

THE LEADER

The official newsletter of the African Nutrition Leadership Programme



Leading change in nutrition

Evidence-Informed Decision-Making on the African continent

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Foreword

BY CHRISTINE TALJAARD

In our first issue of The Leader this year we focus on Evidence-Informed Decision-Making (EIDM). This term is well known throughout our nutrition fraternity and most of us are involved in the process in some way, shape or form. Some of us are the decision-makers, others the evidence generators. Nevertheless, this process has proven itself to be non-linear by which I mean that it doesn't necessarily follow a specific order. Even with the best of framework, each set of decisions are unique. EIDM entails many challenges that may prevent us from truly making evidence-informed decisions. EIDM also forces us to admit, at times, that some decisions really aren't evidence-informed and that, sometimes, that was the correct decision. But if I were to be utterly honest with myself, I very often feel that we (as the nutrition fraternity) have only started to scratch the surface in our understanding of EIDM.

Four invited writers from various fields, share their views, opinions and personal experiences on the topic. It is inspiring to see that Africans are actively working and taking the lead in this field (See the articles on the African Evidence Network as well as Cochrane Nutrition). From these articles, it is clear that leadership is, and should be,

fundamentally part of evidence-informed decision-making. As ANLP alumni, I hope that you are all left encouraged by the articles of Roos, Edelweiss and Bianca who discuss how they have been actively engaging with decision-makers.

We also provide you with some of our own evidence in this issue. In 2017, we conducted a survey on the preferred ways of communication for ANLP Alumni. In conclusion, the results of the survey indicated that our alumni enjoy the ongoing communication from the ANLP in the current format of The Leader as well as through other communication avenues such as Facebook and LinkedIn.

May this year be a fruitful year for ANLP alumni, may we never grow tired to learn. I leave you with the encouraging declaration of the 2018 ANLP alumni.

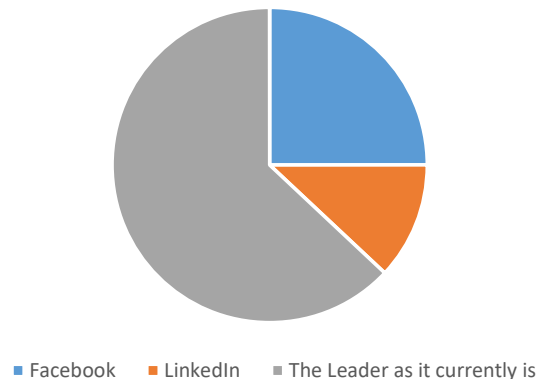
We, the 2018 ANLP, affirm the need for influential nutrition leadership in Africa due to the malnutrition burden. We commit to work together at every opportunity and, to remain resilient in transforming the current nutrition situation. We will proactively learn, and advocate for the nutrition agenda in Africa by leading from where we stand.



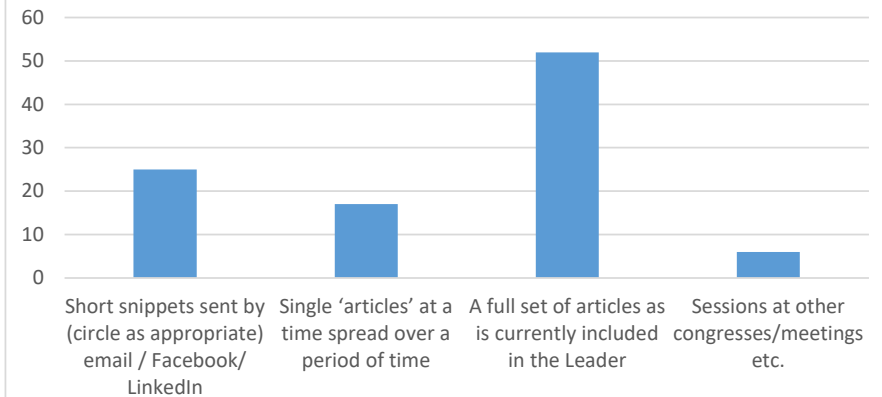
Alumni feedback

In 2017 we conducted a survey amongst ANLP alumni. The survey focused on the preferred way of ongoing communication for alumni. We received 100 survey responses with the results being illustrated below. It was encouraging to see that the ANLP alumni have found The Leader in its current form useful. It was also insightful to see that a large number of alumni do prefer communication avenues such as Facebook and LinkedIn. The ANLP will actively incorporate these findings in our ongoing communication with alumni.

