

From Double Burden to Double Duty: Policy Implications of Double-Duty Actions to Address the Full Spectrum of Malnutrition

Technical Consultation – December 3, 7, 9, 2020



Acknowledgments

This report summarizes the inter-agency technical consultation, ***From Double Burden to Double Duty: Policy Implications of Double-Duty Actions to Address the Full Spectrum of Malnutrition***, held virtually on 3, 7, 9 December 2020. The report was prepared by Kate Kennedy-Wood and Silvia Holschneider (Consultants, Global Financing Facility), with support from Julie Ruel-Bergeron and Leslie Elder (Global Financing Facility). We thank the members of the technical organizing committee, Francesco Branca, Luz Maria De-Regil, Laurence Grummer-Strawn, Jorgen Johnsen, and Lina May (WHO), Marie Ruel (IFPRI), Corinna Hawkes (City, University of London), Barry Popkin (University of North Carolina), Meera Shekar (World Bank) and Rachel Nugent (RTI), for their invaluable contributions to the design and implementation of the consultation. The contributions of the presenters including several authors of the 2019 *Lancet Series on the Double Burden of Malnutrition*, the "country snapshot" presentations from Mexico, South Africa, Indonesia, India, and the Philippines, and inputs from key technical partners, including the Bill & Melinda Gates Foundation, IFPRI, and others, laid the foundation for rich discussions during the breakout sessions. Consultation participants represented multiple agencies, disciplines, and geographies and brought valuable perspectives to the virtual venue. We thank everyone for their contributions, questions, and collaboration (See Annex C for a list of participants). We also extend our sincere gratitude to the facilitators and producers of the consultation from the Training Resource Group, Inc. (TRG): Chevaun Jackson, Sherise Liles, and Stephanie Schalk-Zaitsev. Lastly, we are grateful to the Global Financing Facility for funding the consultation and the production of this report.

Photo credit: Cover@ Bart Verweij/World Bank, 2012. Laos: Nutritious meals are bringing more children to school.

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ACRONYMS

DBM	Double burden of malnutrition
DDA	Double-duty actions
DR-NCD	Diet-related non-communicable diseases
FSSAI	Food Safety and Standards Authority of India
GFF	Global Financing Facility
GOI	Government of Indonesia
IFPRI	International Food Policy Research Institute
INSP	National Public Health Institute (Mexico)
IYCF	Infant and young child feeding
LMIC	Low- and middle-income countries
NCD	Non-communicable disease
StraNas	Multisectoral Nutrition Strategy and Program to Accelerate Stunting Reduction (Indonesia)
SSN	Social safety net
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

This report provides a summary of the technical consultation *From Double Burden to Double Duty: Policy and Programmatic Implications of Double-Duty Actions to Address the Full Spectrum of Malnutrition*.

The purpose of the consultation was to:

- Assess policy implications of the double burden of malnutrition (DBM)¹ and how double-duty actions (DDA) are or can be integrated into existing or new nutrition policies;
- Identify the key conditions and actions that underpin effective policy formulation/adaptation for DDA;
- Consider how to design new or adapt existing programs for DDA;
- Reflect on the need for improved data collection mechanisms for nutrition to provide evidence on the DBM and on the effectiveness and importance of DDA; and
- Build on the current experiences of select country examples to inform the consultation's conclusions about the principles and best practices for formulation and adaptation to support the integration of DDA in national policies and programs.

The meeting was hosted by the Global Financing Facility (GFF) in partnership with the World Health Organization (WHO), the International Food Policy Research Institute (IFPRI), City University of London, and other development partners. It was held virtually via Zoom on December 3, 7, and 9, 2020 with a 2.5-hour session each day.

The consultation provided a valuable experience-informed discussion and framing for the renewed interest in the DBM and the role that DDA can play in addressing the DBM. The meeting served to identify critical conditions, actions, and activities that set the stage for adapting the existing nutrition policies to incorporate DDA and enable the reformulation and redesign of programs to include DDA. Participants identified the next steps that country implementers and decision-makers should take. A summary of the discussion is provided below.

INTEGRATING DDA INTO EXISTING OR NEW NUTRITION POLICIES

Creating the enabling conditions needed for a shift to DDA policy

- Increase awareness of diet-related non-communicable diseases (DR-NCDs), the link to early life nutrition, and the role of diet in protecting from all forms of malnutrition and related NCDs.
- Develop improved indicators for measuring the DBM and double-duty actions and establish a system to collect data and mobilize and translate evidence (including evidence of impact and cost to support decision making, advocacy, and program planning).
- Identify champions (individuals and networks) to push the DDA agenda and develop clear and cohesive language around DDA.
- Use existing program platforms from different sectors (e.g., health, social protection, agriculture/food systems, education) to bring about the integration of DDA without waiting for (longer-term) policy actions to be completed.

¹ The double burden of malnutrition is the "coexistence of undernutrition along with overweight and obesity, or diet-related non-communicable diseases, within individuals, households and populations, and across the life course" ([WHO | Double burden of malnutrition](#)). It is sometimes described as the triple burden of malnutrition, depending on the author and reference.

- Provide integrated governance and financing structures that enable multiple ministries and sectors to implement and finance DDA in an integrated fashion.
- Update dietary guidelines to reflect the role of healthy diets in the full spectrum of malnutrition and use them as a guide to policy formulation.
- Address sociocultural norms about thinness, overweight, foods as status symbols, etc. that contribute to unhealthy conditions of undernutrition and overweight/obesity and the DBM.

Integration of DDA into existing policies

- Shift the narrative from a narrow focus on reducing child stunting to an emphasis on promoting healthy diets (which addresses all forms of malnutrition) in policies with high potential for integrating a DDA lens.
- Strengthen existing policies for early childhood and school-age to address DDA.
- Understand priorities for related sectors and leverage the desired outcomes to drive integrated DDA policies.

Implications of the COVID-19 pandemic on DDA policy

- Capitalize on the pandemic as an opportunity to promote healthy diets and nutrition behaviors to boost the immune system and reduce risk factors for increased severity and poor outcomes from COVID-19.
- Integrate DDA into the health system strengthening response to the COVID-19 pandemic.
- Use COVID-19 response funds going to non-health sectors/programs such as social protection and social safety nets as a potential entry point for DDA.
- Ensure that food and beverage companies' philanthropy during COVID-19-induced food insecurity is not undermined by negative contributions of highly-processed foods to the DBM.
- Integrate DDA policies and programs as part of One Health.

KEY ENTRY POINTS TO DESIGN AND ADAPT SECTORAL PROGRAMS TO INTEGRATE AND OPERATIONALIZE DDA

The consultation discussed the following entry points to design and adapt sectoral programs and operationalize DDA among four sectors, based on the recommendations of Paper #3 in the 2019 Lancet Series on the DBM. These included the following and are further expanded on in Section 2.2:

Health

- Use the multiple existing entry points for DDA in the health sector throughout the life cycle.
- Be opportunistic in implementing DDA, as well as leading action in other sectors.

Social Protection, including Social Safety Nets

- Use existing cash or food transfer programs as an entry point to make nutritious food more available and affordable while pairing with knowledge transfer to promote optimal purchasing behaviors.
- Frame nutrition around healthy diets to reduce all forms of malnutrition using DDA. Having a menu/listing of all DDA is helpful to program planners.
- Build on financing opportunities like the UN Food Systems Summit to move towards greater financing for DDA.

Education

- Define/standardize an essential package for schools that has a double-duty lens.
- Apply a double-duty lens to meal programs and nutrition education by redesigning, reforming, and integrating them to emphasize meal quality standards, not just quantity standards.
- Engage with and use youth leaders to create demand for nutritious foods among children/students.

Food systems/ Agriculture

- Increase the production of and access to nutritious foods while decreasing the availability and appeal of unhealthy products and highly-processed foods.
- Promote a coordinated approach that includes actors and actions across the food system.
- Consider and address inequities in the food system, including gender and commercial inequities (skills in marketing and distribution of unhealthy products).
- Invest in research and data to identify incentives that increase the availability and affordability of nutritious foods while reducing those for unhealthy products.

AGREED-UPON ACTIONS AND COMMITMENTS

Participants agreed on the following actions and commitments for each DDA intervention. These are expanded upon in Section 2.4.

1. Implement policies to improve food environments from the perspective of malnutrition in all its forms

- Develop new case studies based on the existing implementation of DBM policies for the operationalization of DDA.
- Support research to expand the knowledge base on the health and economic impacts and costs of DDA on healthy diets and on indicators of undernutrition and overweight/obesity.
- Develop improved indicators for assessing the DBM in national household expenditure surveys, including measuring the consumption of unhealthy products.

