced language clarifying that lifestyle interventions are most effective as an adjunct to, rather than a replacement for, appropriate clinical and pharmacological management, particularly for patients with more advanced disease or comorbidities.
- We suggest also integrate prevention budget guidance with innovation and access funding frameworks. The document treats diet and physical activity prevention budgets in isolation. We would ask OECD to cross-reference its own budgetary recommendations, such as directing immunization budgets toward 2% of health expenditure and funding diagnosis and screening infrastructure, so that lifestyle interventions are positioned within a comprehensive NCD prevention investment framework rather than as a substitute for investment in diagnostics, immunization, and innovative therapies.
- We would invite explicitly including chronic respiratory diseases, particularly COPD, as a major NCD burden with lifestyle dimensions. Chronic respiratory diseases, including COPD and asthma, represent the third leading cause of death globally and account for a significant share of the overall NCD burden. These conditions have well-established links to modifiable lifestyle and environmental risk factors - including tobacco use, physical inactivity, poor air quality, and occupational exposures, that are directly relevant to the scope of this document. The current text does not reference respiratory NCDs, creating a significant gap. We would

strongly encourage OECD to include chronic respiratory disease prevention as part of this best practice framework, recognizing that lifestyle interventions such as smoking cessation, physical activity promotion, and environmental exposure reduction are among the most impactful tools available. Doing so would also align with OECD's own work on respiratory health and with WHO guidance on integrated NCD prevention strategies.

- Additionally, obesity is presented primarily as a behavioural risk factor and a target for population-level prevention, thereby omitting recognition of obesity as a disease in its own right. Obesity is classified by the World Health Organization (WHO) as a chronic, relapsing disease arising from complex interactions between genetics, neurobiology, eating behaviours, access to healthy diet, market forces, and the broader environment. In this context, ensuring that obesity is accurately characterized as a complex chronic disease is important for scientific consistency and effective policymaking. Approaches that do not fully reflect this complexity may not be aligned with the positions of the WHO as well as numerous national and international medical associations.

Specific Comments

- **Page 2:** In several sections of the report, obesity is labelled as a lifestyle condition and not a disease as defined by WHO for example in this sentence in the report: "The promotion of healthy diets and active lifestyles is a key policy priority given the high prevalence of overweight and obesity and the substantial burden of non-communicable diseases (NCDs) across OECD countries. Poor diet and physical inactivity are among the leading modifiable risk factors for a range of chronic conditions, including cardiovascular diseases, diabetes, and cancer."
- **Page 3, section 8 and page 29:** We are concerned with the conclusions from the program, which is given emphasis on (very) positive personal experiences. [Keer Diabetes2 Om | Inspirerende verhalen van deelnemers | Voeding Leeft](#). We are concerned that the project sends the message to participants that if you do not achieve similar results, then that is your own 'fault' because others can. Ultimately, this project has the risk of confirming the (self)stigma of obesity and type 2 diabetes.

WHO classifies obesity as a relapsing chronic disease. However, once obesity is established, physiological mechanisms act to defend body weight. These include increased hunger signalling and metabolic adaptations that favour energy storage, making sustained weight loss challenging¹. As a result, for many individuals living with obesity, behavioural change alone is often insufficient due to these underlying biological factors².

With the focus on 'less medication is better', patients might not adhere to their prescription treatment, thereby risking that their diabetes is in control which can be harmful to their health due to the interconnection of diabetes with other diseases such as cardiovascular disease³.

- **Paragraph 13:** The report describes the RD2N intervention primarily as a lifestyle intervention and diabetes reversal programme. To align more closely with self-care policy frameworks and enhance the applicability of the intervention, we suggest explicitly framing RD2N as a comprehensive self-care support programme that equips people with type 2 diabetes to manage their health, make informed decisions, monitor their condition, and

¹ Spiegelman BM, Flier JS. Obesity and the Regulation of Energy Balance. Cell. 2001/02/23/ 2001;104(4):531-543. doi:[https://doi.org/10.1016/S0092-8674\(01\)00240-11](https://doi.org/10.1016/S0092-8674(01)00240-11)

² WHO "Health service delivery framework for prevention and management of obesity", p. 1

³ [Diabetes and Obesity web-FINAL.pdf](#)

maintain healthy behaviours.

