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# Double burden of malnutrition and the implementation of double duty actions in low- and middle-income countries: A scoping review of health systems policies

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Low- and middle-income countries (LMICs) experience a shifting nutrition landscape marked by rising overweight and obesity alongside persistent undernutrition. This new nutrition reality results in a double burden of malnutrition (DBM) (1). DBM is classified as the coexistence of overweight and obesity alongside undernutrition and micronutrient deficiencies, at all levels of the population. To address DBM, a set of recommended nutrition actions called double duty action (DDA) was publish by the World Health Organization (2) and Hawkes et al., (3). DDAs aims to lift the siloed view of malnutrition. For example, health services such as breastfeeding counselling is a DDA as breastfeeding prevents undernutrition and reduces the risk of overweight and obesity later in life. However, LMICs health programmes often prioritize undernutrition, hindering comprehensive DBM management (1). This scoping review aim to map existing LMICs' health systems policy on the narrative of DBM and the implementation of DDAs to identify gaps and opportunities to tackle the DBM.

Arksey and O'Malley's framework (4), with recommendations from Levac, Colquhoun, and O'Brien (5) was used. Countries were selected based on the 2022 World Bank criteria for LMICs (n = 102).

Policy documents were extracted from WHO's Global database on Nutrition Action Implementation (6) between June 16th and September 2nd, 2023. Exclusion criteria included policies predating 2011, lacking English translations, and countries facing significant domestic challenges.

To identify relevant text key search terms were based WHO DBM narrative (7) and DDAs characteristics were based on Hawkes et al., framework (3). When identified a full-text review of the relevant sections captured the narrative and extracted into an excel-sheet using a rubric format divided by country, policy title, and themes based on DBM narrative and DDAs characteristics.

This study included 51 countries (21 Southeast Asia, 19 Sub-Saharan Africa, 7 South Asia, and 4 Latin America and the Caribbean). Ninety-eight policy documents were identified and analysed. The majority focused on non-communicable disease prevention, national nutrition strategies, and health sector plans. Thirteen countries explicitly acknowledged DBM. Miscommunication or mistranslation were found as barriers to DBM narrative in six countries. Majority of the countries (54.9%) had a mismatch on the use of malnutrition definitions mainly focusing on undernutrition issues. If obesity was mentioned, the narrative was separated. Tanzania had incorporated the DDA framework into its policies. Regarding relevant DDA health system characteristics, 42 countries acknowledged breastfeeding, 29 nutrition in antenatal care, 28 complementary feeding, 21 growth monitoring, and 15 supplementation programmes.

Differential global efforts are needed to enhance advocacy, clarify definitions, and improve understanding of DBM and DDA narrative for health workers. Clearer terminology, DDA acknowledgment and consistent communication are crucial. Further research on health workers' knowledge, attitudes and practice is essential to build capacity for effective DDA implementation.

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