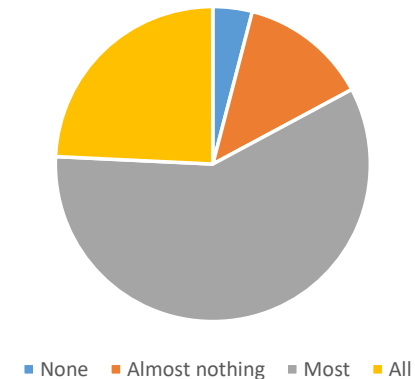
What media would you like to receive ongoing 'education' on leadership themes through?



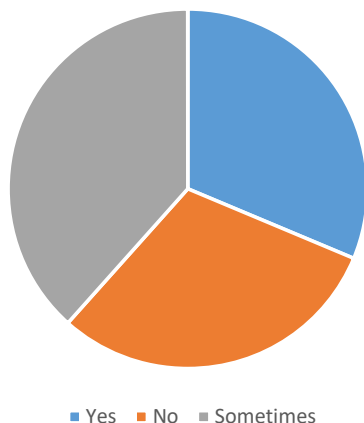
What format would you value most for receiving 'education' on leadership themes?



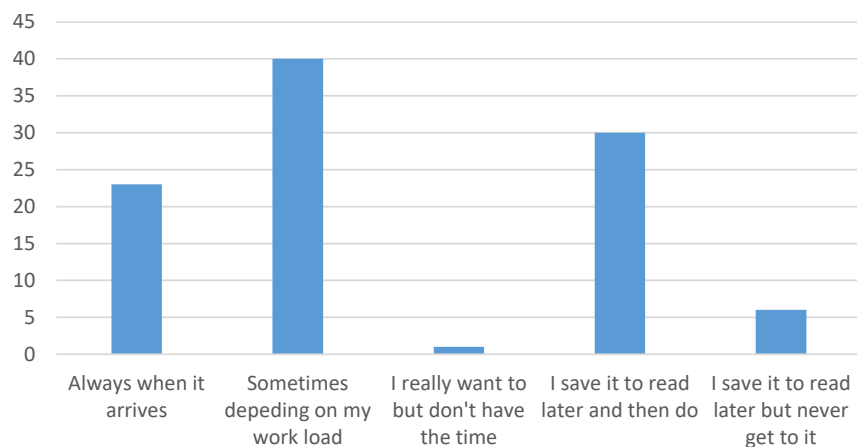
What percentage of articles in the Leader do you generally read?



Do you ever share The Leader with others?



Do you find time to read the Leader?



Creating an appetite for evidence: how to induce change?

BY ROOS VERSTRAETEN

The past few years have seen an increase in both the importance and utility of evidence-informed decision-making (EIDM) for advancing public health. This is especially true in low- and middle-income settings ([Vaka Yiko](#), [AEN](#), [Think thank initiative](#)), including in the field of nutrition (see [Holdsworth et al.](#) for an overview). There are many assumptions and related challenges underpinning the concept of EIDM; what is *evidence*, what is *decision-making*, and what role does evidence play in informing decisions beyond other influencing factors (e.g. politics, resources, etc.)? From my point of view, evidence is a broad concept which goes beyond research evidence obtained from rigorous RCTs or epidemiological studies. Evidence also includes *other knowledge* obtained from experience, expert opinion, or grey literature. Decision-making, on the other hand, includes any decisions made by various groups of stakeholders, including at policy level, at hospital settings, or when implementing programs.