2. Redesign school feeding programs and devise new nutritional guidelines for food in and around educational institutions

- Reframe school feeding programs to focus on nutrition and diet quality, not solely on feeding and diet quantity.
- Develop indicators to effectively/feasibly monitor the health and nutritional status of school-aged children and the quality of school feeding programs (including outputs and outcomes).
- Build on existing initiatives and examples such as those listed in 2.4.2.

3. Scale-up programs to protect, promote, and support breastfeeding

- Provide concrete advocacy on breastfeeding and DDA, targeting different audiences (donors, implementers, policymakers).
- Create a menu of options on how to easily integrate DDA into breastfeeding programs.
- Focus on specific messages, actions, and behaviors and less on conceptual frameworks.

4. Redesign cash and food transfers, subsidies, and vouchers

- Develop targeted policy brief to raise awareness and push for programming and advocacy for DDA in social safety net (SSN) programs, including the need to incentivize and use cash transfers to purchase nutritious foods; ensure focus on quality (versus quantity) for foods delivered through food transfer programs, and protect against doing harm.
- Widely disseminate positive study results to policymakers on the effectiveness of using DDA in SSN programs.
- Disseminate WHO framework on the procurement of foods in the public sector (e.g., through schools and social protection programs), outline results and next steps.

1 INTRODUCTION AND BACKGROUND

The coexistence of overweight and obesity and undernutrition (stunting, underweight, wasting, and micronutrient deficiencies) at all levels of the population is referred to as the double burden of malnutrition (DBM).² Many low- and middle-income countries (LMICs) are currently facing a new nutrition reality in which stunting and wasting remain significant public health issues while overweight and obesity rates are accelerating.

The many forms of malnutrition have previously been managed separately, which has led to the exclusion of obesity from nutrition initiatives and the implementation of undernutrition interventions that inadvertently increased risks of obesity and diet-related non-communicable diseases (DR-NCDs). In 2019, the World Health Organization (WHO) led a four-paper Lancet Series on the Double Burden of Malnutrition that proposes new approaches to the DBM through Double-Duty Actions (DDA). By holistically and simultaneously tackling both undernutrition and overweight, obesity, and DR-NCDs through the same intervention, program or policy, DDA have the potential to accelerate progress towards health and nutrition at the global level.

Given the renewed interest in the DBM and DDA, a virtual technical consultation titled "From Double Burden to Double Duty: Policy and Programmatic Implications of Double-Duty Actions to Address the Full Spectrum of Malnutrition" was held by the Global Financing Facility (GFF), WHO, the International Food Policy Research Institute (IFPRI), the World Bank, and other development partners on December 3, 7, and 9, 2020. The consultation was timely, not only because of the urgent need to focus on all forms of malnutrition but also considering the COVID-19 pandemic, which has likely greatly exacerbated both undernutrition and excess weight gain.

The consultation aimed to:

- Assess policy implications of the DBM and how DDA are, or can be, integrated into existing or new nutrition policies;
- Identify the key conditions and actions that underpin effective policy formulation/adaptation for DDA;
- Consider how to design new or adapt existing programs for DDA;
- Reflect on the need for improved data collection mechanisms for nutrition to provide evidence on the DBM and on the effectiveness and importance of DDA; and
- Build on the current experiences of select country examples to inform the consultation's conclusions about the principles and best practices for formulation and adaptation to support the integration of DDA in national policies and programs.

More than 50 nutrition experts, country implementers, and nutrition policymakers were invited to come together to discuss these issues (see **Annex B** for the Agenda and **Annex C** for a list of participants).

² The double burden of malnutrition is the "coexistence of undernutrition along with overweight and obesity, or diet-related non-communicable diseases, within individuals, households and populations, and across the life course" ([WHO | Double burden of malnutrition](#)). Thus, it is sometimes described as the triple burden of malnutrition, depending on the author and reference.

1.1 FORMAT and OBJECTIVES OF THE TECHNICAL CONSULTATION

The technical consultation utilized a moderated Zoom platform format, with a different theme for plenary and breakout discussion on each day of the meeting. The objectives of each session were as follows:

Session 1: Identify how DDA are, or can be, integrated into existing or new nutrition policies, including the key conditions and actions that underpin effective policy formulation/adaptation for DDA.

Session 2: Drawing from country examples, identify effective entry points to design or adapt sectoral programs to integrate DDA.

Session 3: Reflect on data needs and data gaps, including gaps in policy and outcome indicators for DDA, along with the key operational research gaps that must be addressed to support a paradigm shift for increased uptake of DDA. Also, synthesize the results of Sessions 1 & 2 to a) Agree on the most feasible DDA for the short- and medium-term; b) Identify next steps for design or adaptation of policies for implementation of DDA; and c) Identify priority programming entry points for operationalization of DDA.

2 PRESENTATION SUMMARIES

2.1 SESSION 1: POLICY FOCUS

Session 1 of the technical consultation was a stage-setting session. Authors from The Lancet Double Burden of Malnutrition Series presented the key results from the Series papers and discussed how DDA can be incorporated into nutrition policies. Paper 1 ([Dynamics of the double burden of malnutrition and the changing nutrition reality](#)) provides justification for convening the consultation: In LMICs, undernutrition is declining while overweight is increasing. Increases in overweight are leading to a high DBM. Of the 126 LMICs with data from the 2010s, 38% face a DBM prevalence that is very high or severe. Also, the DBM is shifting towards countries in the poorest income quartiles, particularly South and Southeast Asia and sub-Saharan Africa. The COVID-19 pandemic has likely exacerbated stunting, wasting, and excess weight gain, although documentation so far is limited to a few studies. Globally, there are significant decreases in physical activity because of COVID-19 controls and reduced active employment and production. In addition, there are rapid increases in consumption of both highly-processed food and less-nutritious, cheaper food from vendors, stalls, and home cooking in most regions.

Paper 3 of the Lancet series, [Double-duty actions: seizing programme and policy opportunities to address malnutrition in all its forms](#), outlines ten DDA which span health services, social safety nets, educational settings, and agricultural and food systems/environments that have strong potential to reduce the risk of the DBM (see **Table 1**). The need to operationalize these actions was discussed.

Table 1. Ten priority candidates for double-duty action

Health services
1. Scale-up programs to support antenatal care and include counseling on healthy eating and balanced energy and protein intake
2. Scale-up programs to promote optimal breastfeeding and eliminate the promotion of breastmilk substitutes
3. Redesign guidance for complementary feeding practices that emphasizes healthy and diverse diets and snacks
4. Redesign growth monitoring programs to include diagnostic of overweight and obesity, if operationally feasible
5. Prevent undue harm from energy-dense and micronutrient-fortified foods and supplements
Social Safety Nets
6. Redesign social safety nets to include counseling on nutrition, healthy diets, and health education; and facilitate access of beneficiaries to healthy foods, snacks, and beverages or introduce rewards for transfers or vouchers spent on nutritious foods
Education
7. Redesign school feeding programs to offer meals that meet children's energy and nutrient needs and devise new nutrition guidelines that restrict unhealthy products, snacks, and beverages in and around schools
Food systems
8. Scale-up agriculture programs that promote the production and consumption of nutritious foods
9. Design new agricultural and food system policies with healthy and affordable diets in mind
10. Deliver public policies to improve food environments to tackle all forms of malnutrition

In addition, the "contextualization of DDA to address the DBM" was discussed. In other words, to meet the Sustainable Development Goal 2.2 *End all forms of malnutrition*, the traditional siloed approach (i.e., considering undernutrition and overweight/obesity separately, including in policies and programs) needs to end. As food environments shift, there is evidence that some programs to address undernutrition have unintentionally increased risks for obesity and DR-NCDs, and yet these risks can go unrecognized. This underscores the need for the DDA lens. By considering all aspects of malnutrition (undernutrition and overweight/obesity and DR-NCDs), the same policy or program can prevent or address multiple forms of malnutrition simultaneously, given the fact that there are common drivers that can be leveraged for double impact. As discussed in the Lancet Paper 3, these drivers include early life nutrition, diet diversity, food environments, and socioeconomic factors. Putting a double-duty approach into action involves assessing the potential harm of existing activities and redesigning policies and programs with a focus on DDA.

Country case studies of Mexico and Indonesia were presented, providing examples of enabling conditions for DDA policy and challenges to overcome to integrate DDA into existing policies (see **Annex A** for more information).

After the case study presentations, the participants were divided into small groups to discuss the following questions:

- 1) What are some of the critical enabling conditions, actions, and activities that set the stage for moving from siloed nutrition policies to policies that incorporate DDA?
- 2) How can existing nutrition policies be modified to incorporate DDA actions?
- 3) Does COVID-19 present an opportunity for policy reform with respect to DDA? If so, how?

