AfricaCDC
Centres for Disease Control and Prevention

Safeguarding Africa's Health

2025

FROM MANDATE TO PUBLIC HEALTH IMPACT

ANNUAL REPORT

An entity of the African Union


Safeguarding Africa's Health

Contents

AfricaCDC
Centres for Disease Control and Prevention

Africa Centres for Disease Control and Prevention,
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Africa CDC is a continental autonomous health agency of the African Union established to support public health initiatives of Member States and strengthen the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats.

An entity of the African Union

Safeguarding Africa's Health

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Abbreviations and Acronyms

AES	African Epidemic Service
AfDB	African Development Bank
AfEF	Africa Epidemics Fund
AFRO	WHO Regional Office for Africa
AHSS	Africa Health Security and Sovereignty
AMR	Antimicrobial Resistance
APPM	African Pooled Procurement Mechanism
ART	Antiretroviral Therapy
ATC	Advisory Technical Council
AU	African Union
AVoHC	African Volunteer Health Corps
CAR	Central African Republic
CCM	Community Case Management
CDR	Central Data Repository
CHSG	Committee of Heads of State and Government
CHW	Community Health Worker
CPHIA	Conference on Public Health in Africa
DG	Director General
EBS	Event-Based Surveillance
ECDC	European Centre for Disease Prevention and Control
EMRO	WHO Regional Office for the Eastern Mediterranean
EOC	Emergency Operations Centre
EPI	Expanded Programme on Immunisation
ERP	Enterprise Resource Planning
EX.CL	Executive Council (African Union)
FETP	Field Epidemiology Training Program
GA	General Assembly
G20	Group of Twenty
G7	Group of Seven
Gavi	The Vaccine Alliance
GHEN	Global Health Expenditure Network
HIE	Health Information Exchange
HIS	Health Information System
HTA	Health Technology Assessment
IHR	International Health Regulations
IMST	Incident Management Support Team

INS	National Institute of Statistics
ISO	International Organization for Standardization
JPHIA	Journal of Public Health in Africa
KAGHLP	Kofi Annan Global Health Leadership Programme
KAP	Knowledge
LMS	Learning Management System
MECA	Multisectoral Engagement
MEL	Monitoring
MELP	Ministerial Executive Leadership Programme
MOF	Ministry of Finance
MOH	Ministry of Health
MS	Member State
NCD	Non-Communicable Disease
NCDIMH	Non-Communicable Diseases
NPHI	National Public Health Institute
NTD	Neglected Tropical Disease
OOP	Out-of-Pocket (health expenditure)
PABS	Pathogen Access and Benefit-Sharing
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHEC	Public Health Emergency of Continental Security
PHEOC	Public Health Emergency Operations Centre
PHAHM	Platform for Harmonised African Health Manufacturing
PPPR	Pandemic Prevention
RCC	Regional Coordinating Centre
RCCN	Regional Capability and Capacity Network
REC	Regional Economic Community
ReSCO	Regional Technical Advisory Committee
ReTAC	Regional Ministerial Steering Committee
RH	Reproductive Health
RISLNET	Regional Integrated Surveillance and Laboratory Network
RMNCAH	Reproductive
RRT	Rapid Response Team
SDG	Sustainable Development Goal
SOP	Standard Operating Procedure
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
WAEMU	West African Economic and Monetary Union
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHA	World Health Assembly
WHO	World Health Organisation

Foreword

Chair of the African Union and Chair of the Africa CDC Committee of Heads of State and Government

H.E. João Manuel Gonçalves Lourenço
President, Republic of Angola,
Chairperson, African Union

Africa stands at a defining moment in its history. The question before us is no longer whether health matters to our security, sovereignty, and development. That debate is settled. The question now is whether we, as African leaders, have the courage to fully assume ownership of our health destiny and to invest accordingly.

This 2025 report of the Africa CDC provides a clear and compelling answer.

In a world marked by geopolitical fragmentation, fiscal tightening, climate shocks, and recurrent public health emergencies, Africa has chosen a different path: to lead rather than react; to build systems rather than manage crises; and to anchor health security as a core function of the African state. The transformation documented in these pages is not accidental. It is the result of deliberate political choices made by African leaders, acting collectively through the African Union, and operationalised through an autonomous, credible, and execution-capable Africa CDC.

From vulnerability to sovereignty

Only a few years ago, Africa's health security was largely shaped by external supply chains, fragmented financing, and delayed responses. The COVID-19 pandemic exposed, with painful clarity, the cost of dependence and the risks of exclusion. It also awakened a new political consciousness across the continent: health is not a social expenditure; it is a strategic investment in sovereignty, economic resilience, and national security.

As I underscored in my recent reflections, Africa cannot continue to outsource its survival. This conviction now finds concrete expression in the Africa Health Security and Sovereignty (AHSS) Agenda, a framework designed by Africans, endorsed by African Heads of State, and implemented through African institutions. The 2025 report demonstrates that AHSS is no longer a vision on paper; it is an operating reality.

Africa CDC has moved decisively from mandate to impact.

A continental institution that delivers

The evidence is unmistakable. In 2025 alone, Africa CDC supported all 55 African Union Member States, mobilised more than USD 151 million in direct resources with a record **95% budget execution rate**, expanded functional Public Health Emergency Operations Centres to 32 countries, and strengthened genomic sequencing capacity in 46 Member States—up from just seven a few years ago

The future will bring new pandemics, new shocks, and new uncertainties. But if Africa continues to lead with unity, invest with purpose, and govern with integrity, we will face that future not as a continent at risk but as a continent prepared.

Africa has chosen sovereignty.

Most importantly, Africa CDC proved its value where it matters most: in the field, during crises. The coordinated response to the multi-country mpox outbreak, declared a Public Health Emergency of Continental Security, demonstrated that Africa now possesses the political authority, technical competence, and operational speed to act collectively, decisively, and with legitimacy. This was African leadership in action.

Such performance is inseparable from governance reform. Autonomy has given Africa CDC the agility to act; strengthened oversight, audits, and risk management have ensured accountability. This balance of speed without sacrificing integrity is precisely what our institutions require in an era of permanent risk.

Financing health as security

This report also sends a clear message to Ministers of Finance, investors, and partners: Africa is no longer asking for charity; Africa is presenting an investment case.

Through the Lusaka Agenda and aligned continental platforms, over USD 40 billion has been mobilised for health security, while domestic resource mobilisation, pooled procurement, and public financial management reforms are beginning to reduce inefficiencies and leakages. Health financing is being repositioned not as recurrent consumption, but as a driver of stability, productivity, and industrialisation.

Nowhere is this more evident than in local manufacturing. With more than USD 10 billion mobilised for production, the operationalisation of the African Pooled Procurement Mechanism, and the acceleration of vaccine, diagnostics, and therapeutics manufacturing initiatives, Africa is laying the foundations of true health sovereignty. This is not protectionism; it is strategic resilience.

The road ahead: leadership and responsibility

The gains of 2025 must now be consolidated. Preparedness must become permanent. Digital transformation must translate into intelligence and early warning. Markets must be shaped to reward African producers. And Africa's unified voice must continue to shape global health governance not from the margins, but from the centre.

This requires sustained political leadership. It requires difficult budgetary choices. And it requires trust in African institutions that have proven they can deliver.

Africa CDC has earned that trust.

As Chairperson of the African Union, I commend the Governing Board, the Director General, and the entire Africa CDC workforce for translating political ambition into measurable impact. More importantly, I call on my fellow Heads of State and Government to stay the course. Health security is not an episodic concern; it is the foundation upon which our sovereignty, our economies, and our people's dignity rest.

The future will bring new pandemics, new shocks, and new uncertainties. But if Africa continues to lead with unity, invest with purpose, and govern with integrity, we will face that future not as a continent at risk but as a continent prepared.

Africa has chosen sovereignty. This report shows we are delivering it.

Foreword

Chairperson of the African Union Commission

H.E. Mahmoud Ali Youssouf
Chairperson,
African Union Commission

The African Union was founded on a simple but powerful principle: that Africa's greatest challenges require African solutions, delivered through strong continental institutions. Nowhere is this principle more evident than in the domain of public health.

The 2025 Annual Report of the Africa CDC documents a pivotal year in the maturation of Africa's continental health architecture. It demonstrates how political mandate, institutional reform, and operational execution, when aligned, can deliver tangible results for the people of Africa.

At a time when the continent is navigating overlapping epidemiological risks, constrained fiscal space, climate stress, and geopolitical uncertainty, this report provides evidence that continental coordination is no longer an aspiration but a functioning reality.

Translating political mandate into continental delivery

Africa CDC's evolution reflects a broader transformation within the African Union itself: a shift from normative ambition to implementation capability. The decision of the Assembly of Heads of State and Government to grant Africa CDC full autonomy has proven to be both timely and consequential. Autonomy has enabled speed, scale, and coherence, while strengthened governance, oversight, and accountability mechanisms have ensured credibility and trust.