EIDM does not happen necessarily in a linear way (see [EVIDENT](#)), even though

underlying principles are similar, no context is the same and the EIDM system will vary from country to country. Understanding the current national or regional systems and what role evidence plays in any setting is thus a crucial first step to foster an EIDM culture. Only after this step, can we address the following fundamental questions: *i)* How can we get a culture and appetite for using rigorous evidence as part of decision-makers daily work life, i.e. make the approach business-as-usual?; *ii)* How can evidence be curated for the right person, in the right way, and at the right time? Otherwise phrased, how can we ensure that new or existing evidence that is developed by knowledgeable experts in the field is *fit for purpose*?

Despite the clear appetite for EIDM in the African context, we risk losing momentum to translate this opportunity into action due to various challenges, including lack of capacity and leadership. Let me give an example of such a challenge in the EIDM process around the concept of time. This can reflect individuals being too busy, politicians requiring a response 'yesterday',

but can also be related to the very time-consuming nature of gathering and using *evidence*. On the other hand, it can also partly reflect an organisation's culture of evidence use. Does the organisation/agency permit sufficient time and space to explore and include research evidence in the decision-making process? Even if an EIDM approach is adopted, the local context and

issues or the ability to understand and use different types of evidence, but also how to lead change. Individual skills such as: communication and active multi-sectoral engagement (e.g. how do you talk to policy-makers as a researcher and vice versa? How do you develop relationships?); understanding the needs or incentives for decision-makers to use evidence; improving



needs for certain types of evidence may still be neglected or ignored.

This example brings me to the crucial point of **capacity and leadership** (the latest buzzwords), both required to take EIDM forward. Building capacity must happen at individual, organisational, and institutional level. This is not just about increasing technical knowledge around specific health

one's belief and confidence in the capability to negotiate or to speak up? To some of us this may come naturally but, as a good friend once told me, what comes naturally for one person is not necessarily the case for another. Some of these skills have been provided to the nutrition community for years now by the Nutrition Leadership Programs (NLP) (see [ANLP](#), [ENLP](#), [SEANLP](#), [ONLP](#), [LILANUT](#), [MEANP](#)). Yet, it is not just

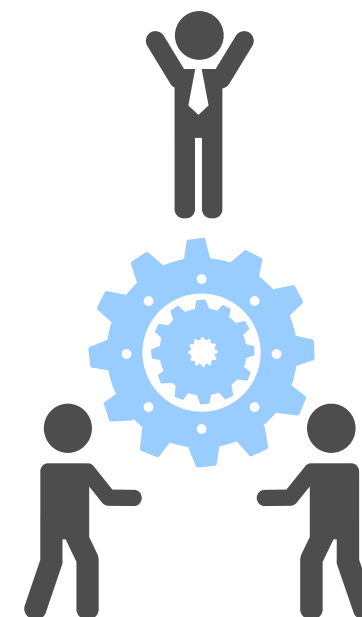
about individual change or building people's knowledge and skills to do their job.

Having a supportive organisation is a key contextual factor. What happens when we, as individuals, have undergone such NLP training and we take that experience back to our work environment, with its own social norms, its collective identity and culture? How do our organisations support such change - if acknowledged at all? How could this be influenced to shift collective thinking within an organisation? And what makes an environment enabling or not? Can this be influenced through convincing the organisation of the benefits that evidence can bring to decision making or by training? Changing such a whole system requires not only personal transformation, but also a change in relationships, structures and systems, and collective patterns of thinking and action on the work floor.

Acknowledging that in this process, within and across sectors, we may speak different languages (literally as well as figuratively). Organisational tools and systems may help to install an EIDM system by increasing the value an organisation places on evidence. If we were to succeed, a virtuous circle may emerge in which increased use of evidence would in turn lead to greater demand for evidence.

As for the African continent, momentum is built for EIDM through various promising initiatives: the African Leaders for Nutrition ([ALN](#)) (aiming to develop a nutritional scorecard to inform Head of States); [Transform Nutrition-West Africa](#) (which aims to synthesize and mobilise evidence, and strengthen capacities of leaders to be informed by evidence and data);

the Knowledge for Implementation and Impact Initiative (KI3) initiative (focusing on implementation knowledge); the RISING programme (UNICEF) (to strengthen capacity of regional systems); the technical assistance to the Multi-Stakeholder Platforms (MSPs) of the SUN movement; and many more. Combined with NLPs or other individual programs, these represent an important and promising investment in low- and middle-income settings to induce scale across the whole system for EIDM. I firmly believe change starts when you start dreaming, I dare to dream that these efforts will make a difference for nutrition on the African continent.