- **Paragraphs 13-17 - Intervention design and self-management:** The Reverse Diabetes2 Now programme combines education, nutrition and physical-activity guidance, biometric feedback and support over two years. Its effectiveness therefore depends not only on the formal intervention, but also on participants' ability to sustain behaviours between sessions. We suggest making this mechanism more explicit by recognising health literacy, self-monitoring and supported self-management as part of the intervention pathway, and by considering measures of confidence, adherence and ability to act on health information alongside biomedical outcomes. Health literacy also equips participants to advocate for themselves within their wider care, including by discussing with their healthcare professionals the assessments that clinical guidelines recommend for their condition. Liver health is one example. The 2024 EASL-EASD-EASO Clinical Practice Guidelines recommend case-finding for liver fibrosis in people with type 2 diabetes, starting with a blood-based score such as FIB-4. Participants who understand their own measurements and risks are better placed to ask for such assessments. The programme's education sessions on physiology (paragraphs 14 and 17) could offer a natural place to build this capability.
- **Paragraphs 33-46 - Broader metabolic and liver-health outcomes:** The OECD modelling already considers effects beyond diabetes, including cardiovascular disease, musculoskeletal disorders, dementia and BMI-related cancers, with liver cancer included among the latter. We suggest that future iterations also consider whether steatotic liver disease, particularly metabolic dysfunction-associated steatotic liver disease (MASLD), could be reflected as a relevant outcome or explicitly noted as outside the current model. This is increasingly important given its close association with type 2 diabetes and obesity. The second EASL-Lancet Commission estimates that cirrhosis and liver cancer together cause around 284,000 deaths each year in the WHO European Region and are associated with substantial economic losses, while WHA79.4 calls for steatotic liver disease to be integrated into NCD prevention and monitoring frameworks.
- **Paragraphs 47-68 - Equity, adherence and health literacy:** We support the proposed focus on tailoring guidance, multilingual materials, community outreach and healthcare-professional awareness. We suggest explicitly adding health literacy to the equity and implementation considerations. For lifestyle interventions to be sustained, participants need to understand dietary and physical-activity advice, interpret health information and translate recommendations into daily decisions. Measuring these capabilities would help identify whether differences in adherence reflect affordability, access, health literacy or other barriers, and could strengthen assessments of transferability across population groups.

Paragraph 63 notes that vulnerable groups may face greater barriers to accessing continuous, patient-centred healthcare. Health literacy is most effective when people also have accessible points of care where they can act on it. Community pharmacies are one such point, where people can get advice, appropriate self-care products and referral to further care where needed. Erectile dysfunction illustrates this: it affects more than half of men with diabetes and is associated with an increased risk of cardiovascular events. In the United Kingdom, making sildenafil available as a pharmacy medicine was associated with more visits to physicians and pharmacists among the men who used it. People who understand what a symptom may signal, and who can reach appropriate products and advice, are better placed to maintain their health while living with a non-communicable disease.

- **Paragraphs 47-48 - Emerging evidence on complementary metabolic-health interventions:** As the evidence base evolves, the OECD framework could remain open to complementary interventions that may support established diet and physical-activity

approaches. For example, a 2025 systematic review and meta-analysis of 12 randomised controlled trials involving 657 participants with MASLD found probiotic supplementation was associated with improvements in liver enzymes and selected lipid markers. However, heterogeneity was substantial for several outcomes, and evidence varies by formulation and population. We therefore do not suggest classifying probiotics as a best practice at this stage, but rather monitoring this emerging evidence as part of the wider research agenda on metabolic and liver health.

- **Paragraph 58:** As recognized in the WHO self-care interventions, caregiving represents a significant part of the health workforce but is often invisible, unrecognized and underappreciated (WHO, Implementation of self-care interventions for health and well-being: Guidance for health systems, 2024). We encourage the inclusion of family involvement as a future enhancement option for the programme, as a core self-care enabler. Family support could be made more central by involving family members in education sessions, providing resources for caregivers, supporting family-based meal planning, or encouraging shared physical activity, while being mindful of the well-being of the family members and caregivers.
- **Paragraph 63:** In the discussion of enhancing equity, particularly when considering barriers to care and compliance to the RD2N programme's guidelines, it is important to consider health literacy as an important factor. Country evidence demonstrates that self-care capability depends strongly on health literacy. The Self-Care Readiness Index found that more than one-third of people across 17 European countries had inadequate or problematic health literacy, rising to nearly two-thirds in some countries. Among surveyed populations, difficulties understanding written health information were reported by 17% in Indonesia, 15% in India, 9% in Canada, 8% in Australia and 7% in Kenya (GSCF, Self-Care Readiness Index 2.0, 2022). These findings underline the importance of treating health literacy as an enabling condition for effective and equitable self-care.

Supporting Resources

- WHO. Health Topics: Physical Activity. September 2026. Available from: https://www.who.int/health-topics/physical-activity#tab=tab_1
- WHO. Implementation of self-care interventions for health and well-being: Guidance from health systems. July 2024. Available from: <https://www.who.int/publications/i/item/9789240094888>
- GSCF. Self-Care Readiness Index 2.0. October 2022. Available from: <https://www.selfcarefederation.org/sites/default/files/2024-10/self-care-readiness-index-report-2022-05122022-v2.pdf>
- Global Self-Care Federation (2025). How self-care contributes to the risk-reduction, prevention & management of NCDs. [Access here](#)
- World Health Assembly (2026). WHA79.4, Steatotic liver disease: a missing piece in the global noncommunicable disease response. [Access here](#)
- Karlsen, T.H. et al. (2026). Implementing sustainable liver health in Europe: a second EASL-Lancet Commission. The Lancet, 407(10541), 1825-1890. doi:10.1016/S0140-6736(26)00138-8. [Access here](#)
- Lu, J. et al. (2025). Probiotics as a therapeutic strategy for metabolic dysfunction-associated steatotic liver disease: A systematic review and meta-analysis. Current Research in Food