2.1.1 Enabling conditions

The group outlined the following enabling conditions for the transition from siloed nutrition policies into those that include DDA:

- **Improve understanding among policymakers and key stakeholders of the problem of the DBM and what is meant by DDA**, including shared and common drivers of malnutrition. It would be helpful to identify champions (individuals and networks of people) in a country or region to push the DDA agenda and develop clear and cohesive language around DDA. Also, it would be useful to provide practical examples that policymakers can use to look at their existing policies and evaluate their DDA potential.
- **Ensure that policymakers work with representatives** from all aspects of the food system, including the food industry, agriculture system, consumer forces, etc., to address the food environment.
- **Establish a system to collect data and mobilize and translate evidence about DDA** (including evidence of impact and cost to support decision making, advocacy, and program planning).
- **Address sociocultural norms about thinness, overweight, foods as status symbols**, etc. that contribute to unhealthy conditions of undernutrition and overweight/obesity and the DBM.
- **Develop global normative guidance that incorporates DDA as an approach to address the DBM.**
- **Identify common goals and deliver clear and cohesive messages to transition from siloed to DDA-inclusive nutrition policies.**
- **Increase awareness of DR-NCDs**, the link to early life nutrition, and the role of diet in protecting from all forms of malnutrition and related NCDs.
- **Provide integrated governance and financing structures** that enable multiple ministries and sectors to implement or finance DDA in an integrated fashion.

2.1.2 Integrating DDA into existing policies

Several key strategies to incorporate DDA into existing nutrition policies were brought forward. These include:

- **Shift the narrative of nutrition policies from a narrow focus on reducing child stunting to emphasize the impact of micronutrient deficiencies and the importance of healthy diets (which address all forms of malnutrition) to protect nutrition and prevent DR-NCDs.** This shift in framing would create more opportunities for incorporating DDA in nutrition policies.
- **Understand and leverage the priorities of nutrition-related sectors (such as the agriculture, education, and government sectors) to drive DDA integration into nutrition policy.** Use existing program platforms from different sectors (e.g., health, social protection, agriculture, education) to bring about the integration of DDA without waiting for (longer-term) policy actions to be completed. For example, it was suggested that nutrition policies targeted for early childhood and school-age could be modified to include DDA. Such modifications could include shifting from hunger alleviation policies to the provision of diverse diets, including nutrient-rich foods, regulating food marketing to children, and prohibiting the sale of sugar-sweetened beverages (SSBs) around schools.
- **Update dietary guidelines** to reflect the role of healthy diets in the full spectrum of malnutrition and use them as a guide to policy formulation.

2.1.3 Implications of the COVID-19 impact on DDA policy

In December of 2020, it was impossible to hold a technical consultation without including a discussion of COVID-19. All participants in the consultation felt that COVID-19 might present an opportunity for policy reform for DDA, including a renewed emphasis on malnutrition, given that undernutrition and overweight/obesity are risk factors for COVID-19. The following suggestions were made:

- Capitalize on the pandemic as an opportunity to **promote healthy diets and nutrition behaviors to boost the immune system and reduce risk factors for increased severity and poor outcomes from COVID-19.**
- **Integrate DDA into the health system strengthening response to the COVID-19 pandemic.**
- **Use COVID-19 response funds going to non-health sectors/programs** such as social protection and social safety nets as a potential entry point for DDA.
- **Ensure that food and beverage companies' philanthropy during COVID-19-induced food insecurity is not undermined by contributions of highly-processed foods to the DBM.**
- **Integrate DDA policies and programs as part of One Health.**

Session 1. Summary Points

- Bring together nutritionists working in siloes: undernutrition (underweight, stunting, micronutrient deficiencies) and overweight/obesity.
- Improve the evidence on financial costs of overweight and obesity – there is a need to build and communicate the evidence.
- Frame the issue for policy action through clear articulation of the problem, strengthened evidence, advocacy, and targeting the evidence to key influential people.
- Work on the elevator pitch for explaining DDA to the non-nutrition community: a cohesive message that comes with practical examples.

2.2 SESSION 2: PROGRAM FOCUS

Session 2 drew from country examples to identify effective entry points to design or adapt sectoral programs to integrate DDA. Country examples were presented from India, the Philippines, and South Africa. The India presentation focused on Eat Right India's multidisciplinary/multisectoral approach to address multiple forms of malnutrition, including large-scale behavior change communication campaigns focused on sustainable, diverse diets. The Philippines presentation provided examples of intentional integration of double-duty actions across several nutrition programs to address infant, young child, and maternal malnutrition. The South Africa presentation focused on specific actions, including those supported by city governments, to address the DBM through DDA (see **Annex A** for more information).

After the presentations, small group discussions were held to discuss how to deliver DDA programs through the education, social protection, health, and agriculture/food systems sectors (see **Table 2**). The following topics were discussed:

- What are the entry points in this sector for supporting the implementation of DDA?
- What immediate action is needed to support program planners in incorporating DDA into their sectoral programs?
- What are anticipated barriers or challenges in the implementation of DDA in your sector?

Table 2. Examples of how to deliver DDA programs through different sectors

Health	
Entry points	<ul style="list-style-type: none"> • There are multiple entry points for DDA throughout the life cycle (both clinical and community-based), including antenatal and postnatal care, childhood immunizations, sick-and well-child visits, etc. • Health should not only be opportunistic in implementing DDA; it should also lead to action in other sectors.
Immediate actions	<ul style="list-style-type: none"> • More work is needed by the sector to: <ul style="list-style-type: none"> ○ Make a good public health case (i.e., provide clear messaging about DBM and DDA; gear messaging to different types of health professionals); ○ Better define overweight/obesity, particularly biomarkers, to promote better prevention and treatment for individuals who present with overweight using double-duty approaches; ○ Take full advantage of funding that exists in both the health sector and other sectors. • Identify the commercial (e.g., profit-driven) determinants of health. • Better categorize at-risk groups since there is not one single route to the DBM. • Emphasize the importance of physical activity and building muscle strength for health. • Shift focus away from focusing on calories and towards dietary diversity.
Barriers/challenges	<ul style="list-style-type: none"> • Need to mobilize other sectors and provide advocacy/clear language about how they will benefit by focusing on DDA and improved health/nutrition of women and children. • Need improved technical resources, capacity building, and training on DBM and DDA. • Need better definitions and indicators of overnutrition, particularly of biomarkers, to better equip health professionals for the prevention and treatment of overweight/obesity. • Standards of care (global and country adaptations) need to be developed for overweight and obesity, with a focus on public health and preventive actions.
Levers	<ul style="list-style-type: none"> • Take advantage of funding that exists in both the health sector and other sectors, especially during/after the COVID-19 crisis.
Social Protection, including Social Safety Nets (SSN)	
Entry Points	<ul style="list-style-type: none"> • Use a supply and demand-side approach: existing cash or food transfer programs as an entry point to make nutritious food more available and affordable, paired with behavior change communication to promote optimal purchasing behaviors.
Immediate Actions	<ul style="list-style-type: none"> • Develop a policy brief to raise awareness and push for programming and advocacy for DDA in SSN. To reduce all forms of malnutrition using DDA, frame nutrition around healthy diets. • Widely disseminate positive program evaluation study results to policymakers and provide a menu of possible DDA actions to social protection program planners. • Examine the impact of the COVID-19 pandemic on diet quality and consumption of nutritious foods (not just quantity of food) for people participating in SSN programs. • Show how financing DDA in SSNs will have a positive return on concrete and long-term development outcomes. • Build on financing opportunities like the UN Food Systems Summit and 2021 Nutrition for Growth summit to improve DDA financing of social safety nets tasking a DDA approach.
Barriers/Challenges	<ul style="list-style-type: none"> • Some social protection programs may have negative impacts or unexpected consequences (e.g., women using money to buy unhealthy snacks; programs leading to an increase in nutrients but also excess caloric intake.)