The South African salt story – from research to policy

BY BIANCA VAN DER WESTHUIZEN AND
EDELWEISS WENTZEL-VILJOEN

The number of people in South Africa (SA) with hypertension has reached worrisome proportions and, while there is a pressing need to combat this crisis, the SA health system is struggling with continuity of care? and frequent drug stock-outs. Treatment of non-communicable disease in SA costs about 8 billion ZAR a year. A change in policy regarding hypertension prevention and management will not only save lives but will also relieve the huge economic burden the government is facing.

Research has shown that South Africans have a very high salt intake. Driven by researchers, a Task Team was formed within the National Department of Health (NDOH) to investigate the best approach to address the hypertension epidemic. SA researchers provided important and relevant research information to the NDOH about the link between high blood pressure and salt intake and indicated, by using statistical models, that by decreasing for example the salt in bread, many lives could be saved from strokes with a decrease in the associated healthcare costs. The first strategy was to decrease the salt (sodium) content of certain foodstuffs. To find a reasonable and yet optimal target sodium level for the different foodstuffs, the NDOH relied on data provided by research

entities in SA. International collaboration with experts assisted the process. With the political goodwill and leadership of the Minister of Health, Dr Aaron Motsoaledi, SA was the first country in the world to publish regulations on the sodium levels for different foodstuffs. Although some industry stakeholders argued that it was not possible to reach some of the Regulation targets, data provided to the Task Team showed that it was feasible and could be implemented. This local research was key to the Minister's decisions. **The success of the process towards a sodium reduction policy was in great part due to the inter-sectoral collaboration between government, academia and researchers, nutrition-related associations and organizations, consumer groups, and organizations representing industry.** In addition, international collaboration and Academia was key in producing local, context-specific research on the salt intake of South Africans and the contributions of different foodstuffs to the total salt intake. While research institutions served to guide policy-makers through data and recommendations, policy-makers in turn helped guide these institutions as to what data they needed.

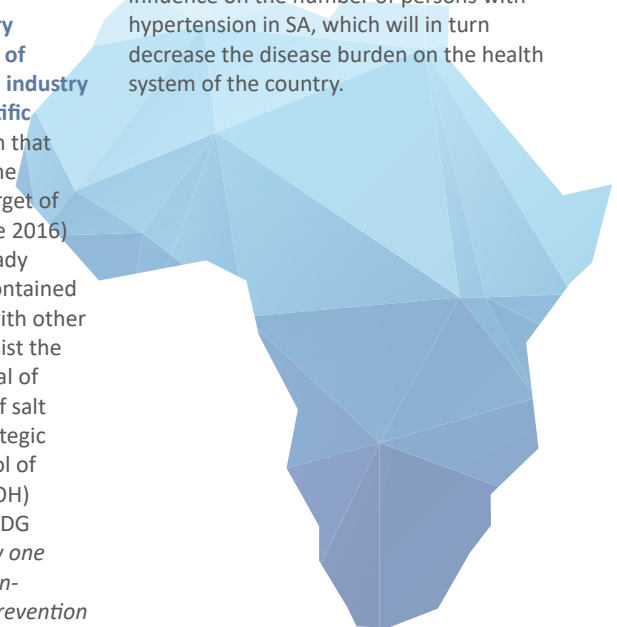
A lobby group called Salt Watch was formed in March 2013 to raise public awareness about appropriate sodium

consumption levels, as well as healthier food choices. In collaboration with the NDOH, Salt Watch delivered a mass media campaign to increase the awareness of the SA population regarding salt intake and hypertension as part of the holistic approach to reduce salt intake of the population. The SA Heart and Stroke Foundation played and is still playing a key role to take the message on salt reduction to every household.