General Comments – Chapter 2 – Regulation of food marketing to children

- We welcome the opportunity to comment on the OECD case study assessing the regulation of food marketing to children, submitted for consultation under the Best Practices in Diet and Physical Activity for Non-Communicable Disease Prevention exercise. We also support the objective of strengthening evidence-based approaches to NCD prevention and recognizes the importance of responsible food and beverage marketing to children.
- We share the OECD's underlying concern regarding the substantial health and economic burden associated with childhood overweight and obesity, and we support the evidence-based promotion and support of healthy diets and physical activity as an important complement to clinical care across the life course.⁴ The case study's own assessment – estimating 0.59 DALYs gained per 100,000 people annually across the EU-27 through 2050, and cost savings in two of the countries examined – reflects meaningful evidence that improving children's nutritional and physical activity environments can support long-term health outcomes.⁵ We note that the report itself characterizes the underlying evidence as an ecological study of "moderate quality,"⁶ and that the extent of coverage achievable "depends on the enforcement, policy scope, and cross-border marketing" context in each jurisdiction⁷ – both important caveats for delegates weighing transferability. We would also observe that health-supportive marketing approaches – including voluntary reformulation commitments, portion-appropriate marketing, and industry-led restrictions on the promotion of certain products to children – may complement statutory measures, and that industry self-regulation and continued product innovation may represent a constructive first step toward broader food-industry engagement in supporting childhood health outcomes, alongside, rather than in place of, the regulatory frameworks under discussion. As the design, scope, and enforcement of food marketing standards fall outside our domain of technical expertise, we defer to public health and consumer-protection authorities on the specific regulatory mechanisms best suited to each jurisdiction, and focus our comments below on situating this prevention-oriented work within a broader, comprehensive continuum of obesity care.
- We would also observe that health-supportive marketing approaches – including voluntary reformulation commitments, portion-appropriate marketing, and industry-led restrictions on the promotion of certain products to children – may complement statutory measures, and that industry self-regulation and continued product innovation may represent a constructive first step toward broader food-industry engagement in supporting childhood health outcomes, alongside, rather than in place of, the regulatory frameworks under discussion. As the design, scope, and enforcement of food marketing standards fall outside our domain of technical expertise, we defer to public health and consumer-protection authorities on the specific regulatory mechanisms best suited to each jurisdiction, and focus our comments below on situating this prevention-oriented work within a broader, comprehensive continuum of obesity care.
- We recommend the OECD situate this case study – and future best-practice work on childhood obesity – within the broader continuum described in leading clinical guidance,

⁴Ibid., "Note by the Secretariat," paras. 1-2.

⁵Ibid., Chapter 2, "Regulation of food marketing to children: case study overview," Best Practice Assessment table, "Effectiveness" and "Efficiency" rows (para. 2).

⁶Ibid., "Evidence-base" row.

⁷Ibid., "Extent of coverage" row.

which recognizes obesity as a chronic disease requiring individualized evaluation and management alongside population-level prevention.⁸ Population-level prevention measures, such as improved nutrition and physical activity environments, are appropriately designed as broad public health interventions; however, they are not a substitute for person-centered, evidence-based, and comprehensive obesity care for children and adolescents who already have, or are at risk of having, the disease. We encourage the OECD to acknowledge, alongside its prevention-focused case studies, that a clinician – in partnership with a child’s parent or legal guardian – remains best positioned to determine the appropriate course of care for that individual, including whether behavioral, nutritional, or pharmacological interventions, and combinations thereof are clinically warranted.⁹ Consistent with this principle, we urge that any resulting OECD guidance recognize the importance of access to the full continuum of clinically appropriate, regulatory-approved obesity care – including medications, where prescribed and managed by a qualified clinician in partnership with the patient’s parent or guardian – so that prevention policy and clinical care remain complementary, rather than substitutive, components of a comprehensive national response to childhood obesity.

- We appreciate the OECD Secretariat’s continued efforts to build a rigorous, transferable evidence base in this area and welcome further engagement as this work develops.

Specific Comments

Regulation of food marketing to children

⁸Hampl SE, Hassink SG, Skinner AC, et al., “Clinical Practice Guideline for the Evaluation and Treatment of Children and Adolescents With Obesity,” *Pediatrics*, 2023;151(2):e2022060640. doi:10.1542/peds.2022-060640.

⁹Ibid.

1. **'Ultra-processed food' terminology**

Our members would like to highlight that 'Ultra-processed food' terminology has no legal nor scientifically agreed definition globally or in the EU, is vague, contradicts the established evaluation of foods based on nutrient composition, and could hamper our collective efforts to improve public health and environmental outcomes. NOVA is the most famous and widely referenced food classification system based on the level of processing, but there is a large and growing body of evidence that questions NOVA, and other classifications.

In particular, the draft at times uses "ultra-processed foods" alongside or as a proxy for high-fat, sugar and salt (HFSS) foods, although the intervention assessed is principally defined through nutrient composition and nutrient profiling. "Ultra-processed foods" and HFSS foods are not equivalent classifications, and conflating them may obscure meaningful differences in nutritional quality.

We would also recommend greater qualification of conclusions comparing statutory regulation and self-regulatory approaches. The principal study used in the assessment examines policies implemented between 2003 and 2014, and OECD itself assesses the evidence as moderate overall, with weaknesses relating to confounding. Responsible-marketing frameworks have evolved materially since that period, including broader media coverage, common nutrition criteria and independent monitoring.