In 2025, Africa CDC demonstrated its capacity to translate high-level political decisions into coordinated action across all regions of the continent. The declaration and management of Public Health Emergencies of Continental Security, most notably during the multi-country mpox outbreak, showed how continental authority, when exercised responsibly, can reinforce national leadership rather than replace it. This is the African Union at its most effective: convening, aligning, and enabling Member States to act decisively.

Strengthening Africa's institutional backbone

This report is not only a record of emergency response; it is a chronicle of institution-building. Africa CDC has systematically invested in governance, internal controls, risk management, audit maturity, and results-based management foundations that are essential for any autonomous African Union organ entrusted with significant resources and responsibilities.

In 2025, Africa CDC demonstrated its capacity to translate high-level political decisions into coordinated action across all regions of the continent. The declaration and management of Public Health Emergencies of Continental Security, most notably during the multi-country mpox outbreak, showed how continental authority, can reinforce national leadership.

The results are clear. In 2025, Africa CDC achieved the highest budget execution rate in its history, expanded its grant portfolio nearly ninefold since 2022, and successfully passed multiple independent due diligence and audit processes by international partners. These achievements matter not only for Africa CDC, but for the African Union as a whole. They strengthen confidence in our institutions and reinforce the case for channelling resources through African-led mechanisms.

Advancing the Africa Health Security and Sovereignty Agenda

The Africa Health Security and Sovereignty (AHSS) Agenda marks a decisive shift in how the continent conceptualises health: not as a peripheral social sector, but as a strategic pillar of security, economic resilience, and sovereignty. This report shows concrete progress across all five pillars of AHSS: pandemic preparedness and response, sustainable financing, digital transformation, local manufacturing, and Africa's leadership in global health governance.

Through initiatives such as pooled procurement, investment in local manufacturing, strengthened surveillance and laboratory networks, and the deployment of a skilled continental workforce, Africa is reducing structural vulnerabilities that were laid bare during previous global crises. These efforts are not inward-looking. They contribute directly to global health security by ensuring faster detection, more reliable response, and more resilient supply chains.

A stronger African voice in global health governance

One of the most significant developments documented in this report is Africa CDC's emergence as a unifying platform for Africa's engagement in global health forums. By consolidating technical evidence, political positions, and diplomatic engagement, Africa has moved from fragmented participation to coordinated leadership in negotiations on pandemic preparedness, financing, and reform of the global health architecture.

This strengthened voice reflects the African Union's broader commitment to multilateralism that is fair, inclusive, and responsive to the realities of all regions. It also underscores a central lesson of recent years: global solutions are stronger when Africa is not merely consulted but empowered to lead.

Looking ahead

As Chairperson of the African Union Commission, I view the achievements of Africa CDC in 2025 as both a milestone and a responsibility. The foundations have been laid; the expectations are now higher. Preparedness must be institutionalised. Financing must become more predictable and increasingly domestic. Digital and data systems must be secured and interoperable. And continental institutions must continue to earn trust through performance, transparency, and impact.

The African Union Commission remains fully committed to supporting Africa CDC as the continent's public health agency, and to ensuring that health remains firmly embedded in Africa's broader agendas for peace, development, industrialisation, and integration.

This report is a testament to what Africa can achieve when vision is matched with execution. It affirms a simple truth: strong continental institutions are not a luxury; they are essential to Africa's sovereignty and future.

Message

Chairperson of the Africa CDC Governing Board

H.E. Dr Elijah Julaki Muchima,
Chairperson, Africa CDC Governing Board,
Minister of Health, Republic of Zambia

The Africa CDC stands today at a critical juncture in its institutional evolution. The 2025 Annual Report provides clear evidence that Africa CDC has matured into a capable, credible, and accountable continental public health agency—one that is delivering on the mandate entrusted to it by the African Union and its Member States.

As the Governing Board, our responsibility is to ensure that Africa CDC's growing authority is matched by strong governance, sound fiduciary management, and measurable results. In 2025, we observed significant progress across all these dimensions. The institution achieved its highest budget execution rate to date, expanded and diversified its grant portfolio, strengthened internal oversight and audit systems, and embedded results-based management across its operations. These are not merely technical achievements; they are the foundations of institutional trust.

The Governing Board has also closely followed Africa CDC's operational performance during major public health events. The coordinated continental response to multi-country outbreaks, including mpox, demonstrated that autonomy—when paired with accountability—can accelerate action while reinforcing Member State leadership. Africa CDC's ability to translate political decisions into timely, technically sound, and coordinated support across regions reflects a delivery model that is now fit for purpose.

Importantly, this report shows that Africa CDC is no longer operating in isolation. It is increasingly acting as a system integrator—aligning surveillance, laboratories, emergency response, financing, digital platforms, and local manufacturing under a single continental framework. This coherence is essential for sustainability and for maximizing the return on investments made by Member States and partners alike.

Africa CDC is no longer operating in isolation. It is increasingly acting as a system integrator—aligning surveillance, laboratories, emergency response, financing, digital platforms, and local manufacturing under a single continental framework.

Looking ahead, the Governing Board remains committed to its oversight role as Africa CDC enters its next phase. Expectations will continue to rise. Preparedness must be institutionalized, financial sustainability strengthened, and risk management continuously refined. The Board will continue to support Africa CDC in maintaining the highest standards of governance, transparency, and performance, while safeguarding its autonomy as a strategic asset for the continent.

This report affirms a shared conviction: Africa CDC is not only executing programmes, but it is building a durable continental institution that Africa will rely on for decades to come.

Vote of Thanks

Director General, Africa CDC

H.E. Dr Jean Kaseya
Director General,
Africa CDC,
African Union Commission

The year under review marked a decisive transition for Africa CDC from a period dominated by crisis response toward one defined by system transformation, institutional maturity, and continental leadership.

Africa CDC was born out of necessity, shaped by emergencies, and tested by successive public health crises. 2025 demonstrated that Africa CDC is no longer only a responder to shocks; it is an architect of systems. The transition from the New Public Health Order (NPHO) to the Africa Health Security and Sovereignty (AHSS) Agenda reflects this evolution, placing preparedness, financing, digital transformation, and local manufacturing at the centre of Africa's health future.

Throughout the year, Africa CDC worked side by side with Member States to strengthen surveillance, respond to outbreaks, mobilise resources, and align partners behind African priorities. We engaged globally to ensure Africa's voice is heard in shaping norms, financing mechanisms, and governance arrangements that affect our collective security.

The message to Member States is clear: Africa CDC delivers when empowered. Where political backing, data sharing, and financing alignment were present, results followed faster detection, more coordinated responses, stronger national ownership, and better outcomes for communities.

Africa CDC delivers when empowered. Where political backing, data sharing, and financing alignment were present, results followed faster detection, more coordinated responses, stronger national ownership, and better outcomes for communities.

As we conclude this important moment of reflection and accountability, allow me, on behalf of Africa CDC, to express our deepest appreciation to all those whose leadership, commitment, and trust have made the progress captured in this report possible.

First, I wish to convey my sincere gratitude to the Heads of State and Government of the African Union, whose political leadership has elevated health to a matter of security, sovereignty, and continental priority. Your decisions, particularly in granting Africa CDC full autonomy, have empowered us to move with speed, coherence, and purpose, while remaining firmly accountable to the people we serve.

I extend special appreciation to the Chairperson of the African Union and to the Chairperson of the African Union Commission for their unwavering stewardship and strategic guidance. Your

support has reinforced Africa CDC's role as the public health agency of Africa and strengthened our collective capacity to act decisively in moments of crisis and transformation.

I am deeply grateful to the Chairperson and Members of the Africa CDC Governing Board for their diligent oversight, wise counsel, and steadfast commitment to good governance. Your guidance has ensured that Africa CDC's growing mandate is matched by robust fiduciary discipline, transparency, and results-based performance. The institutional maturity reflected in this report is, in many ways, a testament to your leadership.

To the Ministers of Health and Ministers of Finance of our Member States, thank you for your partnership and trust. Africa CDC exists to serve you. Every deployment, every technical mission, every investment in surveillance, laboratories, preparedness, and workforce development is grounded in national priorities and implemented in close collaboration with your institutions. Your leadership at country level remains the foundation of continental health security.

I also wish to acknowledge our partners: multilateral institutions, development banks, philanthropies, and technical agencies, who have chosen to invest through African systems. Your confidence in Africa CDC strengthens not only our institution, but the broader African Union architecture. Together, we are demonstrating that African-led solutions can deliver impact at scale.