The decision to enforce mandatory regulation on the sodium content of certain foodstuffs within the food industry was thus based on relevant scientific evidence. We have recently shown that most of the foodstuffs named in the regulation are meeting the first target of sodium level (implemented in June 2016) and half of the food products already complying to the 2019 target as contained in the Regulation. This, together with other approaches like education, will assist the Minister of Health to reach the goal of 'Reduce mean population intake of salt to <5 grams per day by 2020' (Strategic Plan for the Prevention and Control of Non-Communicable Diseases, NDOH) and contribute towards reaching SDG 3.4 that states "By 2030, reduce by one third premature mortality from non-communicable diseases through prevention

and treatment and promote mental health and well-being".

Leadership from government's side was central in bringing all the aspects together to ensure that Regulation R.214 was implemented in June 2016, thereby showing commitment to a healthier South Africa. In addition, if the goal of a salt intake of less than 5 grams by 2020 could be reached, it will have a profound influence on the number of persons with hypertension in SA, which will in turn decrease the disease burden on the health system of the country.



Cochrane – advancing evidence-based healthcare



Cochrane (www.cochrane.org) is a global network of researchers, healthcare professionals, patients and people interested in health. It is a not-for-profit with collaborators from over 130 countries working together to produce credible, accessible health information free from commercial sponsorship and conflicts of interest.

A Cochrane systematic review usually asks a specific research question about a healthcare intervention in a defined group of people; for example: What is the best way to administer chemotherapy and radiotherapy following surgery for early breast cancer? Reviews summarise the results of healthcare studies and provide evidence on the effectiveness of the interventions. These reviews are then published in the Cochrane Library (www.cochranelibrary.com).

Cochrane South Africa (<http://southafrica.cochrane.org>), based at the South African Medical Research Council, is part of the Cochrane network and has been in existence

for almost 20 years. The vision of Cochrane SA is that healthcare decision making within Africa will be informed by high-quality, timely and relevant research evidence.

Where disease burden and health-system challenges are greatest, the need for evidence to support decision making and resource use is most critical. However, capacity to conduct reviews is limited, particularly in low- and middle-income countries. With this in mind, Cochrane SA played a substantial role in the establishment of Cochrane Africa (<http://africa.cochrane.org>) which brings together researchers from across the continent and focuses on disease conditions affecting the continent. Since 2007, African collaborators have worked to improve the production of high-quality, Africa-relevant reviews and to support their use in policy and practice. Reviews from Africa have informed national and international guidelines, particularly in malaria, tuberculosis and HIV/AIDS. Cochrane Africa's work builds on and aims to expand these activities.

BY MICHELLE GALLOWAY, COCHRANE SOUTH AFRICA
& TAMARA KREDO, COCHRANE SOUTH AFRICA

Cochrane Nutrition

Another exciting development has been the establishment of the Cochrane Nutrition Field (<http://nutrition.cochrane.org/>) under the leadership of Cochrane SA and the Centre for Evidence-based Health Care (www.cebhc.co.za), Stellenbosch University, along with international partners.

A Cochrane Field is responsible for disseminating evidence related to the topic area, building stakeholder relationships, co-ordinating methods research for conducting reviews, and supporting authors of relevant reviews. The topic area usually focuses on a cross-cutting dimension of healthcare not specific to a certain body system or healthcare condition.

Cochrane Nutrition will aim to co-ordinate activities related to Cochrane nutrition reviews; to ensure that priority nutrition reviews are conducted with rigorous methodological approaches; and, to promote the use of evidence from nutrition systematic reviews to inform healthcare decision making.

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A network of people who believe in the use of evidence in decision-making in Africa

BY NATALIE TANNOUS AND SIZIWE NGCWABE

The **Africa Evidence Network (AEN)** is a community of people working in Africa who all have an interest in the use of evidence in decision-making within the sectors of health, the environment, social development, education, and many more. The AEN is maintained by a secretariat at the **Africa Centre for Evidence (ACE)**, hosted by the University of Johannesburg in South Africa. The team maintaining core AEN functions consists of a chairperson, senior manager, coordinator, and content engineer, drawing on the wider ACE team for expertise when needed. It is governed by an advisory group, senior manager, and chairperson. The members of the AEN come from different spheres within the evidence ecosystem: they are evidence users, producers, brokers, and sometimes a combination of all these. We are all connected by one thing: the belief that only by working together can evidence-informed decision-making (EIDM) become a reality in Africa.