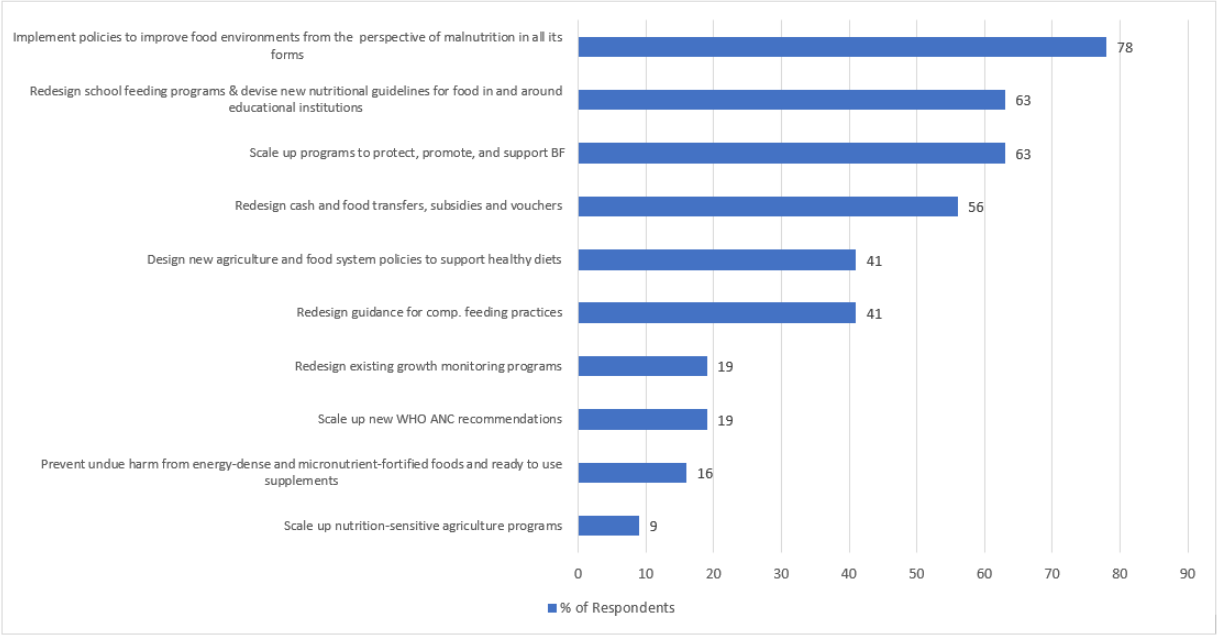
	<ul style="list-style-type: none"> • Difficulty in defining what can/cannot be purchased with cash/food transfers. This challenge falls at the intersection between the food environment and food assistance programs. • Misalignment between programmatic objectives and what is actually measured (e.g., if the issue is reframed around healthy diets, one will measure healthy diets rather than just focusing on stunting). • Routine collection of dietary data is lacking in some countries. • It is difficult to identify indicators that measure healthy diets.
Levers	<ul style="list-style-type: none"> • Capitalize on frequent inclusion of nutrition conditionalities and benefits in SSN programs to integrate the DDA lens in social protection programming.
Education	
Entry Points	<ul style="list-style-type: none"> • School-based child health programs (e.g., school nurse/doctor). • School curricula (e.g., health education/physical activity/hygiene/nutrition/marketing; integration of messages across other subjects [science, literacy]). • School gardens. • School governance involving students, teachers, peers, and parents. • School meal programs.
Immediate Actions	<ul style="list-style-type: none"> • There is a need to define/standardize an essential nutrition and healthy diets package for schools that has a double-duty lens and includes: a curriculum for nutrition education; nutritional guidance on school feeding and meal content; how to improve the school food environment so that access to unhealthy products and snacks in and around school environments is limited or eliminated; promote children's literacy about labeling and nutritious foods; and a data monitoring package that allows tracking of the health, nutrition, and well-being of school-aged children. • Apply a DDA lens to nutrition education and food literacy programs to ensure children are educated about the link between food and undernutrition, obesity, and diet-related NCDs. • Engage with and use youth leaders to create demand for nutritious foods among children/students. • Reshape school feeding programs to make them healthier and more nutritious, rather than focusing only on quantity. • Develop a standard package of policies, key interventions, social behavior change communication strategies, and tools to support countries in implementing healthy and nutritious school feeding and school health and nutrition programs. • Develop a standard set of indicators to monitor health and nutritional status of students and the quality of school feeding programs (including output and outcomes). • Build on existing successful initiatives and examples of school feeding programs that have a DDA lens through study tours and cross-country sharing/knowledge exchange.
Barriers/Challenges	<ul style="list-style-type: none"> • Possible private-sector interference with school governance. • The potential ethical issues around growth monitoring (i.e., BMI for an indicator on obesity/NCDs among children/adolescents). • Difficulty in changing the perception of what is "normal" for children in terms of activity, weight, diet. • Shelf-stable foods and food safety measures are necessary for school meal programs. • There may be poor implementation, monitoring, and enforcement by schools of established guidelines, standards, and commitments. • Frequent program dependence on donors.
Levers	<ul style="list-style-type: none"> • Use school meals budgets more effectively to improve the quality of the meals provided (i.e., prioritize DDA integration in the budget).

	<ul style="list-style-type: none"> • Demonstrate that health-promoting school environments have wide-reaching effects (school attendance, student performance).
Food Systems/Agriculture	
Entry Points	<ul style="list-style-type: none"> • Should be guided by the driving principle of considering the entire healthy diet, including increasing the production of, access to, and consumption of nutritious foods (and healthy diets) while decreasing the availability and appeal of unhealthy, highly-processed foods. • Promote a coordinated approach that includes actors and actions across the food system. • Consider and address inequities in access to, affordability, and consumption of healthy diets in the food system, including t gender, geography, and commercial inequities, including skills in marketing and distribution of unhealthy products, among others.
Immediate Actions	<ul style="list-style-type: none"> • Raise awareness among food system program planners to demonstrate the importance of DDA to address the DBM. • Review consumption patterns, nutrient gaps to strategically think about dietary guidelines. • Research: <ul style="list-style-type: none"> ○ Support research to develop one or more models that capture the health and economic impacts and costs of DDA for maternal and child undernutrition and overweight/obesity outcomes; ○ Integrate improved indicators for assessing the DBM and simple indicators to measure dietary quality (and not just dietary diversity) in current national household expenditure surveys; ○ Conduct a landscape analysis of entry points at the country level, including the production and consumption of nutritious under-utilized crops, taking into consideration local palatability of foods, acceptability, and convenience. • Identify and implement incentives to food system actors along the value chain that increase the availability, access to, and affordability of nutritious foods while reducing access and affordability of foods high in sugar, salt, and fat, including by investing in research and data. • Invest in home and community food production of nutritious foods and in improvements in urban access to healthy diets. • Use retail food outlets and consumer engagements as entry points to DDA to increase consumption of healthy diets. • Use DDA strategies to control and regulate some aspects of the food industry. • Develop DDA case studies that capture examples of effective food environment policies and programs to increase consumption of healthy diets at the population level. • Use current data on how the COVID-19 pandemic affects income and dietary practices to inform the 2021 UN Food Systems Summit and the 2021 Nutrition for Growth Summit.
Barriers/Challenges	<ul style="list-style-type: none"> • The commercial food sector is efficient in marketing and distributing unhealthy products and provides substantial employment opportunities. • In some rural areas, healthy green vegetables are associated with perceived low socioeconomic status (i.e., social class and poverty). • Commercial crops are usually controlled by men, and women produce for homestead production. • Lack of access to capital, technical expertise, and technology for small and medium enterprises to produce alternative or increase production of nutrient-rich foods.

Levers	<ul style="list-style-type: none"> • Explicit plans of action and policies for DBM for agriculture and food systems that include guidance and possibly repackaging of existing nutrition and food system metrics that capture DBM for monitoring; consider equity and gender in policies. • Legislation to support reduced production and consumption of unhealthy products. • Show evidence and economic benefits of DDA. • Assurance that DDA do not harm (e.g., if governments subsidize farmers, they do not promote the production of unhealthy products).
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To conclude the second session of this consultation, participants were asked to select the four DDA that are most feasible, high impact, and timely out of the list of ten presented in Lancet Paper 3, [Double-duty actions: seizing programme and policy opportunities to address malnutrition in all its forms](#) (Table 1). The purpose of the poll was to inform the discussion for the third session of the consultation by narrowing down actions to the four selected DDA. The poll results are shown in Figure 1. The discussions for each of these are summarized in the next section of this report.

Figure 1. Participants' ranking of most feasible, high impact, and timely Double-Duty Actions



Session 2. Summary Points

Health

- Use the multiple existing entry points for DDA in the health sector throughout the life cycle.
- Be opportunistic in implementing DDA, as well as leading action in other sectors.

Social Protection, including Social Safety Nets

- Use existing cash or food transfer programs as an entry point to make nutritious food more available and affordable while pairing with knowledge transfer to promote optimal purchasing behaviors.
- Frame nutrition around healthy diets to reduce all forms of malnutrition using DDA. Having a menu/listing of all DDA is helpful to program planners.
- Build on financing opportunities like the UN Food Systems Summit to move towards greater financing for DDA.