Various national health authorities concluded that the evidence is currently insufficient to drive policy action dietary recommendations based on such classification. In June 2023, the Nordic Nutrition Recommendations (NNR) were revised. The Nordic Nutrition Council decided not to include any dietary guideline based on the concept of "ultra-processed foods" and noted that this categorization captures a heterogeneous group of foods with various nutrient quality. The Nordic Nutrition Council also noted that it has not been possible to assess causality on the type of processed foods and health outcomes. Moreover, it indicated that the dominating NOVA classification contains a variety of food products that are essentials in a healthy and balanced diet. Hence a guideline including the concept of "ultra-processed foods" would introduce conflicting messages about some foods, for example some ready-made foods, wholegrain bread, and granola.

In July 2023, the UK Scientific Advisory Committee on Nutrition (SACN) published a [position statement on processed foods and health](#). The UK SACN concluded that there is currently insufficient evidence to make any dietary recommendations on the topic. The UK SACN underlined that "there are uncertainties around the quality of the available evidence on food processing and health. Studies are almost exclusively observational and confounding factors or covariates may not be adequately accounted for".

For these reasons, we question the use of the terminology "ultra-processed foods" and its use in the report.

2. **Regulation of food marketing for children**

The evidence warrants greater caution in the policy conclusions. The OECD's conclusions rely heavily on moderate-quality evidence from a country-level ecological study and on subsequent modelling assumptions. The underlying evidence identifies associations between food marketing restrictions and decreasing 'HFSS' food sales but does not by itself establish causation or demonstrate that broader statutory measures on food marketing

would produce better long-term health outcomes.

The OECD then translates an observed association in sales data into estimated changes in calorie intake, BMI, disease incidence, DALYs and healthcare expenditure. These modelled outcomes may be useful for scenario analysis, but they should be clearly distinguished from directly observed effects.

The OECD relies on a 2018 study by Kovic et al. which concludes that countries with broadcast marketing restrictions saw a decline in per capita 'HFSS' food sales post-implementation. However, this does not necessarily infer a decline in obesity rates. Advertising evidently has an impact on behaviours, preferences and purchases and advertisers have a role to play in supporting healthy diets, particularly when it comes to children. However, the size and relative importance of the impact of food marketing, and any demonstrable impact on health outcomes, are important research questions that have not been settled to date. The UK government-funded Foresight Obesity System Map¹⁰ was an early attempt, followed by McKinsey's 2014 discussion paper on overcoming obesity and comparing different measures and their outcomes¹¹.

There are various examples that very strict food marketing regulation does not automatically translate into positive public health outcomes. The legislation in Chile, adopted in 2016, went further than both the UK at the time and Quebec restrictions in that it adopted stricter nutrition criteria and imposed a 10pm watershed ban for TV. 'HFSS' products cannot be advertised from 6am to 10pm, all packs and visual ads for 'HFSS' products must display warning labels, and the use of cartoons and characters of appeal to children are also prohibited. Sadly, childhood obesity continued to rise from 51.2% in 2016 to 54% in 2020¹², 58% in 2022¹³ and reaching 60% in 2025¹⁴ while studies years after the entry into force of the restriction show a 73% decrease of children exposure of foods labelled 'high-in' in television advertisement¹⁵.

International Food & Beverage Alliance (IFBA), which has adopted a Global Responsible Marketing Policy since 2008. As part of that commitment, IFBA members either do not advertise products to children under 13 or advertise only products meeting common nutrition criteria based on accepted science-based dietary guidance. The policy covers a broad range of media, prohibits product marketing communications to children in primary schools, early childhood education centres and children's care service centres, and is subject to third-party monitoring. On behalf of IFBA and its members, we encourage OECD to take contemporary frameworks such as these into account when assessing the current policy landscape.

We encourage the OECD to reflect these uncertainties more clearly and to distinguish between evidence that marketing can influence children, evidence that a measure reduces exposure or purchasing, and evidence that a particular regulatory design improves long-

¹⁰ [Reducing obesity: obesity systems map](#), UK Government Office for Science, 2007.

¹¹ [Overcoming obesity: An initial economic analysis](#), McKinsey & Company, 2014.

¹² BBC article: [The labels encouraging Chileans to buy healthier food](#), August 2021. Overweight and obesity data from JUNAEB, the National Board of School Aid and Scholarships, under the Ministry of Health in Chile.

¹³ In **2022** there are approximately 34% of students with a normal weight, 31% with some degree of obesity, and 27% overweight, that is, **in total, 58% are overweight** (in 2020 they were 54.1%). Since 2009 total obesity has increased 15.1pp, almost doubling in 13 years (from 15.9% to 31%), while severe obesity has increased 6.6pp. Source: [The Chilean Society of Obesity](#) (SOCHOB).

¹⁴ [SOCHOB, 2025](#)

¹⁵ Dillman Carpentier, F.R., Mediano Stoltze, F., Reyes, M. et al. [Restricting child-directed ads is effective, but adding a time-based ban is better: evaluating a multi-phase regulation to protect children from unhealthy food marketing on television](#). *Int J Behav Nutr Phys Act* **20**, 62 (2023).

term population-health outcomes.

3. Robust self-regulation has demonstrably reduced exposure

The OECD argues that ‘industry pledges often lack penalties for non-compliance’ and ‘fail to significantly reduce children’s exposure to ‘HFSS’ marketing’. This assessment is based on a 2013 study¹⁶ and overlooks recent findings and initiatives.