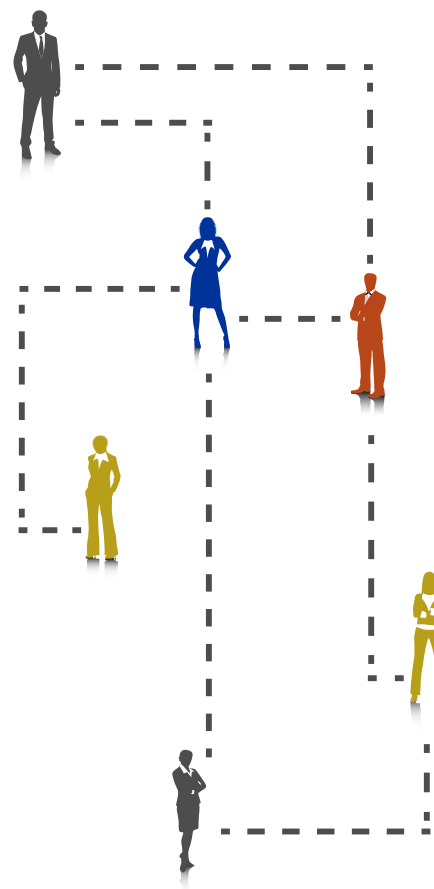
The AEN was founded in 2012 out of the meeting of African delegates at Campbell Collaboration's mini-colloquium in Dhaka, Bangladesh. Connected by a passion for the use of EIDM, and recognizing the interest of and relevance to Africa, the AEN was born.

These first 12 members were the founding membership of the AEN. Since then, the network has grown to include over 1000 individuals from across Africa and the rest of the world.

The AEN functions to bring people together to support EIDM on the continent. To do this, it maintains information channels to its members via monthly **newsletters** and regular social media posts via **LinkedIn** and **Twitter**. The AEN also publishes a regular **blog**. The Network also hosts a biennial conference – **EVIDENCE** – where delegates from all over Africa and the globe can engage with and learn from one another on a variety of topics related to EIDM. In addition to encouraging event and blog submissions by members, the AEN maintains an **EIDM capacity-building resources database** on its website. The resources included in the database focus on Africa and include those resources that have been developed inside of healthcare. The AEN strives to celebrate the exceptional EIDM work that is taking place in Africa and in 2018, has introduced an award for evidence leadership: **The Africa Evidence Leadership Award**. This award aims to highlight exceptional EIDM work taking place on the continent and to celebrate

evidence champions by awarding the recipient with a prize to the value of over R47000.

Signing up to be a member of the AEN is free, although the offering is valued at over R700. We maintain as many activities as possible free of charge to ensure that the Network remains accessible to people from all over Africa and across all spheres of the evidence ecosystem. We publish four blog posts every month and actively invite our members to share their work via our blog. Alternatively, members can also share news stories from their work that they would like to see featured in the monthly newsletter. Currently, **abstract submissions for EVIDENCE 2018** are open and members – as well as non-members alike – are invited to submit work. Anyone interested in EIDM in Africa should participate in the AEN to gain access to a broad network of individuals from different backgrounds and fields, connected by one belief: that only by working together can evidence-informed decision-making in Africa become a reality.



Leading change in nutrition

BY LEON COETSEE

“Progress is impossible without change, and those who cannot change their minds, cannot change anything.”
George Bernard Shaw

“In times of change, the learners will inherit the earth, while those attached to their old certainties will find themselves beautifully equipped to deal with a world that no longer exists.”
Aiken & Higgs (2010) Developing change leaders

All things on Earth are temporary and in a constant state of change. Change is also a permanent and very prominent feature of life in all organisations, systems and bodies dealing with nutritional matters. As is the case in other organisations, management and leadership excellence in nutrition will be determined by managers' abilities to manage change and the abilities and skills of leaders to initiate and to guide change effectively.