To the Africa CDC staff, across headquarters, regional collaborating centres, and the field: I thank you profoundly. Your professionalism, resilience, and dedication, often under intense pressure, are the true engine of this institution. Whether responding to outbreaks, building systems, managing resources, or supporting Member States quietly behind the scenes, you have shown what excellence in public service looks like.

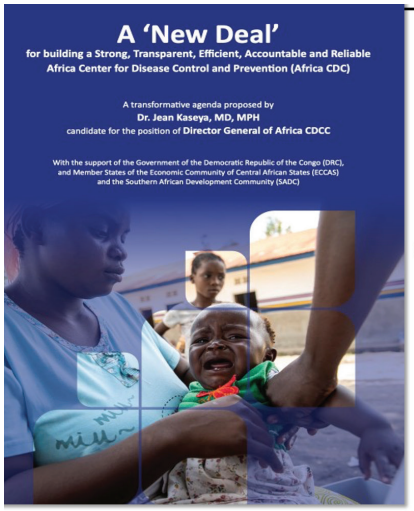
Finally, I thank the people of Africa, in whose name and for whose protection we work. The progress reported here is not an end in itself. It is a foundation. Much remains to be done. But this report confirms a fundamental truth: when Africa leads, aligns, and invests in its own institutions, it delivers results.

As we look ahead, Africa CDC remains fully committed to safeguarding the health of our continent, strengthening preparedness, advancing sovereignty, and earning every day the trust placed in us.

I thank you all.

Throughout the year, Africa CDC worked side by side with Member States to strengthen surveillance, respond to outbreaks, mobilise resources, and align partners behind African priorities. We engaged globally to ensure Africa's voice is heard in shaping norms, financing mechanisms, and governance arrangements that affect our collective security

The 2025 Africa CDC at a glance



Make OUR Africa CDC:
(1) Stronger – with strong governance, proven technical expertise and authority

make OUR Africa CDC:
(2) reliable – through its effective response on the ground when Member States face Public Health threats.

Make OUR Africa CDC:
(3) Efficient – to generate funds and use them to achieve tangible results

Africa CDC is guided by its 2023–2027 Strategic Plan, which operationalizes African Union decisions adopted to date in the health sector and translates them into concrete, deliverable priorities, while also giving full expression to the Director General's leadership vision as articulated in his manifesto, "A New Deal for Building a Strong, Transparent, Efficient, Accountable, and Reliable Africa CDC."
With 2025 marking a decisive midpoint in the 2023–2027 Strategic Plan, the progress achieved to date demonstrates substantial institutional strengthening and accelerated delivery across all priority areas since 2022:

2023

- Missing Annual reports 2021 and 2022 developed and posted in the Africa CDC website
- 5 Yr Strategic plan 2023-2027 developed and disseminated
- Adoption and implementation of the 2023 Action plan
- Advocate and accelerate operationalization of the Africa CDC autonomy
- Made functional all Governance mechanisms
- Training of senior staff on Grant management and accountability mechanisms
- Correction of huge Gender and geography imbalance on recruitment
- Appropriate funding and initiate replenishment

2024

- Attract African and international talents: Reinforcement of HR, Finance and Operations capacities
- Correction of huge Gender and geography imbalance on recruitment
- Timely adoption of 2024 Action plan monthly, quarterly and annually evaluated
- Creation of the Program Implementation Unit (PIU)
- Acceleration of the autonomy of Africa CDC
- Exercising our mandate and taking control of the health security in Africa: declaration of Mpox as PHECS and creation of IMST

2025

1. Institutional Strengthening, Talent, and Governance

- Attracted top African and international talent: significant reinforcement of HR, Finance, Operations, PPPR, Health Economics, Digital Health, and Local Manufacturing capacities.
- Corrected long-standing gender and geographic imbalances in recruitment.
- Established a results-driven planning and accountability culture, with the 2025 Action Plan adopted on time and monitored monthly, quarterly, and annually.
- Created the Office of Internal Oversight (OIO) and institutionalized risk champions across divisions, embedding enterprise risk management and compliance into day-to-day operations.
- Developed and operationalized robust anti-fraud and anti-corruption frameworks, including whistle-blower protection mechanisms, and strengthened internal controls
- Operationalized the African Pooled Procurement Mechanism (APPM), transforming Africa's purchasing power and reducing commodity prices, fragmentation, and supply insecurity.
- Supported the operationalization of the African Medicines Agency (AMA), strengthening regulatory harmonization, market confidence, and local manufacturing readiness.
- Led the continental R&D agenda for Pandemic Prevention, Preparedness and Response (PPPR), tightly linked to local manufacturing of vaccines, diagnostics, and therapeutics.

2. Flagship Continental Public Health Deliverables

- Completed the first-ever Continental Landscape Survey on Community Health Workers (CHWs)
- Developed the Continental Investment Case for CHWs and the Continental Acceleration Framework
- Developed the Continental Immunization Strategy fully aligned with the Gavi LEAP,
- Strengthened Africa CDC's leadership role in integrated PHC linked to Maternal Health and SRH, surveillance, digital health, and emergency response coordination.

3. Strategic Vision and Continental Leadership

- Developed the Africa Health Security and Sovereignty (AHSS) vision, now endorsed by African leadership and positioned as the continent's unifying public-health doctrine.
- Defined Africa's alternative model for global health financing and governance, advocated for the funding approach of America First Global Health Strategy (AFGHS) as a respectful direct financing of African government while leverage their cofinancing.
- Positioned Africa CDC as the continental anchor for peace, stability, and health, including leadership on the Regional Epidemic and Health Security Investment Framework (REIF) linking health security to conflict prevention and economic resilience.

4. Financing, Partnerships, and Resource Mobilization

- Provided strategic leadership and advocacy that supported the mobilization of over US$50 billion for Africa's health sector, including support for implementation of AFGHS, replenishment of Gavi and GFATM, and repurposing of the Pandemic Fund toward more country ownership and leadership
- Shifted the narrative from aid dependency to domestic financing, efficiency, and pooled mechanisms, aligned with the Lusaka Agenda and AHSS.

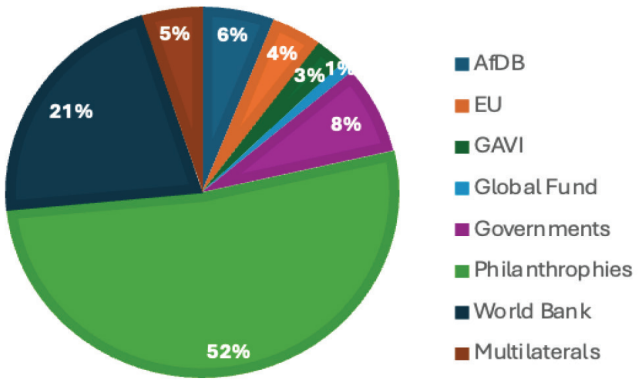
5. Market Shaping, Regulation, and Local Manufacturing

- Established the Program Implementation Unit (PIU) to ensure faster, higher-quality execution of large and complex grants and multi-partner programmes.

6. Fiduciary Credibility and Due Diligence Milestones

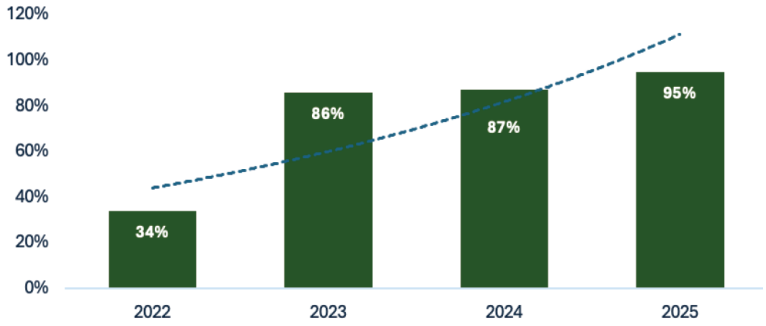
- Successfully passed the UK Government (FCDO) due-diligence assessment, confirming Africa CDC's financial management, procurement, and safeguarding systems.
- Successfully completed the Gavi, CEPI, UNITAID and Pandemic Fund (PF) assessment,

The grant portfolio directly managed by Africa CDC grew from **US$52 million in 2022 to US$463 million in 2025**, with portfolio diversification over 66 active grants.
For the 2025 budget, key funding sources include Philanthropies (52%), World Bank (21%), AfDB (6%), Governments (8%), Gavi (3%), Global Fund (1%), EU (4%), and other partners (5%).