Today, there is a tight network of legal and self-regulatory rules in place which stipulates, among other things, that advertising shall be recognisable as such and does not mislead or unduly influence its recipients. In view of this target group’s limited experience, any advertising aimed at children and adolescents is subject to particular legal and regulatory requirements. Well-designed self-regulatory frameworks are built around these objectives. The EU Pledge is an example of a successful voluntary initiative by leading food and beverage companies to change the way in which they advertise to children. Available evidence shows substantial reductions in children’s exposure in markets where these approaches operate.

- Data from the EU Pledge demonstrates that ‘HFSS’ food advertising around children’s TV programmes fell by 83% compared with the 2005 baseline. In 2025, child audiences saw an average of 0.67 daily TV spots for restricted products, compared with 3.02 for adults.¹⁷
- Nielsen looked at online environments in 12 markets around the world and concluded that on average only 1.45% of online ads served to children are for ‘HFSS’ foods and beverages.¹⁸
- A European Commission study showed that just 1.7% of ads that EU children saw online in 2019 were for food products.¹⁹

These figures demonstrate that existing self-regulatory and co-regulatory systems can materially reduce children’s exposure and can evolve as media and technology change.

The report highlights the example of Quebec which has enforced since the 1980s legislation to protect children from advertising through its Consumer Protection Act. However, this has not translated into significantly lower obesity rates in Quebec compared to the rest of Canada²⁰. In this case, the OECD fails to mention that Canada recently updated its mandatory Food Advertising Code, which applies to the entire industry, offers preclearance services and a complaint handling mechanism. This is enforced by Ad Standards, the Canadian national self-regulatory body for advertising.

The OECD should therefore assess contemporary systems on their actual scope, monitoring, enforcement and demonstrated outcomes, rather than treating ‘self-regulation’ as a single or inherently weaker intervention category. Food and beverage advertising restrictions should not be seen as a silver bullet to the childhood obesity problem. Instead, food marketing policies should be designed in a way that is proportionate and protects the most

¹⁶ [Galbraith-Emami and Lobstein, 2013](#)

¹⁷ See [2016 annual report](#) of the EU Pledge.

¹⁸ The [Digital Avatar Project](#) used four avatars (simulated consumer profiles) to track advertising activity across 12 markets (Belgium, Brazil, Czechia, Denmark, Ireland, Japan, Mexico, Netherlands, Nigeria, Philippines, South Africa, and Spain). Through the findings, Nielsen estimated the general pervasiveness of HFSS advertising, as well as the probabilistic rate of a child’s exposure to HFSS advertising.

¹⁹ [Study on the exposure of children to linear, non-linear and online marketing of foods high in fat, salt or sugar](#), ECORYS, 2021. Fieldwork September–October 2019; n=228 children, n=262 adults. HFSS accounted for 64% of the 184 food and drink advertisements served to children. Across the full 490-participant panel, 305 of 29,716 advertisements were for HFSS products.

²⁰ See Share of Canadian adults who were overweight in 2024, by province [here](#), and Continuation of Table 3c ‘Overweight/Obesity’ of [Obesity Statistics in Canada: Report](#).

vulnerable.

Recommended measures should be proportionate and targeted

Where existing systems have already reduced children's exposure substantially, policymakers should consider whether new measures would realistically prevent additional exposure, and whether that incremental benefit justifies the wider restriction. The OECD should assess the proportionality of specific policy options separately, rather than assume that broader age coverage, wider scope or more restrictive placement rules will necessarily deliver proportionately greater public-health benefits.

In response to the OECD's policy options to enhance performance, we suggest taking into account the below criteria when looking into responsible food marketing to children.

Age thresholds and general audiences

The OECD recommends protection of all under-18s but does not estimate the additional exposure reduction, dietary effect or health gain attributable specifically to moving from U13, U15 or U16 to U18. We strongly support that advertising shall be recognisable as such and does not mislead or unduly influence its recipients, especially children and adolescents. Most academic reviews recognise that by the age of 12 children develop their behaviour as consumers, effectively recognise advertising and can adopt critical attitudes towards it. A landmark review by Sonia Livingstone²¹ found no justification for why older children, e.g., those above 12 years of age, should be targeted for restrictions to food advertising. She concluded:

- Before the age of four or five, children regard advertising as simply entertainment.
- Between four and seven, they begin to be able to distinguish advertising from programmes.
- By the age of eight, the majority have generally grasped the intention to persuade.
- After 11 or 12 they can articulate a critical understanding of advertising.

A U18 threshold materially expands the communications affected and risks restricting advertising intended for general or adult audiences, particularly where it is combined with broad tests based on whether advertising may 'appeal' to children. Creative executions that appeal to a 16- or 17-year-old will often also appeal to young adults. Across the statutory measures implemented globally, there has been little evidence-based justification for distinguishing between the appeal of content to a 17-year-old and that to a 19-year-old. In practice, governments have struggled to define objective criteria for what appeals to older adolescents but not young adults, calling into question the rationale for extending the definition of a child beyond 16 years of age.

We therefore support clear criteria focused on whether advertising is primarily directed at or appealing to children, together with reliable audience data where available. Food and non-alcoholic beverages should not automatically be regulated in the same way as inherently age-restricted products such as tobacco or gambling.