Organisations and teams all have an ingrained tendency to become dysfunctional, and to decline to a chaotic state, if left alone. This phenomenon is known as 'entropy'. These kinds of events and behaviours must be anticipated, and if not anticipated, be recognised early and then managed proactively. However, manager-leaders who believe that they can institute change in a matter of days or even weeks are

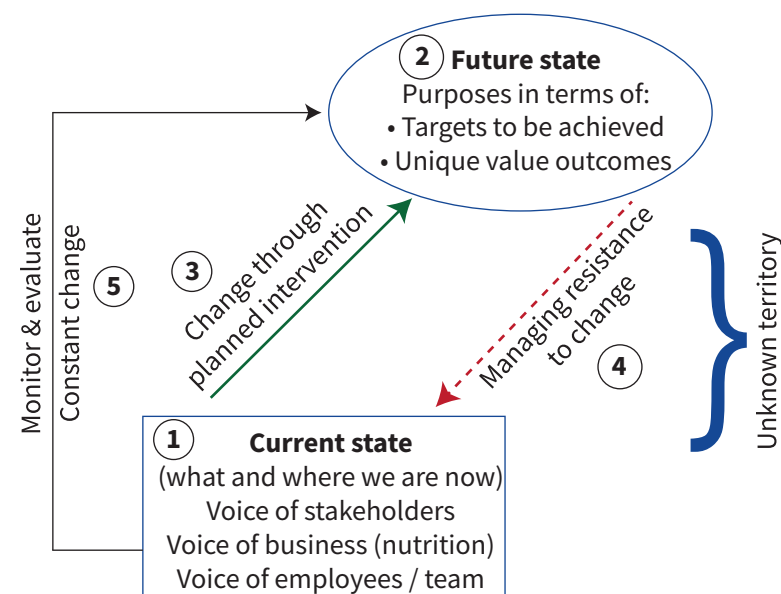
destined to fail. How an organisation, a team or a district, or an individual deals with nutritional problems cannot be addressed effectively with 'quick fix' interventions.

To achieve the desired results of change processes, nutritional leaders must become erudite with the principles and applications of the discipline of change management (also known as organizational development and change or OD). From this perspective a change process must be a purpose-directed, needs-based, planned and systematic process of long-term change, based on scientific knowledge; incorporating all organisational sub-sections and stakeholder groups and one where resistance to change is pro-actively managed. The end purposes of such changes are not only to achieve the stated end objectives, but also to ensure the effective survival of the particular organisation, team, agency, or district team.

The most effective of these approaches to managing change emphasize crucial departure points to be considered when leaders want to change things: the organisations current state of functioning; the desired future state: a well-planned

change process consisting of a series of change interventions; resistance to change must be managed and that change is a constant feature of individual, team and organisational life. This is illustrated in Figure 1.

The 5 crucial elements of change management/ leadership



The objective of change management (OD) is to develop the capacity and capability of the organisation to constantly keep on improving and adapting in order to satisfy the dynamic requirements of customers, employees and other stakeholders. The implication of this is that effective change

management depends on the knowledge and skills (competencies) of change leaders, managers and facilitators to lead the change process and to implement and embed change. The three change intervention categories are reform, transformation and transitional change.

Reform and Transformation

Change interventions, including nutritional interventions, can entail either reformational change or transformational change.

Transformational change, implies profound change and is much more risky and difficult to execute than reformational changes - which are the more superficial changes. These two categories of change differ in many respects of which a few are included in Table 1.

Table 1: Reform and transformation

REFORM	TRANSFORMATION
Superficial change: e.g. to re-structure processes, methods, markets.	Fundamental change: e.g. affecting strategy, culture, behaviour.
Keeping the status quo intact but striving to increase efficiency.	Discovering/developing something new (e.g. a new vision) to increase effectiveness.
Basic structure stays intact.	Basic structure changes fundamentally.
Small, one-dimensional changes, often made in isolation, over a period of time.	Major, multi-dimensional, continuous changes.
Low levels of complexity, initial cost and uncertainty.	High levels of complexity, initial cost and uncertainty.
Primarily an 'add on to the existing' process.	Primarily a process of 'pruning' and/or 'substituting' that which exists.
Short-lived, rapid spurts of energy.	Extended, sustained energy investment.
Adaptation.	Metamorphosis.
New planning or re-planning.	Redefinition even of core business.
A limited number of members are involved and/or affected.	Involvement and commitment of all stakeholders necessary and all members are affected.
Resistance to change lower.	Resistance to change stronger.
Low risk.	High risk.
Changing perceptions, attitudes and behaviour within the existing paradigm.	Changing to a paradigm with new visions/purposes, strategies, practices and behaviour.
Requires effective management.	Effective management and leadership