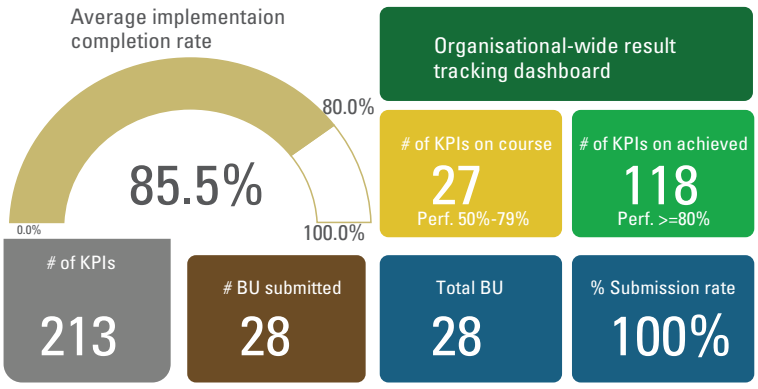
The 2025 Africa CDC Grant Portfolio by source category

In delivering its programmatic function, Africa CDC achieved its highest financial performance (execution of 95%), with record revenue and budget implementation. The overall financial performance and budget execution have continued to improve over the years as the institution's capacity and internal systems have strengthened. The budget performance has increased from 34% in 2022 to 95% in 2025.

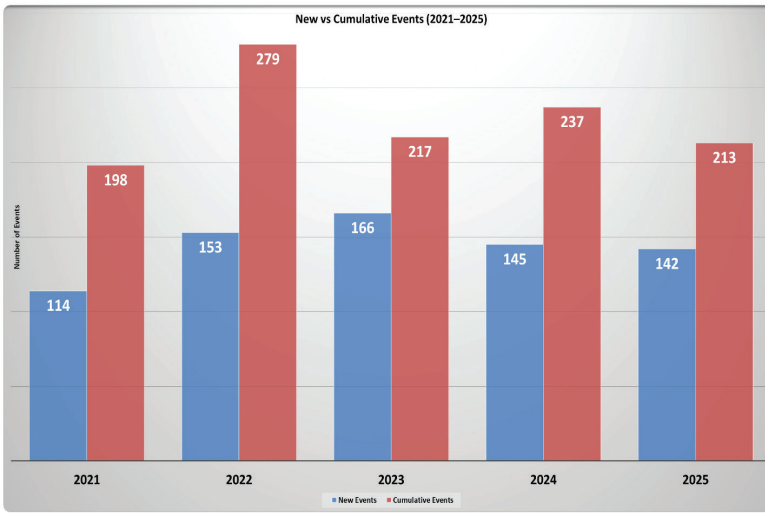


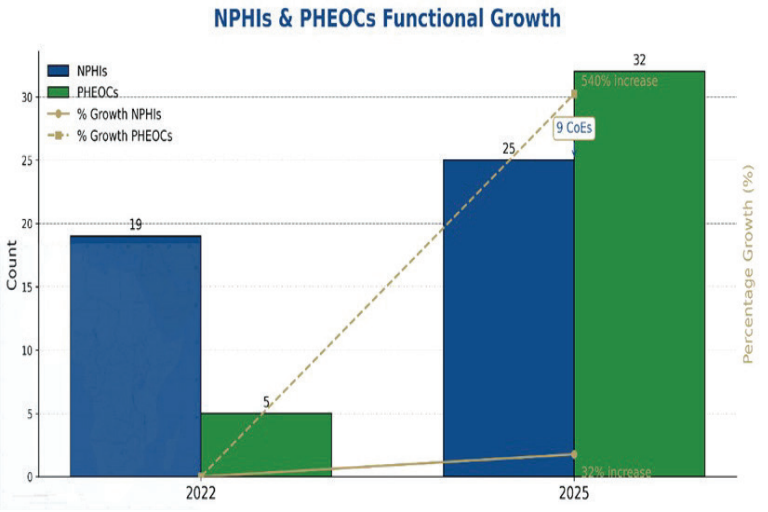
Africa CDC Budget execution rate trend 2022 - 2025

Out of 213 Key Performance Indicators (KPIs) in the 2023–2027 Strategic Plan, Africa CDC has already delivered 85.5% of its targeted results midway through the cycle, on track to achieve 100% of our commitments by 2027. All 28 Business Units are fully reporting, achieving a 100% compliance rate showing accountability and performance discipline. This progress is underpinned by a strong Planning, Monitoring, Reporting and Learning Division, which systematically tracks both programmatic and financial performance, and drives continuous efficiency, and institutional learning.



Iterative monitoring dashboard





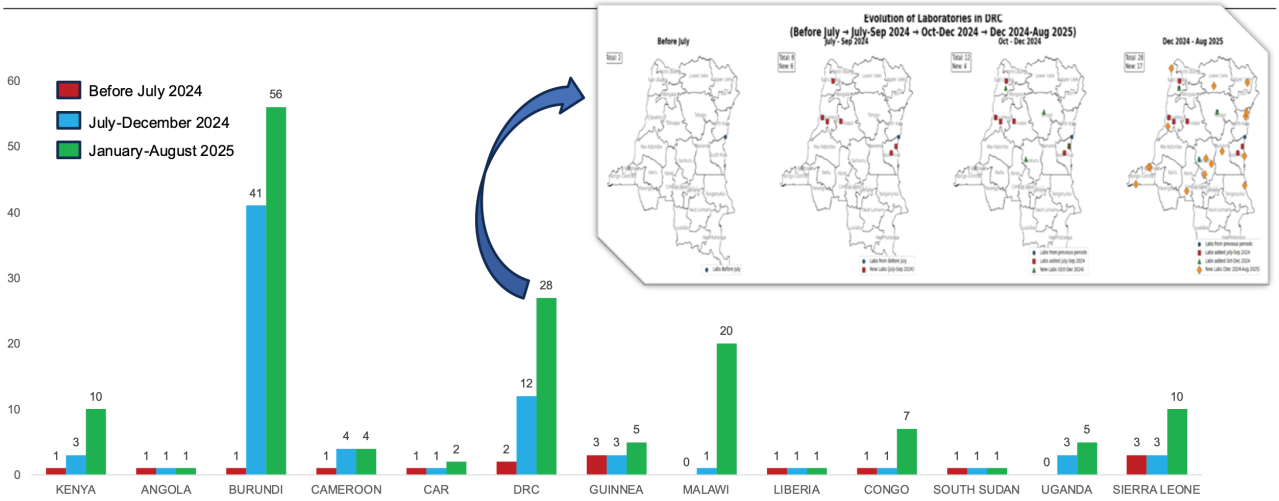
Supported all 55 AU Member States, mobilised over USD 600 million in the past 3 years, expanded functional Public Health Emergency Operations Centres to 32, strengthened

These reforms and investments have translated into concrete results. Today, Africa CDC has compelling success stories to demonstrate the impact of its transformation—across governance, financing, operations, and continental health leadership.

From a programmatic perspective, this overall performance reflects the aggregation of multiple concrete results delivered across Africa CDC's core intervention pillars. Together, these results translate into tangible, continent-wide impact, demonstrating how Africa CDC's support has strengthened national health systems, advanced health security, and reinforced Africa's health sovereignty across the continent.

This result is supported by strong agenda on Research and Development for PPPR and local manufacturing agenda allowing Africa to get appropriate health commodities on a reduced timeline compared to period before 2023.

Testing labsdecentralisationevolution: A key legacy of the IMST



- **Burundi: from 1 to 56 laboratories.** / DRC: from 2 to 28 laboratories / Malawi: from 1 to 20 laboratories.
- Kenya, Sierra Leone, and Uganda show more modest but still important increases in testing capacity.

In 2025, we have the lowest number of public health events since 2021.

Key factors of success are:

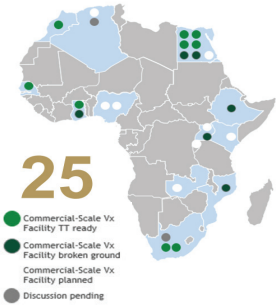
1. **Stronger early warning and faster detection:** More functional surveillance, decentralization of lab networks, and faster information-sharing to catch signals earlier

2. **More operational readiness and quicker response capacity**: Expansion/strengthening of PHEOCs, incident management systems, surge staffing, and clearer SOPs to shorten time from alert to response.