Education

- Define/standardize an essential package for schools that has a double-duty lens.
- Apply a double-duty lens to meal programs and nutrition education by redesigning, reforming, and integrating them to emphasize meal quality standards, not just quantity standards.
- Engage with and use youth leaders to create demand for nutritious foods among children/students.

Food Systems/Agriculture

- Increase the production of and access to nutritious foods while decreasing the availability and appeal of unhealthy products and highly-processed foods.
- Promote a coordinated approach that includes actors and actions across the food system.
- Consider and address inequities in the food system, including gender and commercial inequities (skills in marketing and distribution of unhealthy products).
- Invest in research and data to identify incentives that increase the availability and affordability of nutritious foods while reducing those for unhealthy products.

2.3 SESSION 3: CONSOLIDATION AND SUMMATION

2.3.1 Data and research needs

The third session of the consultation began with a panel discussion to reflect on data needs and data gaps, including gaps in policy and outcome indicators for DDA along with the key operational research gaps that must be addressed to support a paradigm shift for increased uptake of DDA. Several key themes were raised, as they relate to data needs and gaps:

- **Measurement and indicator work**
 - We need to be very specific in how we define "all forms of malnutrition," how we quantify the burden, and how we assess the impact of our actions. Because poor-quality diets are the common cause of all forms of malnutrition, it is appropriate to use indicators of diet quality to track progress in tackling the DBM, along with other relevant anthropometric indicators and biomarkers (GBD 2017 Diet Collaborators 2019).
 - We can understand the DBM quite well for children under the age of five: We have relatively good estimates for stunting, wasting, underweight, and overweight for this age group, though not enough data on micronutrient status. We do not have sufficient information on the prevalence of the DBM for other groups (school-age children, adolescents, women of reproductive age, pregnant and lactating women). We should think about platforms that could allow us to collect this data and fill the knowledge gap.
 - We need better ways to collect dietary data, new tools, and new indicators of diet quality across

the life cycle. Infant and young child feeding (IYCF) indicators were developed almost 15 years ago. They were catalytic in helping to assess the quantity and quality of children's dietary intake through breastfeeding and complementary foods for children under two. Although useful, the original set of indicators failed to include ways to measure unhealthy dietary patterns in this age group (e.g., consumption of 0 fruits and vegetables, consumption of sugar-sweetened beverages (SSB), or highly-processed foods). The revised IYCF indicators for children under two years of age now fill this gap and include new indicators to measure the consumption of unhealthy products (WHO and UNICEF 2021). For other ages or other life cycle stages (e.g., school-age children, adolescents, women of reproductive age, adult men), however, we need to develop new approaches and indicators to measure dietary quality. Several efforts are underway to improve and simplify dietary recall data collection and to measure dietary quality, including the Global Diet Quality Score, the Diet Quality Index, and the Global Dietary Recommendations Score (Intake -- Center for Dietary Assessment 2021; INDDX Project 2018; Herforth, Martínez-Steele, and Monteiro 2020).

- We need data that is publicly accessible to monitor the exposure of households and communities to the marketing of breastmilk substitutes, follow-on formula, and unhealthy diets.
- We need to do better on tracking compliance and enforcement of nutrition policies.

- **Underlying pathways**

- There is a need to better understand the underlying pathways and drivers of the DBM (e.g., epigenetics and nutrition in early life, socioeconomic, demographic and cultural factors, physical activity and lifestyle, food system and food environment influences, and dietary factors) to guide DDA design and implementation. For example, much attention and 'blame' is placed on the food environment, but food environments are complex and difficult to measure, and their influence on purchasing and consumption behaviors and the DBM is poorly understood and perhaps overstated. Moreover, the food environment is not an exogenous force, and both 'directionalities' (e.g., the role and power of the food environment on consumer's consumption versus the effects of consumer demand on what is offered in the food environment) need to be better understood and measured.
- We also need to focus on the coverage and quality of DDA implementation, including better estimates of the costs to inform financing of scaling these up.

2.4 ACTIONS AND COMMITMENTS THAT CAN BE MADE TO SUPPORT DDA:

Using a "World Café" format³, participants considered the following "way forward" questions for each DDA intervention that were prioritized during Session 2 (see Figure 2 above). For each of the four targeted DDA, the following questions were discussed:

- What policies are needed (either newly designed or adapted) to shift from the current siloed approach (solely undernutrition or overweight/obesity) to consideration of DDA and addressing malnutrition in all its form?
- What are priority programming entry points for the operationalization of each DDA?

³ This is a structured knowledge-sharing activity where groups discuss pre-defined questions in time-bound "rounds." Using this method, each group has the chance to discuss every question, building on and expanding the recommendations of each previous round.

- Which policy and outcome indicators are needed for each DDA, including the development of new metrics?
- What are key operational research needs to accelerate the implementation of DDA policies and programs?
- What are concrete actions/commitments that could be made to support DDA?

Below is a list of agreed-upon actions and commitments.

2.4.1 Implement policies to improve food environments from the perspective of malnutrition in all its forms

- Add to DDA case studies currently being done by NCD Alliance.
- Support research to develop one or more models that capture the health and economic impacts and costs of DDA on both stunting and overweight.
- Integrate improved indicators for assessing the DBM in current national household expenditure surveys. There is a need to add a focus on prepared, packaged, and highly-processed foods in addition to the existing indicators for fruits, vegetables, and other components of healthy diets.
- Use current data on how COVID-19 affects income and dietary practices to inform the UN Food Systems Summit 2021 and the 2021 Nutrition for Growth Summit.

2.4.2 Redesign school feeding programs and devise new nutritional guidelines for food in and around educational institutions

- Reshape school feeding programs to make them more nutritious and in line with a healthy diet, rather than focusing mostly on quantity.
- Adapt existing or develop a standard package of policies, key interventions, monitoring indicators, SBCC strategies, and tools to support countries in the implementation of school feeding using a DDA lens.
- Develop a standard set of indicators to monitor the health and nutrition status of school-aged children and the quality of school feeding programs.
- Build on existing initiatives and examples to integrate DDA, such as:
 - WHO's health-promoting schools framework.
 - Germany's Healthy School Foods Peer Learning Platform, which can be leveraged for information-sharing.
 - FAO nutrition guidelines and standards for school meals for consideration of nutritional needs and food systems based on local context.
 - The Global Research Consortium for School Health and Nutrition (based at the London School of Hygiene and Tropical Medicine with funding from the World Food Programme [WFP] and Dubai Cares), including Kenya collaboration that is looking more closely at school health and nutrition.

2.4.3 Scale-up programs to protect, promote, and support breastfeeding

- Provide concrete advocacy on breastfeeding and DDA:
 - Tailor DBM and DDA messaging to different audiences (e.g., policymakers may need to understand the potential synergies and gains in efficiency that would result from DDA that target multiple forms of malnutrition at the same time (and with breastfeeding, DDA actions target multiple forms of malnutrition at different stages of the life cycle – early life and adulthood); whereas health workers may be more interested in ways to measure and report on the DBM).
- Create a menu of options on how to easily integrate DDA into breastfeeding programs.
- Focus on specific messages, actions, and behaviors and less on conceptual frameworks.

2.4.4 Redesign cash and food transfers, subsidies, and vouchers

- Develop policy briefs to raise awareness and push for programming and advocacy for DDA in SSN:
 - They should encompass SBCC on healthy diets and lifestyle and recommendations to use cash transfers to purchase nutritious foods and ensure a focus on quality (versus quantity) for foods delivered through food transfer programs. It is important to include these approaches as there is evidence that failure to provide well-designed SBCC on healthy diets in SSN programs has caused unintended impacts on overweight and obesity in Latin American countries and Egypt that are experiencing a rapid nutrition transition (Shrimpton, Mbuya, and Provo 2016; Hawkes, Demaio, and Branca 2017).
 - Develop clear criteria for the implementation of double-duty actions within safety net programs (for example, for programs benefitting women/young children, ensure that subsidies/food vouchers assist families in accessing nutritious foods as opposed to processed foods/snacks high in sugar, fat, and salt; SSN programs must be accompanied with information/education focused on healthy diets including promotion of exclusive and continued breastfeeding for children under two years; etc.).
- Widely disseminate positive study results to policymakers:
 - Demonstrate the benefits of using DDA in SSN programs to improve nutrition and prevent harm.
 - Disseminate [WHO framework on the procurement of foods](#) in the public sector (e.g., through schools and social protection programs), outline results and next steps.
- Examine the impact of COVID-19 on diet quality and consumption of nutritious foods (not just quantity of food) in the context of SSNs.