The delivery or implementation of nutritional interventions by organisations can entail either reformational change or transformational change, depending on the focus, scope and nature of the change and the change effort. For example, if the decision is made to change only one or two of the elements of a SUN initiative it will most probably be a small-scale change. Say a nutritional governing body in a country decides to introduce changes to the approach to reduce stunting - this is (although a very challenging intervention which will probably meet with a lot of resistance) still a small-scale, fine-tuning change - it is thus a reformational change.

Should an intervention, however, be planned to create a totally new approach and strategy to reduce stunting it can be labelled a transformational change. An example could be the- introduction of a new vision and a new purpose statement aimed at changing the approach from management-controlling (traditional management) to creating an alignment and commitment of all stakeholders to a new stunting paradigm with the introduction of new approaches to reduce stunting. The reason for this is that it: is large scale (it affects all stakeholders and systems); is fundamental (it introduces a new purpose statement and changes the strategy, culture and behaviour); is multi-dimensional, continuous, and highly complex; requires an extended, sustained energy investment; and implies a metamorphosis. (Consider this example while you compare the different characteristics of transformational and reformational change listed in Table 1).

Transitional change

This is an important third category of change that is closely linked to transformational change. Where transformation and reform refer more to external changes, transition is an internal and a very specific personal experience. Transition includes changes in one's awareness, attitudes, focus, and habits and in certain behaviours.

This is very aptly explained by the following quotes:

"The range of what we think (our thoughts) and what we do (our deeds) is limited by what we fail to notice."

- Anon

"There is nothing either good or bad, but thinking makes it so".

- Anon

"When you change the way you look at things, the things you look at change"

- Lao Tzu

"Change your thoughts - change your life".

- Anon

Transitional change refers to behavioural change of and in individuals. This has to do with the transitions leaders have to undergo through personal growth and development to become effective transformational leaders, as well as the individual transitions which followers and stakeholders sometimes have to undergo to become aligned with and committed to transformational changes. Transition is an internal and a very specific personal experience.

Transitional change also includes the psychological process which people experience (and have to experience) to come to terms (adapt) to a changing or a new situation. Thus, unless transition takes place, transformational change will most probably not happen! Lack of underlying transitional processes within the individuals concerned is often the main reason for resistance to change and for the failure of many change efforts.

Transformational leadership

Based on the descriptions of the concept “transformation” above, transformational leadership is essentially about instilling a sense of purpose in those who are led, encouraging emotional identification (commitment) with the organisation and/or a team and its goals, empowering employees through growth and their development and by giving them opportunities to achieve these goals.

This implies that the transformational leader must create an organisational climate (motivating climate) which enhances growth, development, commitment, goal achievement and enjoyment, and an organisation culture which encourages behaviour based on a set of shared values and beliefs such as learning and growth and acceptance of responsibility and accountability...

Developing such transformational leadership competencies and skills include developing self- insight, fostering being open to change, the ability to deal effectively with ambiguity, being flexible in approach and style , enhanced

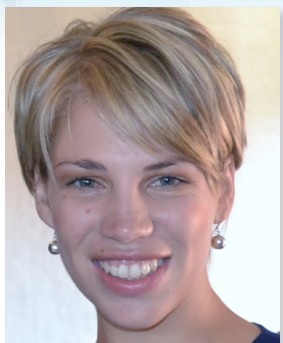
emotional intelligence and the application of transformational leadership knowledge and skills to develop, mentor and train others towards empowering them as transformation leaders. In so doing, more transformational leaders are created enabling application of the principle to “lead from where they stand”.



“WHEN YOU
CHANGE
THE WAY YOU
LOOK AT THINGS,
THE THINGS YOU
LOOK AT **CHANGE**”

- LAO TZU

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