Audience data and targeting tools

We recommend that placement restrictions be based on audience data and, where available, demographic targeting tools rather than simply on the time of airing. Audience thresholds can identify media where children make up a significant share of the audience, while digital platforms allow advertisers to apply age filters, exclude unknown-age audiences and avoid

²¹ Ofcom, Childhood Obesity - Food Advertising in Context (review of academic research conducted by Prof. Sonia Livingstone, LSE, London, UK), 22 July 2004

content primarily appealing to children. These approaches are already reflected in several regulatory and self-regulatory frameworks, including the UK (under 16s, 25%), Australia (under 15s, 25%), the Netherlands (under 13s, 25%) and Canada (under 13s, 15%). Digital platform policies and targeting capabilities continue to evolve, enabling increasingly precise approaches to reducing children's exposure while preserving responsible communication with general audiences.

Changes in the media landscape have accelerated the exposure decline and continue to do so, which is why recent exposure data needs to be the basis of any food marketing to children framework. Specifically, for the past decade, children have been abandoning television in favor of digital media. And when they do so, ad exposure plummets thanks to platforms' demographic targeting tools.

Because food ads are rarely targeted to children on digital media, children largely are not exposed to them, which explains not only the mere 9 seconds of daily exposure in the UK, but also similar findings in other markets. For example, a recent U.S. study²² examined the exposure of children to food and beverage marketing when using mobile devices in 2022 and 2023 and found the median number of estimated food and beverage advertisements seen on mobile devices per day per child to be 0, with only a small percentage of children seeing more than 1 instance of food marketing per day.²³

Broad time-based or all-day restrictions should therefore not be treated as the default where more targeted approaches are available. Watersheds can capture substantial general-audience advertising regardless of whether children constitute a meaningful share of the audience. A proportionate approach should instead rely on audience-based placement criteria and available targeting tools to minimise children's exposure while avoiding unnecessary restrictions on communications directed at adults.

The OECD recommends explicitly including all aspects of digital marketing in the marketing regulations (including sponsorship, brand marketing, mascots, etc.). We believe instead that brand communications, company-owned characters, sponsorships or packaging should not automatically be treated as equivalent to advertising a restricted product. As an example, the UK has excluded brand marketing from its most recent food advertising restrictions. The overall execution, placement, likely audience and whether the communication directly or indirectly promotes a restricted product should remain relevant.

Company-owned characters are part of a brand's intellectual property. Many companies are proactively using their children-appealing licensed characters to promote healthy diets including the consumption of fruits and vegetables. While many licensed characters appeal to children, not all licensed characters are intended for young audiences. Additional decision filters including primary audience, overall market position and placement on adult foods and in adult content should be considered in lieu of blanket bans.

Likewise, a blanket ban on sponsorships, or limitations that fail to distinguish between audience types, could disproportionately harm companies whose names align with their products. Sponsorships are often crucial for grassroots sports and cultural events, which heavily depend on these funds for their survival. Denying this support risks undermining public access to such events, counteracting public health and community engagement

²² Kenney, et al, "Estimating Young Children's Exposure to Food and Beverage Marketing on Mobile Devices," *Current Developments in Nutrition*, 2024 (Nov. 8).

²³ *Id.* Specifically, only 28% of children saw more than 1 instance of food marketing per day, and even that figure is inflated because it includes "brand appearances" (such as in user-generated content that is not paid advertising). If limited to just paid advertising, the instances of exposure would be even lower. These results challenge the presumption that declines in children's exposure to food ads on television are offset by children's increased exposure to food ads in digital media.

goals. Instead, a targeted approach using audience thresholds, could better prevent children's exposure without jeopardizing essential sponsorship funding. The new Self-Regulatory framework of New-Zealand²⁴ includes a section on sponsorships and specifically restricts sponsorships of products that do not meet the framework's nutrition criteria when targeted to children under 16.

The final report would be strengthened by calibrating its conclusions more closely to the evidence, assessing current and remaining exposure, recognising the demonstrated contribution of robust self- and co-regulation, and ensuring that any further measures are proportionate to the audience, market context and incremental benefit they are expected to deliver. Transferability should likewise reflect national media use, existing safeguards and enforcement rather than assume that one regulatory model will produce the same effects across markets.

Specific Paragraph Comments

- **Paragraph 7:** The paragraph refers to children increasingly encountering "processed and ultra-processed foods that are rich in salt, sugar, and fat," before stating that these foods are often referred to as HFSS foods. We recommend revising this language to avoid implying that "ultra-processed foods" and HFSS foods are interchangeable. Where the underlying evidence concerns nutrient composition, the report should use "HFSS foods" or the terminology of the applicable nutrient-profile criteria. If "ultra-processed foods" is retained because it reflects terminology in a cited source, OECD should clarify that it represents a distinct processing-based classification.
- **Paragraph 15:** The paragraph describes Chile as having high potential to address harms associated with marketing of "unhealthy, ultra processed foods to children." However, the policy subsequently described is principally operationalized through thresholds for nutrients including sugar, sodium and saturated fat and for energy. We recommend aligning the terminology with the intervention assessed, for example by referring to foods meeting the applicable HFSS or nutrient-profile criteria.
- **Paragraph 20:** The description of Chile's legislation again characterizes the products concerned as "ultra-processed, HFSS products," while the operative thresholds described are nutrient-based. We recommend removing the implication that "ultra-processed" status is equivalent to HFSS status, unless OECD provides a specific processing-based definition and evidence supporting that characterization.
- **Paragraphs 16 and 51-52:** We recommend qualifying the conclusion that statutory regulation is more effective than voluntary self-regulation. The principal evidence cited is an ecological study examining policies implemented between 2003 and 2014. OECD's own assessment characterizes the evidence as moderate overall and rates confounding as weak. The report can accurately state that the statutory policies examined in the underlying evidence were associated with stronger effects than the self-regulatory policies examined, without generalizing this finding to all contemporary voluntary frameworks.
- **Paragraphs 28-34 and case-study overview:** We recommend more clearly distinguishing observed evidence from OECD-modelled outcomes. The underlying evidence concerns changes in food sales following marketing policies, whereas changes in BMI and subsequent estimates of DALYs, disease incidence, healthcare expenditure and labour-market outcomes are modelled. OECD also notes that the model operates through BMI and does not account