3. **Improved prevention and countermeasure coverage:** focus on availability of MCMs, better IPC in facilities, and better case management guidance

4. **More coordinated leadership, accountability, and partner alignment**: Increased number of National Public Health Institutes (NPHIs) coupled with Public Health emergency Operation Centers (PHEOCs) and a decentralized network of laboratories ensures strong continental coordination, clearer national ownership, stronger cross-border coordination, and tighter alignment of partners under one response architecture can reduce duplication

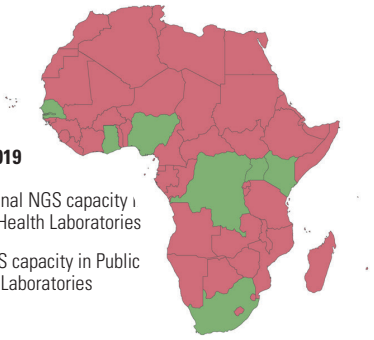
Significant progress in African Health Products manufacturing



Pathogen Ger capacity in 2019

7 Functional NGS capacity i Public Health Laboratories

48 No NGS capacity in Public Health Laboratories

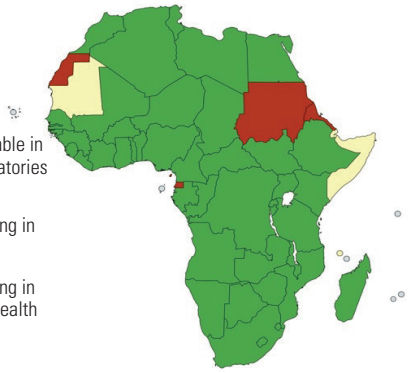


Pathogen Genomics capacity in 2025

46 NGS capacity available in Public Health Laboratories of affiliate

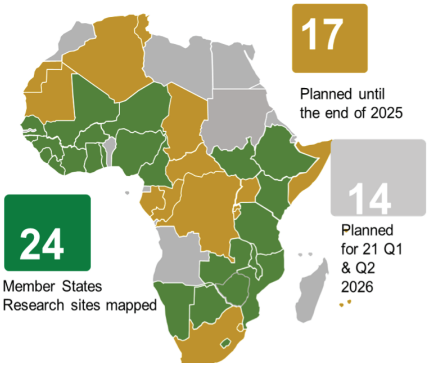
4 NGS capacity building in progress (2025)

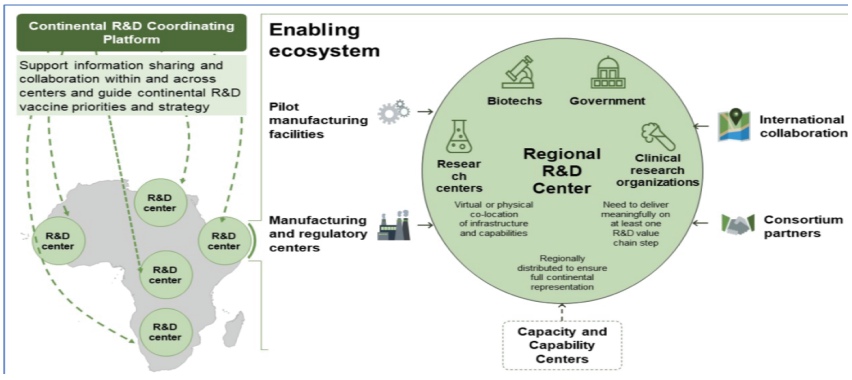
5 NGS capacity building in progress in Public Health Laboratories



What changed from 2022-2025 : R&D

Indicator	2022	2025	Change (%)
Active continental research projects coordinated by Africa CDC	0	48	New
Scientists engaged in continental network	200	2,500	+1,150 %
Sequenced mpox genomes shared	< 200	1,971	+885 %
Biobank nodes operational	2	7	+250 %
Research blueprints published (Africa CDC)	0	3	New





Executive **Summary**

Africa CDC Annual Report (2025)

Introduction

The year 2025 marked a transformative chapter for Africa CDC, firmly positioning the institution as a leading force in advancing health security and sovereignty across the continent. Moving beyond its initial crisis-response orientation, Africa CDC delivered tangible, measurable impact while redefining governance, shaping the continental health narrative, and producing demonstrable outcomes across the five strategic pillars of the Africa Health Security and Sovereignty (AHSS) Agenda. Responsive to Africa's realities and the evolving global context, this shift reflects a decisive transition from reactive emergency management to a phase defined by system strengthening, institutional maturity, and sustained continental leadership

In 2025, the continent confronted a convergence of epidemiological risk, fiscal stress, and geopolitical fragility. Africa faced simultaneous outbreaks of cholera, Marburg, mpox, and measles, with public health events rising to 213 in 2025. This complex landscape necessitated a strategic shift from the New Public Health Order to the Africa AHSS Agenda, which responds to the reality where health shocks carry profound security, economic and sovereignty implications. Amid shrinking fiscal space and geopolitical supply chain vulnerabilities, the AHSS framework reframes health security as a core state function -- requiring continental leadership, sustainable financing, and local manufacturing to reduce dependence and safeguard national agency.

Grounded in African solidarity and reinforced by strengthened governance and operational systems, Africa CDC has effectively translated political mandates into coordinated action—supporting Member States during health emergencies while simultaneously driving long-term structural transformation. This report provides a comprehensive account of these achievements, offering critical insights into the evolving health security landscape and documenting progress in implementing the 2023–2027 Strategic Plan as Africa CDC continues to consolidate its role as the cornerstone of Africa's public health architecture.

Mandate, Governance & Delivery Model

1. Operationalisation of Autonomy

Since 2022, when the Africa Union elevated Africa CDC to an autonomous organ, the institution has evolved from a primarily crisis-response entity into an execution-capable public health authority delivering measurable results across the continent. Autonomy has provided Africa CDC with the authority, speed, and flexibility to translate political mandates into coordinated action—strengthening national capacities to detect, prevent, and respond to threats, while aligning efforts under the AHSS agenda. This shift was exemplified by the August 2024 declaration of mpox as a Public Health Emergency of Continental Security (PHECS), which unified Member States around a regional declaration that catalysed a rapid, efficient and harmonised continental response.

Practically, autonomy removes intermediary bottlenecks and enables Africa CDC to act at a continental scale. It allows early threat detection and cross-border coordination; rapid mobilisation, leveraging, and deployment of resources; direct financial management and fiduciary oversight; faster procurement and logistics – and access to medical countermeasures; and the ability to negotiate partnerships on Africa's terms. In sum, autonomy has transformed Africa CDC into the world class institution for continental health security—advancing African priorities with African leadership and African solution.

2. Governance as a Facilitator

The full operationalisation of Africa CDC's governance structure, comprising the Committee of Heads of State and Government (CHSG), the Governing Board, and the Advisory Technical Council (ATC), has strengthened the agency's ability to exercise its mandate. This tiered architecture ensures that decisions are evidence-driven, politically legitimate, and operationally executable. In 2025, the CHSG elevated health as a top-tier political priority and provided strategic direction and oversight; the Governing Board examined the annual workplan

and budget, deliberated strategic issues and provided recommendations; and the ATC provided technical advice on matters of disease control and prevention and scientific aspects – as well as views on advocacy, resources mobilization, and strategy. Together, the governance structure helped Africa CDC ensure strategy was evidence-based and aligned with continental priorities; its operations were sound; and the agenda and institution were supported by political leadership.

3. Operationalising the Delivery Model

The agency has implemented an "Africa CDC without walls" delivery model, supporting the continent at the point of need, without duplicating national efforts. Central to this approach has been the continued strengthening of the five Regional Collaborating Centres (RCCs), serving as critical regional hubs that translate continental priorities into context-specific action through coordinated leadership, technical delivery, and strategic partnerships. Each RCC has three committees to support its work and the continent: Regional Ministerial Steering Committee (ReSCo) comprised of Minsters of Health to provide guidance, support coordination and drive political will; Regional Technical Advisory Committee (ReTAC) comprised of senior officials within Ministries of Health to provides technical support and guidance; and the Regional Integrated Surveillance and Laboratory Network (RISLNET) to integrate laboratory, surveillance, and emergency response capacities. As the primary platforms for coordination and engagement with RECs and strategic partners, the RCCs advanced pandemic preparedness, surveillance, laboratory systems, and emergency response, while reinforcing political alignment and institutional capacity at both regional and country levels.

At the country level, Africa CDC continued to anchor its support to the National Public Health Institutes, Ministries of Health and in-country presence in key health security strategic countries. This model ensured delivery remained country-centric, while AU Member States gained more ownership of the institution and of the shared continental public health agenda.

4. Strengthening Africa CDC Structure & Workforce

Africa CDC invested in building a fit-for-purpose workforce, scaling up technical capacity and emergency readiness. The agency has expanded its workforce from 262 staff in 2023 to 459 in 2025, prioritising technical gaps in surveillance, laboratories, and emergency response, while increasing diversity in regional and gender representation. Africa CDC has expanded the continental African Volunteers Health Corps (AVoHC) to 1,180 deployable responders serving as a surge capacity to fill and skill gap during public health emergencies. Other workforce strengths are described under the different pillars of AHSS in section 4 below.

5. Internal Systems strengthening

Africa CDC has achieved financial autonomy, operationalised direct receipt and management of funds, and secured accreditation from major partners like the UK FCDO. Financial management reforms enabled Africa CDC to receive and manage a diversified source of resources, implement robust audit systems, and reduce delays in emergency financing.