Session 3. Summary Points

1. Implement policies to improve food environments from the perspective of malnutrition in all its forms

- Develop new case studies based on the existing implementation of DBM policies for operationalization of DDA.
- Support research to expand the knowledge base on the health and economic impacts and costs of DDA on healthy diets and on indicators of undernutrition and overweight/obesity.
- Develop improved indicators for assessing the DBM in national household expenditure surveys, including measuring the consumption of unhealthy diets.

2. Redesign school feeding programs and devise new nutritional guidelines for food in and around educational institutions

- Reframe school feeding programs to focus on nutrition and diet quality, not solely on feeding and diet quantity.
- Develop indicators to effectively/feasibly monitor the health and nutritional status of school-aged children and the quality of school feeding programs (including output and outcomes).
- Build on existing initiatives and examples such as those listed in 2.4.2 above.

3. Scale-up programs to protect, promote, and support breastfeeding

- Provide concrete advocacy on breastfeeding and DDA, targeted for different audiences (donors, implementers, policymakers).
- Create a menu of options on how to easily integrate DDA into breastfeeding programs.
- Focus on specific messages, actions, and behaviors and less on conceptual frameworks.

4. Redesign cash and food transfers, subsidies, and vouchers

- Develop targeted policy brief to raise awareness and push for programming and advocacy for DDA in SSN, including the need to incentivize and use cash transfers to purchase nutritious foods; ensure focus on quality (versus quantity) for foods delivered through food transfer programs; and protect against doing harm.
- Widely disseminate positive study results to policymakers on the effectiveness of using DDA in SSN programs.
- Disseminate WHO framework on the procurement of foods in the public sector (e.g., through schools and SP programs), outline results and next steps.

2.5 NEXT STEPS

As a conclusion to the consultation, the participants discussed potential areas for action and agreed on specific steps each of the agencies/ organizations they represent could take. These are summarized below.

- **NCD Alliance:** NCD Alliance has made a commitment to take DDA forward. It will translate and adapt DDA for geographic and language diversity.
- **World Food Programme:** WFP has been in conversation with different organizations (e.g., WHO, UNICEF, World Bank, FAO, UNESCO, among others) to support countries to scale up school health and nutrition integrated packages. The Global Research Consortium for School Health and Nutrition has been launched with the London School of Hygiene and Tropical Medicine and Dubai Cares. As part of the consortium's work program, it will develop different communities of practice around issues of school-age health and nutrition. WFP could coordinate unpacking what was learned during this conference and connecting it with what is already happening.
- **WHO:** WHO is in the process of organizing the third global nutrition policy review. The results will be available around the time of the UN Food Systems Summit 2021 and Nutrition for Growth Summit 2021. The analysis will take into account DDA and provide a good baseline for the health sector.
- **UNICEF:** UNICEF launched a ten-year strategy (2020-2030) for nutrition which addresses all forms of malnutrition, focusing on the life cycle approach. The document contains many practical suggestions and strategies. UNICEF is also focusing on social protection and school food and nutrition (healthy school environment). Mexico, Ecuador, and Indonesia are leading on DDA for UNICEF with the anticipation that more countries will follow.
- **World Bank:** The World Bank recently published a report on the global health and economic impacts of obesity ([Obesity: Health and Economic Consequences of an Impending Global Challenge](#)) that details the need for a whole-of-government and whole-of-society approach to double- and triple-duty actions that have impact on undernutrition, obesity and climate change. The report identifies instruments that the World Bank can use to support countries in addressing the emerging epidemic of overweight and obesity and related NCDs, including policy and regulatory levers (including fiscal policies), technical assistance, and results-based financing instruments as well as investment lending across sectors.
- **GFF:** GFF provides technical assistance to interested countries for school-based adolescent health and nutrition programs/services, with the potential for the implementation of a DDA lens. Ongoing financing to WB/IDA projects for improved health and nutrition service delivery to children in the first 1000 days offers additional space for the inclusion of DDA advocacy/programming as well as policy dialogue on addressing all forms of malnutrition. A new program of investments in improved quality of health and nutrition services is under development. This will offer opportunities for promoting the quality of counseling (including DDA) at critical contact points for families with the health sector (e.g., childbirth and postpartum care).

ANNEX A: COUNTRY EXAMPLES⁴

ACCELERATION OF NUTRITION IMPROVEMENT IN INDONESIA

Dr. Dhian Dipo, Directorate of Community Nutrition, Ministry of Health Indonesia

Indonesia's double burden of malnutrition includes undernutrition, overweight and obesity, and micronutrient deficiencies: 28% of children under five are stunted, and 10% are wasted. Eight percent of children are overweight, and 22% of adults are obese. Moreover, 49% of pregnant women are anemic. In addition, the COVID-19 pandemic has had a negative impact on the health of children. There are many causes of malnutrition in Indonesia during the first 1,000 days of life, including a high incidence of adolescent pregnancies, pregnant women accessing less than four antenatal care visits, a high percentage of pregnant mothers being anemic, babies not being exclusively breastfed, inadequate complementary feeding, babies not being immunized fully, children under five not going to growth monitoring and promotion sessions regularly, poor access to sanitation, diarrhea in children, household food vulnerability, and poverty.

During the last few decades, the Government of Indonesia (GOI) has been strongly committed to malnutrition and has recognized that the root causes of stunting are complex and multisectoral. The GOI is addressing malnutrition through various policies and programs. These include the Medium-term National Development Agenda (RPJMN 2020-2024) and the Multisectoral Nutrition Strategy and Program to Accelerate Stunting Reduction (*StraNas*) (2018-2024), which focuses on addressing multisectoral nutrition through five pillars: 1) National leadership vision and commitment; 2) national behavior change communication campaign and interventions; 3) strengthening convergence and coordination among multiple sectors; 4) food and nutrition security; and 5) monitoring and evaluation as a basis to deliver high-quality services, increase accountability, and accelerate the learning process. The strategy focuses on nutrition-specific and -sensitive interventions implemented across five sectors and the need to coordinate or "converge" these interventions in selected geographical areas and among the most vulnerable populations. Target populations include adolescents, women, and children during the first 1,000 days. Stunting prevention in districts/cities/villages is being carried out through convergence actions. Different mobile applications exist, as well as a convergence scorecard, to measure convergence and to increase accountability. This data can be shared with various stakeholders so that the stunting interventions are more targeted.

In addition, the GOI has developed technical dietary guidelines, visualization of the nutritional elements required in one meal serving, strengthened nutrition surveillance to reduce stunting, and a Maternal and Child Health Services Protocol and mobile application, which is being used during the COVID-19 pandemic. In 2021 the GOI will develop nutrition guidelines for school children and adolescents.

The presentation highlighted that to better integrate DDA to address the DBM, the following would be needed:

⁴The health and nutrition indicator values included in the country examples in Annex A are not referenced and stem from individual country presentations.

- Gain multisectoral support and recognition for the improvement of nutrition services as a priority to prevent nutrition problems. Need to strengthen the commitment of local governments.
- Encourage regional innovation based on local wisdom. Focus on community empowerment in efforts to improve nutrition.
- Deepen leadership and commitment from national to local levels to help ensure the sustainability of development policies and the monitoring and evaluation systems for the policies.
- Support health workers and cadres (community health workers) to conduct home visits and supervise risk groups (adolescent girls and first 1,000 days).

CAN THE MEXICAN EXPERIENCE IN THE DESIGN OF EVIDENCE-BASED NUTRITION POLICIES HELP OUR WAY TO DOUBLE-DUTY ACTIONS?

Dr. Juan Rivera, National Public Health Institute, Mexico

Research institutions play an important role in generating the evidence needed for the design of sound policy to tackle malnutrition. Mexico has successfully used scientific evidence for the design of large-scale nutrition programs and policies. The National Public Health Institute (INSP) in the country has developed two models that show how research evidence can be used for the approval, design, and evaluation of nutrition policies in the country (for more information, see [The Role of Public Nutrition Research Organizations in the Construction, Implementation and Evaluation of Evidence-Based Nutrition Policy: Two National Experiences in Mexico](#)). These models depend on the degree of support of the Federal Government to different policies and programs.

Model 1. Direct interaction between research institutions and policymakers (used when there is the support of the government). For example, in the early 1990s, INSP researched the inadequate targeting of the food aid programs in Mexico and the reasons for the food program's lack of effectiveness. By looking at the distribution of stunted children less than five years by geographic and socioeconomic differences versus the proportion of families who benefitted from food aid programs, they found that the food programs in the country were not being targeted to those most in need. They also found that the nutrition content of the food being distributed was not optimal. Based on the research, INSP provided recommendations to the government to design the nutrition component of *Progressa*, the national conditional cash transfer program started in 1997. These included improved targeting, utilizing evidence-based interventions (e.g., nutrition education, the composition of fortified food supplements, complementary foods for children under age two), coordination of programs and actions, and improved monitoring and evaluation of the program. Evaluation of the program showed positive effects on linear growth and lower rates of anemia in children.