²⁴ [Food and Beverage Advertising Code | New Zealand](#)

for other dietary risk pathways. These distinctions and uncertainties should accompany the headline findings.

- **Paragraph 30:** The report states that foods with a high sugar content were particularly reduced. This does not appear to be consistent with the findings reported in the publication *Pot et al. (2022)* which is cited as a reference. Although carbohydrate intake decreased, sugar intake itself was not directly assessed. Instead, it was reported as part of the consumption of confectionery and/or sweet sauces. The consumption of sugar-sweetened beverages (SSBs) also did not change over the study period.

We therefore suggest removing “(notably high in sugar)” from point 30, as this statement does not appear to be supported by the data reported in the cited publication.

- **Paragraph 39 / Table 2.1:** We recommend verifying an apparent internal inconsistency concerning cost-saving countries. Paragraph 39 states that three countries—the United Kingdom, Latvia and Mexico—recorded a negative cost per DALY gained, while Table 2.1 appears to identify the United Kingdom and Latvia as “Cost saving” and reports a positive cost-per-DALY figure for Mexico. The case-study overview also refers to two cost-saving countries.
- **Paragraphs 42-43:** We welcome OECD’s transparent discussion of evidence quality. We recommend carrying these limitations into the case-study overview and conclusion so that the strength of the evidence is apparent alongside the headline findings. In particular, the ecological study design, limitations relating to confounding and the period covered by the underlying policy evidence are relevant to interpretation and transferability.
- **Paragraphs 46-48 - Keep brand advertising and sponsorship distinct from product advertising:** Brand advertising, corporate communications and sponsorship should not automatically be treated as advertising for a restricted product. This is particularly important where a master brand encompasses a broad portfolio, including low- and no-sugar products. The OECD should assess the nature of the communication, its likely audience, placement and whether it actually promotes a restricted product. The draft itself recognises the need for further research on brand marketing and notes concerns about potential unintended effects of restrictions on sports sponsorship, including reduced opportunities for children to participate in sport. Sponsorship restrictions should therefore focus on communications that target children with non-compliant products, with appropriate treatment for master-brand and low- and no-sugar communications.
- **Paragraphs 49-52:** We agree that digital media require effective responsible-marketing approaches. However, the discussion of self-regulation should reflect the evolution of current frameworks. IFBA’s Global Responsible Marketing Policy covers TV, radio, print, cinema, online and social media, product placement, interactive games, outdoor marketing, mobile marketing and contracted influencers. It also applies common nutrition criteria and provides for third-party monitoring. We recommend that OECD consider contemporary frameworks and evidence when assessing the respective strengths and limitations of statutory and self-regulatory approaches.
- **Paragraphs 49-50, 63 - Replace “all media at all times of day” with audience-based placement rules:** The draft recommends extending restrictions across all media and all times of day. This risks restricting communications intended overwhelmingly for adults regardless of who is actually exposed. The OECD should instead recommend audience-based placement rules where reliable audience data are available and recognise the role of digital age- and audience-targeting tools in limiting children’s exposure. Product packaging

and point-of-sale should not automatically be treated as advertising and should remain outside advertising restrictions.

- **Paragraph 51:** The section correctly notes that the EU Pledge is based on voluntary self-regulation and therefore differs from legally binding regulation. However, the description appears somewhat broad in places. In particular, the statement that the initiative is implemented “without government oversight” does not fully reflect the accountability and monitoring framework underpinning the EU Pledge.

Compliance is subject to independent third-party monitoring on an annual basis in a representative sample of EU Member States. Ebiquity assesses members’ compliance in television advertising, while the European Advertising Standards Alliance (EASA) monitors digital marketing communications, including company-owned websites, social media profiles and contracted influencer content. The results are published in annual monitoring reports, allowing compliance and developments over time to be scrutinised externally. Second, this annual monitoring is complemented by a formal Accountability Mechanism²⁵, allowing any member of the public or organisation to challenge marketing communications against the EU Pledge commitments. Companies have ten working days to take corrective action, otherwise, the complaint can be referred to an independent panel of three experts appointed by EASA. Decisions and any corrective actions are made public.

Since 2021, the EU Pledge has additionally been submitted as a commitment under the European Commission’s EU Code of Conduct on Responsible Business and Marketing Practices, under which signatories are required to monitor and report on implementation. The OECD should therefore distinguish between the absence of statutory government enforcement and the presence of independent monitoring, external adjudication, corrective-action requirements, and public reporting.

Furthermore, the OECD should note that the EU Pledge continuously updates its commitments to address evolution in marketing practices and ensure sustained protection of vulnerable audiences. It includes online advertising since 2012 and specifically covers influencer advertising since 2021.