Procurement and operational systems were reformed to support rapid yet accountable execution, particularly during emergencies. In parallel, a continental supply chain maturity dashboard was developed and is fully operational, providing a snapshot of supply chain capacity across Member States.[1]

To institutionalise excellence, the agency established an Office of Internal Oversight and initiated ISO 9001 certification of its operations to ensure rigorous risk management, process integrity and continuous improvement. Beyond that, Africa CDC institutionalised enterprise risk management across the organisation and advanced programme delivery by adopting the Result-Based Management framework.

6. Establishment of Enterprise Risk Management:

Africa CDC institutionalised a comprehensive Enterprise Risk Management (ERM) framework. A formal, organisation-wide Risk Register was launched, enabling real-time monitoring of financial, operational, and reputational risks. The system is supported by designated Risk Champions across the organisation to ensure active risk identification and mitigation.

Roll-out of Anti-Fraud, Whistleblower and Safeguarding Mechanisms:

The institution implemented robust institutional safeguards to reinforce integrity and accountability. These reforms included:

- The development and implementation of an Anti-fraud and anti-corruption policy.
- The establishment of whistleblower protections and a dedicated "Report a Concern" grievance

1 https://app.akuko.io/post/269dc25a-a188-4911-97be-f78d76e4cd1e

mechanism to enable safe stakeholder feedback.
- The establishment of Environmental, Social and Governance Policy, including Safeguarding
- Digital tracking systems to strengthen oversight and prevent the misuse of resources.

Staff received orientation to and training on the policies so that they are incorporated in daily management and operations of the work.

7. Audit Maturity

Africa CDC demonstrated a commitment to transparency and rigorous external scrutiny by undergoing nine comprehensive audits in 2025. This suite of audits included:

- The annual audit by the AU Board of External Auditors.
- Two Internal audits from the African Union Office of Internal Oversight.
- An independent forensic audit.
- Five donor-specific audits.

The outcome of these audits is transparently shared, and any audit recommendations are tracked for implementation. Africa CDC has established an audit finding tracker to ensure all audit findings are addressed and followed up to completion.

Africa's Health Landscape in 2025

Africa faced a complex health environment in 2025, with simultaneous outbreaks of diseases such as Marburg, cholera, mpox, and measles. Fiscal constraints intensified amid declining external assistance and rising household health care costs, while geopolitical and supply chain vulnerabilities persisted. Amid this, the continent has continued to experience the rise of public health emergencies, from 153 reported in 2022 to 242 and 213 events reported in 2024 and 2025, respectively. Health shocks increasingly carry security and sovereignty implications, underscoring the need for a continental approach.

Delivering the Africa Health Security and Sovereignty (AHSS) Agenda

Pillar 1: Global Health Architecture and African Leadership

Under the direction of the AU Assembly, Africa CDC emerged as the continental voice in global health. In 2025, the institution transitioned the continent from reactive participation to collective leadership, leading continental emergency declarations, establishing a continental coordination mechanism for managing multi-country outbreaks such as IMST, shaping reforms in global health governance, and presenting a unified African position in critical global negotiations such as the World Health Assembly; the pandemic agreement negotiations; the Global Fund and Gavi replenishments; G7, G20, and AU-EU forums. This political consolidation elevated Africa's voice, leveraged strategic resources and partnership to orient themselves to Afrian priorities. It reduced fragmentation among Member States, accelerated decision-making during crises, and elevated health security and sovereignty as a strategic priority alongside trade, industrialisation, and economic resilience.

This leadership translated into better-aligned investments and measurable outcomes for Member States. Through the AHSS Agenda and stewardship of the Lusaka Agenda, global health financing increasingly supported African priorities, including local manufacturing, digital public health systems, and domestic resource mobilisation. The operationalisation of its mandate, most notably the Public Health Emergencies of Continental Security (PHECS) declaration, enabled faster, coordinated action during the Mpox outbreak, strengthening national legitimacy and reducing political risk for governments. Evidence-driven diplomacy, backed by continental surveillance and political scorecards, enhanced the credibility of national decisions, while the launch of the Global Health Diplomacy Fellowship institutionalised Africa's capacity to sustain leadership and protect its interests in future global health negotiations.

Pillar 2: Pandemic Prevention, Preparedness and Response (PPPR)

Africa CDC strengthened Africa's pandemic preparedness and response by institutionalising national structures and scaling up workforce and operational capacity. Notably, Africa CDC made the following progress in implementing the PPPR in the continent:

National Structures: Africa CDC worked with Member States to operationalise 27 fully functional Nation-

Figure 1: The 2025 Africa CDC Performance at a Glance

al Public Health Institutes (NPHIs), with 19 at different stages of establishment. Of these, Africa CDC has designated 9 NPHIS as centres of excellence to support other Member States in strengthening and establishing their own NPHIS. The NPHI anchors all public health functions under one umbrella within the Member States for efficiency and minimising waste, especially during public health emergency responses.

Through the Field Epidemiology Training Program, 303 epidemiologists and surveillance officers were trained across 21 Member States between 2023 and 2025. Africa CDC established the African Epidemic Service, a two-year fellowship programme structured around three strategic tracks: Applied Epidemiology, Laboratory Leadership, and Public Health Informatics. To date, 47 fellows have been recruited across two tracks, including 26 in epidemiology and 21 in public health informatics. Public Health Emergency Management Fellowship has now graduated 27 expert-level public health professionals from 22 Member States, including 19 fellows from 16 countries in 2025 alone. Through the Kofi Annan Global Health Leadership Program, 84 fellows have graduated across 4 cohorts since 2019, many now holding senior leadership roles that advance national and continental health priorities. A fifth cohort of twenty-five fellows is currently in training. A total of 1,436 community health workers were trained and deployed across Uganda, Burundi, and the Democratic Republic of the Congo to support surveillance and infection prevention and control, supported by regional train-the-trainer modules coordinated through Regional Collaborating Centres in Eastern and Central Africa.

Response to public health emergencies: The Incident Management Support Team (IMST) model enabled rapid, coordinated responses to outbreaks such as mpox, mobilising over 1,400 frontline responders and 300 epidemiologists across all five regions. During this period, Africa CDC trained 4,870 public health professionals, including 303 field epidemiologists. Africa CDC supported 33 countries in establishing or upgrading Public Health Emergency Operation Centres (HEOCs) with digital tools and training. Additionally, the creation of emergency logistics hubs in Addis Ababa and Douala, worth $2 million, facilitated the distribution of critical supplies. Over 515,000 vaccine doses, 175,000 test kits, and 192,000 PPE units were distributed to 29 countries, reinforcing Africa's operational readiness and regional response capacity. As of December 2025, 32 Member States have functional PHEOCs at least at the national level.

Surveillance: Africa CDC also advanced surveillance and early warning systems across the continent. Event-Based Surveillance was operationalised in 38 countries, supported by training over 1,000 surveillance officers and 3,400 community health workers. The early detection rate of public health events within seven days rose from 39% in 2022 to 58% in 2025, with 213 public health events monitored across 44 Member States at the continental level.

Laboratories: Genomic sequencing capacity is now present in 46 Member States, up from 7 in 2019. On top of that, Africa CDC invested over USD 8 million to equip more than 120 laboratories and train 1,200 laboratory staff, dramatically expanding diagnostic and genomic sequencing capabilities. As a result, mpox testing labs increased from a median of 1 to 11 per country, sequencing turnaround time dropped from over 30 to under 7 days, and 46 Member States now possess genome sequencing capacity.

Pillar 3: Sustainable Health Financing and Domestic Resource Mobilisation

Africa CDC supported Member States in aligning health security financing with national priorities, embedding financial management experts, and developing investment cases. As of December 2025, over $40 billion dollars had been mobilised for health security in Africa. Efficiency reforms have identified significant potential savings. In 2025, Africa CDC elevated health financing as a core element of health security by deploying 20 Public Financial Management experts to strengthen budget execution and align investments with preparedness and UHC goals. Through the Lusaka Agenda, it launched a continental dashboard to track financing alignment, accountability, and progress. Ten countries completed Health Security Investment Cases, shifting the dialogue from donor-led proposals to nationally owned priorities.

Africa CDC also advanced innovative financing, supporting mechanisms like health taxes, pooled procurement savings, and diaspora bonds. It mobilised $463 million in direct support and influenced over $40 billion in aligned global funding for Member States, including $10 billion for local manufacturing. Agreement to design a blended finance facility for African Health Sovereignty is in place. The proposed Health Financing Observatory will further institutionalise transparency in spending and peer accountability across the continent.