Model 2. Direct interaction between research institutions and civil society (research, lobbying, and advocacy) to mobilize public demand for policy action (used when there is opposition from certain government sectors). INSP conducted research on the link between SSB intake and obesity, diabetes, and other chronic diseases. It then worked with lobbyists and advocacy organizations and the government to shape one of the most effective policy actions for the prevention of obesity (i.e., the approval and implementation of fiscal policies and disincentives for the consumption of unhealthy beverages and foods [e.g., an SSB tax for obesity prevention in Mexico]). Studies have shown that the SSB tax was effective in increasing prices and reducing consumption.

Research institutions are also critical to conduct evaluations. Evaluation provides evidence-based feedback to policymakers, guides decisions about keeping or modifying policies or their design or implementation, and may generate new research questions that feed the research-to-policy cycle.

Mexico's success with reductions in malnutrition has generally been in "single-duty actions" to prevent stunting and micronutrient deficiencies or obesity, with very limited experience in "double-duty actions" to address both conditions simultaneously. A new social protection strategy that embraced a DDA lens was developed, but a government administration change stymied implementation.

To advance DDA in Mexico, the INSP recommends:

- Working with Secretariat of Health on restoring services with a DDA lens to children less than five years of age, with emphasis on the first 1000 days, including prevention of all forms of malnutrition.
- Continued implementation of the multisectoral program aimed at transforming the Mexican food system into a healthy, sustainable, and fair system supported by the Intersectoral Group for Health, Nutrition, Environment, and Competitiveness.
- Implementation of several planned actions including: Front of package warning labels, food marketing restrictions to children, updated dietary guidelines, support to small scale and environmentally friendly agriculture, and prevention of malnutrition in all its forms in young children through multisectoral actions at the local level.

EAT RIGHT INDIA: AN INTEGRATED APPROACH TO ADDRESS FOOD SAFETY, MALNUTRITION, AND SUSTAINABILITY

Ms. Inoshi Sharma, IRS, Food Safety and Standards Authority of India (FSSAI)

This presentation focused on India's DBM. Fifty percent of the population does not meet 50% of the recommended dietary allowance (RDA) for critical micronutrients; 50% of women and children are anemic; and undernutrition among children under five years is high (21% wasted; 36% underweight, 38% stunted). At the same time, the country is facing rapidly rising rates of obesity and DR-NCDs. [Eat Right India](#) is a collective effort of all stakeholders, led by FSSAI, to transform the food ecosystem of the country to ensure safe, healthy, and sustainable food for everyone through a judicious mix of regulatory, supply, and demand-side initiatives. The program uses a whole of government and whole of society approach to achieve five key outcomes: 1) significantly reduce the burden of foodborne illnesses in the country; 2) lessen micronutrient deficiencies through dietary diversification; 3) reverse the burden of preventable DR-NCDs; 4) reduce the carbon footprint of the food sector; and 5) ensure a more sustainable food sector. Included in the program are DDAs to address the double burden of malnutrition. The program's action areas and examples of entry points for DDA are outlined below.

Action Areas	Examples of entry points for DDA
Regulatory Framework	
<ul style="list-style-type: none"> • New and updated food standards • Strengthening food testing laboratories 	<ul style="list-style-type: none"> • Regulations on food fortification – to address micronutrient deficiency • Regulations on front of pack labeling, trans-fats – to address DR-NCDs and obesity • Food Safety and Standards (Advertising and Claims) Regulations, 2018 • Draft Notification on Food Safety Standards (Safe Food and Healthy Diets for School Children) Regulations, 2019
Training and Capacity Building	

<ul style="list-style-type: none"> • Training of food handlers in organized and unorganized food business across all sectors • Training of frontline health workers in Health and Wellness Centres • Training of senior bureaucrats/officials on Eat Right India 	<ul style="list-style-type: none"> • Integrated training on food safety and DR-NCDs in the existing training curricula of frontline workers • Training future leaders on food safety and nutrition: Centre of Food, Planet and Health Nations apex Institute of Civil administrators • Safe and Nutritious Food Initiative – home, schools, hospitals, on-the-go
Benchmarking and Certification	
<ul style="list-style-type: none"> • Certification of vendors • Hygiene rating of individual outlets • Certification of campuses 	<ul style="list-style-type: none"> • Certification: Cluster of street food vendors trained and then certified for maintaining food safety and offering healthy food options – Street Food Hubs, Eat Right Stations • Hygiene rating of restaurants: Training on food safety, hygiene, and healthy eating options followed by certification and auditing • Campus certifications: Eat Right Schools certified for adhering to food safety and nutrition options for children; Eat Right campus – workplaces encouraged to be breastfeeding friendly along with offering safe and healthy food options to employees, tea-coffee plantations; places of worship
Nudging Food Businesses	
<ul style="list-style-type: none"> • Reduction of fat, sugar, and salt in food items • Reduction of food wastage and promotion of food donation • Alternatives to plastic packaging in the food and beverage sector 	<ul style="list-style-type: none"> • Voluntary pledges by food businesses to reduce fat, salt, and sugar • Regulations on packaging and labeling • Active food distribution agencies • Food donation helpline
Social and Behavior Change	
<ul style="list-style-type: none"> • Mass and social media 	<ul style="list-style-type: none"> • Mobile Food Safety Vans Food Safety on Wheels • Mass media campaigns (Swasth Bharat Yatra) • Eat Right Mela (Fairs) • Social Media

DOUBLE-DUTY ACTIONS IN ADDRESSING UNDERNUTRITION AND OVERNUTRITION IN THE PHILIPPINES

Azucena M. Dayanghirang, National Nutrition Council

The Philippines provides examples of intentional integration of DDA across several nutrition programs to address infant, young child, and maternal malnutrition. Malnutrition in the Philippines is comprised of undernutrition, overnutrition, and micronutrient deficiencies: 3.8 million children under five are stunted; 1 million are wasted; 3.8% of children under five are either overweight or obese; and only 31% of households meet energy adequacy. Mainly women and children are affected by micronutrient deficiencies, including vitamin A, iron, and iodine.

Philippine Plan of Action for Nutrition Programs focuses on four major outcomes through nutrition-specific and nutrition-sensitive programs: reducing wasting and stunting among children under five, reducing micronutrient deficiencies, and improving overweight and obesity.

DDA address undernutrition and overweight/obesity in the first 1,000 days through integrated services covering (or including) health, nutrition, early education, and social services. For example, the goal of the Early Childhood Care and Development in the First 1,000 Days program is to ensure the full development of the child through integrated services of health, nutrition, early education, and social services for improved quality of the country's human resource base as a contribution to reduce poverty. The program was initially implemented in selected provinces in 2016 and will be expanded.

Way forward:

- Achieve better convergence of nutrition-specific and nutrition-sensitive interventions at the community and household level.
- Scale-up delivery of quality and coverage of evidence-based programs targeting the most at-risk areas and population groups.
- Strengthen the country's food fortification program (voluntary and mandatory).
- Better integration between supply and demand services through policy coherence and convergence budgeting.
- Sustain capacity-building efforts toward exemplary nutrition leadership and governance in normal and emergency contexts.
- Expand partnerships with various stakeholders (Zero Hunger, SUN networks, etc.).

FROM DOUBLE BURDEN TO DOUBLE-DUTY ACTIONS TO ADDRESS THE FULL SPECTRUM OF MALNUTRITION IN SOUTH AFRICA

Dr. Chantell Witten, University of the Free State Faculty of Health Sciences Division Health Science Education and Nutrition Lead for the South African Civil Society for Women's, Adolescents', and Children's Health

South Africa suffers from both undernutrition and overweight/obesity: 27% of children under five are stunted, 2.5% are wasted, and 44% are vitamin A deficient; 30% of adult males, 70% of adult females (ages 15-19) and 13% of children under five are overweight. Given South Africa's inequity and deepening poverty, these statistics are not surprising.

The South African government has produced numerous nutrition policies, starting in 1999. From the onset of the first nutrition policy, South Africa has embraced the UNICEF conceptual framework and the multisectoral approach. The country's policy environment has been progressive but lacks coordination and sufficient investments in the implementation of nutrition policies.