- **Paragraphs 53-54, Box 2.6 - Give health literacy and complementary prevention policies equal weight:** Diet and obesity outcomes are influenced by physical activity, affordability, health literacy and wider social factors. Marketing rules should therefore be presented as one component of a broader prevention strategy, consistent with the OECD’s own recognition of the value of health literacy and complementary prevention policies.
- **Paragraphs 55: Set nutrient criteria that reward reformulation rather than create moving targets:** The draft suggests progressively lowering nutrient thresholds, including further reductions after companies reformulate products to meet existing thresholds. This risks penalising the very reformulation the policy is intended to encourage. Nutrient criteria should be science-based, fit for their specific policy purpose, developed through a transparent and consultative process, and sufficiently stable to provide meaningful incentives for continued product improvement. They should recognise reformulated and low- and no-sugar products and should not penalise the use of sweeteners that have been assessed and approved as safe by relevant regulatory authorities.
- **Paragraph 56 - Build independent monitoring on existing systems:** We support effective independent monitoring and enforcement. Where established self- or co-regulatory bodies and reporting systems already exist, the OECD should encourage governments to build on

²⁵ The EU Pledge [Accountability Mechanism](#)

these mechanisms rather than create duplicative parallel regimes.

- **Paragraph 58 - Assess the full economic costs of the intervention:** The draft expressly excludes costs incurred by industry from its assessment. A best-practice analysis should consider the full resource cost of the intervention, including compliance costs and wider economic effects on advertising, media and sponsorship, alongside projected healthcare savings. Otherwise, the assessment risks overstating the intervention's economic efficiency.
- **Paragraphs 60-61:** We welcome OECD's acknowledgement that the evidence base should be strengthened, including through research on longer-term health outcomes, digital and brand marketing, shifts across marketing platforms and implementation. We recommend ensuring that recommendations elsewhere in the chapter are appropriately calibrated to these acknowledged evidence gaps.
- **Paragraphs 61, 81 - Retain under 13 as the appropriate baseline and require stronger evidence before recommending higher age thresholds:** The definition of a child for marketing purposes should be science-based. Developmental research indicates that children generally understand the persuasive intent of advertising by around 11-12. The OECD's own review finds that most mandatory policies protect children up to ages 12, 14 or 16; only four extend protection to all children under 18. The draft does not demonstrate the incremental reduction in exposure, dietary effect or health benefit from extending restrictions to all under-18s. Where a higher threshold is adopted, including under-16, it should be accompanied by audience thresholds and appropriate treatment of mixed-audience, brand and sponsorship communications.
- **Paragraph 61 - Define child-directed marketing using audience share and a "primarily appeals" test:** The OECD suggests that general-audience marketing could be classified as child-directed if it is "likely to appeal" to children. This is overly broad, since many products, characters, sports and forms of entertainment may appeal to both children and adults. Marketing should instead be considered child-directed where children comprise a defined share of the audience, typically 25-30%, or where the content primarily appeals to children based on clear and objective criteria. The OECD itself recognises exposure thresholds as one possible approach and should give greater weight to objective measures that can be consistently applied.
- **Paragraphs 62, 80 - Reflect national circumstances, cross-border realities and implementation:** Markets with established protections and low levels of child exposure are not starting from an unregulated baseline, and the incremental benefit of additional restrictions will therefore vary. The OECD should consider actual exposure, existing statutory and co-regulatory safeguards, media-use patterns, enforcement capacity and available targeting tools when assessing transferability. Cross-border approaches should also ensure consistent treatment of domestic, cross-border and platform-delivered advertising rather than disadvantaging locally regulated operators. Best practice should include clear implementation guidance, stakeholder consultation, adequate transition periods—including at least 12 months for significant regulatory changes—and evaluation against clearly defined outcomes.
- **Paragraph 64 - Keep primary schools free of marketing:** We support the OECD's focus on schools and recommend prioritising primary schools and other settings primarily intended for young children, consistent with commitments many companies already apply.
- **Paragraphs 16, 51-52, Box 2.6 - Recognise robust co-regulation as a best-practice option:** The draft contrasts mandatory regulation with self-regulation too starkly and relies in part on older evidence. It should distinguish voluntary company pledges from robust co-

regulatory systems that combine a regulatory framework, industry-wide codes, independent oversight, monitoring and enforcement. The OECD should assess these systems based on their actual scope, compliance and performance rather than treating all forms of self- and co-regulation as inherently weaker than statutory approaches.

- **Paragraphs 26-27, 60 - Match the strength of the conclusions to the strength of the evidence:** The core effectiveness analysis relies on an ecological study that the OECD itself rates as moderate-quality evidence, while the draft acknowledges that relatively few studies assess longer-term outcomes such as obesity, body weight and diet-related NCDs. The modelled gains are modest: approximately 0.59 DALYs per 100,000 people per year and around €0.02 per capita in annual healthcare savings in the EU-27 over 2040-50. Chile also illustrates why reduced advertising exposure should not automatically be equated with improved population-health outcomes: children's exposure to television advertising for "high-in" products fell substantially while childhood overweight and obesity continued to increase. The OECD should therefore make its "best practice" conclusion appropriately conditional and clearly distinguish observed effects from modelled long-term outcomes.