Pillar 4: Digital Transformation and Data Sovereignty

Digital platforms and event-based surveillance expanded across Member States, enabling real-time analytics and decision-making. Africa CDC advanced data governance, interoperability, and digital health innovation, supporting research mapping and digital maturity assessments across Member States. Major strides in digital transformation were made by launching key frameworks to guide data governance, interoperability, and digital health maturity across Member States. Parallel efforts advanced the digitalisation of primary health care (PHC), mobilising USD 40 million to support digital transformation in nine countries and developing a dedicated PHC framework with Member States. The Africa CDC Knowledge Hub (KHub) was launched as a centralised digital portal to support knowledge sharing, policy, and collaboration across Africa. In addition, the Journal of Public Health in Africa published 167 articles, reaching authors in 47 countries.

Pillar 5: Local Manufacturing and Pooled Procurement

Africa is on the path to achieve the continental goal of manufacturing at least 60% of its health products in Africa by 2040.I n 2025, Africa CDC advanced this agenda through a set of concrete, mutually reinforcing actions that strengthened demand, markets, financing, and coordination across the manufacturing ecosystem. Key milestones included:

- **Pooled Procurement:** The African Pooled Procurement Mechanism (APPM) was operationalised, initiating pooled procurement for 10 priority products and two emergency needs. Laying the foundation for predictable, aggregated demand to support African manufacturers.
- **Market shaping:** Market integration and sustainability were strengthened through alignment of pooled procurement alignment, strategic partnerships, and sustained political advocacy for the *Buy African* agenda—reinforcing policy coherence and long-term market confidence.
- **Manufacturing:** The Platform for Harmonised African Health Manufacturing (PHAHM) was institutionalised, mapping over 27 vaccine manufacturing initiatives and more than 20 technology transfers underway for a range of health products - providing a continental view of capacity, gaps, and scale-up pathways.
- **Financing:** Over US$10 billion was mobilised to scale local production, including through GAVI's support for the African Vaccine Manufacturing Accelerator (AVMA) - helping to de-risk investments and accelerate time to marke
- **Research and Development:** Africa CDC is shaping the continental R&D governance and coordination mechanisms to optimally support the local manufacturing of medical countermeasures.

Partnerships

Africa CDC shifted from fragmented projects to strategic partnerships, aligning external support with Africa's priorities. Partnerships with Member States, multilateral agencies, philanthropy, and the private sector were governed for results, strengthening national systems and reducing duplication.

Risks, Lessons & Adaptive Leadership

Africa CDC navigated operational, financial, political, and strategic risks in a complex environment. Key lessons included the importance of structured governance, disciplined autonomy, and unified continental action. Adaptive leadership and continuous learning reinforced institutional resilience.

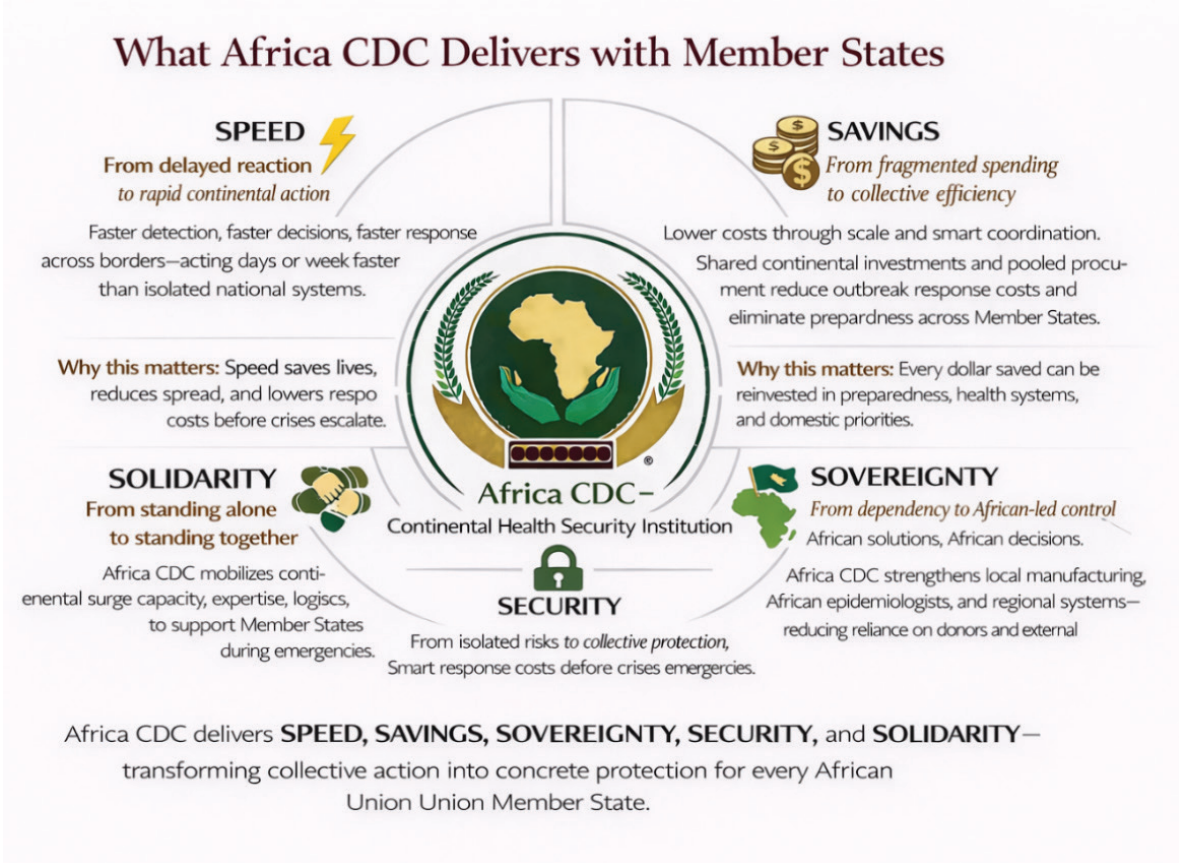
Strategic Foresight for 2026

Looking ahead, Africa CDC's will focus on consolidating gains while accelerating delivery across the health security value chain. Key priorities for 2026 include:

- **Institutionalising preparedness as a permanent public function:** Embedding preparedness within national and regional systems through sustainable financing, clear benchmarks, and routine accountability mechanisms—moving from episodic readiness to standing capability.
- **Scaling integrated delivery at continental scale:** Advancing an integrated operational model that links surveillance, emergency response, sustainable financing, pooled procurement, at-risk financing for medical countermeasures (MCMs), and manufacturing into unified delivery systems.
- **Accelerating local production and market access**: Driving progress toward the continental target of producing , through expanded pooled procurement, predictable demand, and targeted support to African manufacturers to achieve successful commercialisation.
- **Embedding digital intelligence and data sovereignty:** Strengthening digital platforms, analytics, and cybersecurity to enable real-time intelligence, secure data sharing, and sovereign control over Africa's public health data assets.
- **Consolidating Africa's leadership in global health governance**: Advancing a rebalanced global health architecture in which countries lead, regional institutions coordinate, and global entities support—positioning health security as a strategic pillar of economic growth, resilience, and geopolitical engagement.

Africa CDC calls on Member States to sustain political support, embed health security in budgets, support data sharing, and participate in pooled procurement. Partners are urged to align support with Africa's priorities, invest in system-building, and reinforce Africa-led market shaping.

Figure 2: What Africa CDC Delivers with Member States



SECTION 1

Africa CDC
Mandate, Gorvernance and Delivery model

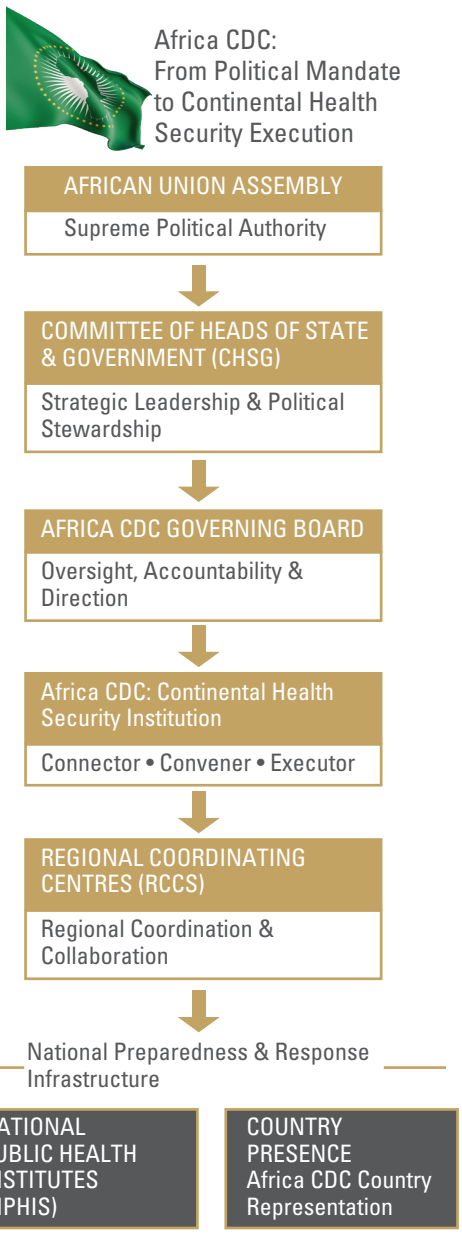


Figure 3: Africa CDC Delivery model

From Political Mandate to Continental

Execution Africa CDC exists because the Heads of State and Government of AU Member States made a delibrate strategic choice: to recognise health security as a matter of continental sovereignty issue**, rather than a sectoral issue to be managed country by country, after crisis have already unfolded. This decision was driven by repeated, large-scale public health outbreaks and emerging threats that exposed systemic vulnerabilities and tested the limits of fragmented national responses across the continent.**

In 2025, a decaded after Africa CDC was first creatd in the AU Commission by the AU Assembly Decision **AU/Dec.499 (XXII),** the institution's relevance has become sharper - not ceremonial. Health emergencies have increased both in frequency and complexity, while Africa faces widening vulnerabilities driven by climate pressures, demographic change, and a more constrained external financing environment.