For the last 25 years, South Africa has had a plethora of interventions to address the priority interventions at various levels of government. These include a focus on the first 1,000 days and improved breastfeeding culture and appreciation of nutrition and cognitive development, social protection during pregnancy program, national dietary guidelines aligned to the availability and access to foods; social protection and aid, emergency programs linked to nutrition outcomes, and an established National School Nutrition Program, among others.

To better address the DBM and DDA, the presenter suggested that the following is needed:

- Knowledge brokering of the DDA; not all sectors and agencies are investing to address the double burden.

- Increased nutrition capacity (human and material) to improve nutrition/health outcomes.
- Continued and strengthened advocacy to support the food and nutrition agenda through the COVID-19 recovery phase.
- Surveillance to track changes (opportunity to use real-time digital platforms like GovChat).
- Monitoring and documentation as initiatives roll out and scale up.
- Intersectoral coordination and community-led actions on the ground.

ANNEX B: AGENDA

From Double Burden to Double-Duty: Policy and Programmatic Implications of Double-Duty Actions to Address the Full Spectrum of Malnutrition

Session 1: December 3, 2020 from 9:00-11:30 am (EST)

Objective

- 1) Identify how double-duty actions (DDA) are, or can be, integrated into existing or new nutrition policies, including the key conditions and actions that underpin effective policy formulation/adaptation for DDA

Time (EST)	Agenda Item	Facilitator or Speaker
9:00-9:15	Welcome: Presentation of consultation and session objectives	Dr. Francesco Branca, Director, Department of Nutrition and Food Safety, World Health Organization
9:15-9:30	Setting the stage for the consultation <ul style="list-style-type: none"> ● Presentation of the global burden of the DBM ● Presentation of 10 priority candidates for DDA (Lancet Series Paper 3) ● Contextualization of DDA to address the DBM 	Dr. Barry Popkin W.R. Kenan Jr. Distinguished Professor Department of Nutrition, University of North Carolina, Chapel Hill Dr. Marie Ruel, Director of Poverty, Health and Nutrition Division, International Food Policy Research Institute (IFPRI)

Time (EST)	Agenda Item	Facilitator or Speaker
		Prof. Corinna Hawkes. Director of the Centre for Food Policy, University of London
9:30-9:40	Country Snapshot 1: Mexico <ul style="list-style-type: none"> Focus on Mexico's utilization of data to stimulate policy change targeting the DBM 	Dr. Juan Rivera, Director General, National Institutes of Public Health, Mexico
9:40-9:50	Country Snapshot 2: Indonesia <ul style="list-style-type: none"> Feasibility of nutrition policy shifts towards the integration of DDA to address the DBM Discussion of DBM policies, challenges in integration and reduction of fragmentation 	Dr. Dhian Probayekti, Direktorat of Community Nutrition, Ministry of Health, Indonesia
9:50-10:00	Q&A: Clarification questions	Dr. Francesco Branca
10:00 – 10:10	Break	
10:10-11:00	Small Group Discussion – DDA policies <ol style="list-style-type: none"> Enabling conditions for shift to DDA policy: What are some of the critical enabling conditions, actions and activities that set the stage for moving from siloed nutrition policies to policies that incorporate DDA? Please share examples of how this was done in your country/context Integration of DDA into existing policies: How can existing nutrition policies be modified to incorporate DDA actions? Please share examples of how this was done in your country/context. Impact of COVID-19 on DDA policy: Does COVID-19 present an opportunity for policy reform with respect to DDA? If so, how? 	
11:00-11:25	Plenary Session <ul style="list-style-type: none"> Presentations of considerations that emerged from breakout rooms 	Dr. Francesco Branca

Time (EST)	Agenda Item	Facilitator or Speaker
11:25-11:30	Wrap Up <ul style="list-style-type: none"> Summarize key themes Exit survey and poll for session 2 breakout rooms 	Dr. Francesco Branca

Session 2: December 7, 2020 from 9:00-11:30am (EST)

Objective

- 1) Drawing from country examples, identify effective entry points to design or adapt sectoral programs to integrate DDA

Time (EST)	Agenda Item	Facilitator or Speaker
9:00-9:10	Welcome & Overview	Dr. Marie Ruel
9:10-9:20	Country snapshot: India <ul style="list-style-type: none"> Eat Right India's multidisciplinary/multisectoral approach addresses multiple forms of malnutrition, including large scale behavior change communication campaigns focused on sustainable, diverse diets. 	Ms. Inoshi Sharma, Director, Food Safety and Standards Authority of India (FSSAI)
9:20 –9:30	Country snapshot: Philippines <ul style="list-style-type: none"> The Philippines provides examples of intentional integration of double-duty actions across several nutrition programs to address infant, young child and maternal malnutrition 	Dr. Azucena M. Dayanghirang, Executive Director, National Nutrition Council, The Philippines

9:30– 9:40	Country snapshot: South Africa -- focus on experience of cities <ul style="list-style-type: none"> • South Africa case scenario looks at actions including those of city governments to address the DBM through DDA 	Dr. Chantell Witten, University of the Free State, Faculty of Health Sciences, Division Health Science Education and Nutrition Lead for the South African Civil Society for Women's, Adolescents' and Children's Health (SACSoWACH)
9:40 – 9:50	Q&A: Clarification questions	Dr. Marie Ruel
9:50 – 10:00	Break	
10:00 - 11:00	Small Group Discussion – Delivering DDA programs through different sectors: Education, Social Protection, Health, Ag/Food Systems <ul style="list-style-type: none"> • What are the entry points in this sector for supporting the implementation of DDA? • What immediate action is needed to support program planners in incorporating DDA into their sectoral programs? • What are anticipated barriers or challenges in the implementation of double-duty actions in your sector? • What policy, advocacy, financing and other types of levers can be used to adapt sectoral programs and policies to include DDA? 	
11:00-11:25	Plenary Session <ul style="list-style-type: none"> • Presentation of sector-specific summary of discussions 	Dr. Marie Ruel
11:25-11:30	Wrap Up <ul style="list-style-type: none"> • Reflections from Session 2 • Exit Survey 	Dr. Marie Ruel

Session 3: December 9, 2020 from 9:00-11:30am (EST)

Session Objectives:

- 1) Reflect on data needs and data gaps including gaps in policy and outcome indicators for DDA along with the key operational research gaps that must be addressed to support a paradigm shift for increased uptake of DDA
- 2) Synthesize the results of Sessions 1 & 2 to:
 - Agree on the most feasible, priority DDA for the short- and medium-term
 - Identify next steps for design or adaptation of policies for implementation of each priority DDA, *e.g. Consideration of need for updating DDA impact pathways*
 - Identify programming entry points for operationalization of each priority DDA

Time	Outline	Facilitator or Speaker
9:00-9:05	Welcome and session overview	Prof. Corinna Hawkes
9:05 - 9:20	Panel discussion on data and research needs	Dr. Jef Leroy Senior Research Fellow IFPRI Dr. Rahul Rawat Senior Program Officer Bill & Melinda Gates Foundation
9:20-10:35	Synthesis of Sessions 1 & 2 and way forward: Interactive discussion (World Cafe method) For each of the top 3-4 DDA identified through a poll at end of Session 2 as the most feasible, high impact, and timely (implementation short- to medium-term), come to consensus on:	

	<ul style="list-style-type: none"> • What policies are needed (either newly designed or adapted) to shift from the current siloed approach to the DDA? • Priority programming entry points for operationalization of each DDA • Policy and outcome indicators for each DDA, including need for development of new metrics • Key operational research needs to accelerate implementation of DDA policies and programs 	
10:35 – 10:45	Break	
10:45-11:15	Plenary Session to agree on next steps <ul style="list-style-type: none"> • Discussion and agreement on next steps. For example, identifying working groups to champion progress on a specific DDA; develop community of practice listserv(s); develop operational guidelines; advocate for financing of the operational research agenda, etc. 	Prof. Corinna Hawkes
11:15-11:25	Interactive activity to wrap up	Prof. Corinna Hawkes
11:25-11:30	Wrap Up with final thoughts	Prof. Corinna Hawkes

ANNEX C: PARTICIPANT LIST

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Camila Corvalan	University of Chile, INTA
Carmen Burbano	World Food Program
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Elizabeth Zehner	HKI
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Indah Nurfitri	Ministry of Health, Indonesia
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Jef Leroy	IFPRI
Jo Jewell	UNICEF
Johanna Ralston	World Obesity Federation
Jonathan Wells	University College, London
Jorgen Torgerstuen Johnsen	WHO
Josepj Robertson	Food System Economics Commission
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Kate Kennedy-Wood	GFF
Kathryn Reider	World Vision
Kyoko Shibata Okamura	World Bank
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Stephanie Zaitsev	Training Resources Group, Inc. (TRG)
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