In February 2022, the AU elevated Africa CDC to an **autonomous Organ of the Union** through **Assembly/AU/Dec.835 (XXXV)**. In July 2022, the Statute amendment consolidated that elevation, empowering Africa CDC to act as *the* public health agency of the continent. This legal evolution matters because it creates the conditions for what Heads of State ultimately require: continental

execution, the ability to detect threats early, coordinate action across borders, mobilise resources and countermeasures rapidly, and report results transparently.

The clearest evidence that Africa CDC's mandate has become operational is the mpox emergency escalation. In 2024, mpox expanded to **21 AU Member States**, with **81,327 notified cases**, **17,899 laboratory-confirmed cases**, and **1,377 deaths** (CFR **1.7%**). Africa CDC declared mpox a **Public Health**

Emergency of Continental Security (PHECS)

On 13 August 2024, following consultations with AU leadership structures and expert review mechanisms; WHO declared a PHEIC on 14 August 2024.

That political-technical escalation produced a delivery platform: Africa CDC and WHO established a continental Incident Management Support Team (IMST) in Kinshasa, the center of the epidemic -- operating under ONE-TEAM, ONE-PLAN, ONE-BUDGET, ONE-M&E, and structured around 10 technical pillars spanning coordination, RCCE, surveillance, laboratories, IPC, vaccination, case management, logistics, research and continuity of essential services.

By December 2024, the IMST coordination mechanism had brought over 28 partners into a single operating structure, mobilized US$1.1 billion and 6 million vaccine doses through pledges/commitments/disbursements/domestic contributions, trained 303 epidemiologists and surveillance officers, deployed 48 epidemiologists and laboratory specialists, trained 169 laboratory experts, and distributed 175,362 testing kits and sequencing reagents to 29 Member States.

This is what "mandate to execution" looks like at a continental scale: not declarations alone, but an operating system that converts authority into measurable outputs.

Institutional autonomy made real: closing the gap between legal status and operational capability.

A central theme in Africa CDC's mandate story is that autonomy had to be operationalised, not simply declared. In March 2022, Africa CDC's baseline constraints were explicit: financial management relied on AU Commission procedures; HR and procurement were centralised; internal audit and risk registers were absent; only 5 national PHEOCs existed; 24 Member States had genomic sequencing capability; the approved staff complement was 155 with fewer than 40% filled; and only 6 Member States submitted real-time surveillance data to Africa CDC.

Africa CDC's own leadership assessment of February 2023 adds institutional clarity: weak planning and accountable reporting; heavy reliance on external consultants; partner control over core administrative functions; low utilisation rates; siloed delivery; and RCCs existing largely as concepts without hosting agreements. That context explains why institutional strengthening in 2023–2025 was not internal bureaucracy; it was the prerequisite for emergency-grade execution.

By late 2025, the institutional shift is measurable:

Grant portfolio growth from US$52 million (2022) to US$451 million (2025) across 66 active grants, reflecting expanded partner confidence and Africa CDC's growing absorption and accountability capacity.
Governance and integrity systems strengthened: risk management, audit action tracking, and multiple audit streams in 2025 (external and internal audits, forensic review, donor audits).
A visible transition toward a performance culture: annual reports developed and posted, strategic planning and action planning institutionalised, and systems reforms (anti-fraud, OIO, risk registry, safeguarding, and ISO readiness pathways).

Continental operational execution at scale: the tangible "public health operating system"

Africa CDC's 2025 performance narrative shows continental delivery in operational terms:

- 213 public health events monitored across 52 Member States
- 32 functional PHEOCs (up from 9 in 2020) and supported with ICT equipment.
- 46 Member States with the capability to conduct genomic sequencing (up from 7 in 2019)
- AVoHC expanded to 1,184 responders, deployed 150+ times in 2025.
- 25 functional National Public Health Institutes, with 19 in development, reinforcing country ownership as the base of sovereignty and 9 of which were designated as centres of excellence to assist countries that are developing their own.
- A measurable emergency financing dividend: the Africa Epidemics Fund reduced average financing delays for emergency operations from 21 days to 7 days (as reported in the 2025 narrative).

These are the building blocks of a continental operating system: early warning, emergency escalation, coordinated incident management, surge workforce, laboratories, logistics, financing, and measurable reporting.

1.1 Africa CDC's Legal Mandate and Autonomy

Africa CDC's authority rests on a clear legal and political compact agreed by African Union (AU) Member States: health security is a continental public good that requires an autonomous institution with the power to act quickly, coordinate across borders, and remain accountable to sovereign governments.

1.1.0. Legal foundation: what Africa CDC is mandated to do

Africa CDC was established by an AU Assembly decision as a continental institution mandated to prevent, detect, and control diseases across Africa, and to strengthen national public health institutions rather than replace them.

This design embeds two principles in law:

1. **Subsidiarity with authority**, Africa CDC acts where collective action adds value (cross-border surveillance, pooled tools, emergency escalation), while national institutions remain the primary implementers.
2. **Continental coordination with sovereign ownership**, Africa CDC coordinates and convenes; Member States decide and implement within their jurisdictions.

The elevation of Africa CDC to an autonomous Organ of the African Union in February 2022 formalised this mandate. The Statute consolidation in July 2022 transformed Africa CDC from a coordination centre into a legally empowered continental authority, capable of leading Africa's public health architecture and interfacing as a peer with global health institutions. In 2023, Africa CDC was clarified by the AU Assembly as *the* Public Health Agency for Africa. Then in 2024 and 2025, Africa CDC was given the leadership on APPM, African Manufacturing, Health Financing, Lusaka agenda, Digital Health and Global Health Initiatives

Why this matters: Authority enables deceive action while anchoring accountability. For exmapl, during emergencies, Africa CDC does not request coordination; it formally triggers it under the AU established governance framework.

1.1.2. Emergency powers: authority to escalate continental risk

Africa CDC's Statutes explicitly empower the institution to declare and coordinate a Public Health Emergency of Continental Security (PHECS) when a health threat poses a multi-country risk requiring collective action. This authority is exercised through a structured decision pathway that combines technical evidence with political accountability:

- Epidemiological assessment and risk analysis.
- Expert review through designated advisory mechanisms.
- Consultation with AU leadership structures.
- Formal declaration by the Director General.

The mpox escalation in August 2024 demonstrated this authority in practice: Africa CDC issued a PHECS declaration, which catalysed continent-wide mobilisation, aligned Member States and partners under a single operating framework, and synchronised continental action with global escalation.

1.1.3. Autonomy in practice: what Africa CDC can now do autonomously

Autonomy is not symbolic. It is operational, fiduciary, and managerial. Since 2022, Africa CDC has progressively operationalised autonomy across four critical domains:

1. **Financial authority:** Africa CDC can receive and manage funds directly, operate dedicated bank accounts, execute emergency expenditures, and report through auditable systems. This enables rapid-response financing and reduces reliance on intermediaries during crises.
2. **Procurement authority**: Africa CDC can procure goods and services, including emergency medical countermeasures, at a continental scale. This authority underpins pooled procurement, market shaping, and emergency logistics.
3. **Human resources authority**: Africa CDC can recruit, deploy, and manage specialised staff and surge personnel under an approved structure, enabling rapid technical deployments during emergencies and sustained capacity building in peacetime.
4. **Operational decision authority**: Africa CDC can activate emergency coordination mechanisms, deploy incident management systems, and issue continental guidance aligned with AU decisions.

Why this matters:

Without operational autonomy, emergency response timelines lengthen, transaction costs rise, and political decisions lose effect at the country level.

1.1.4. Safeguards: autonomy balanced by accountability

Africa CDC's autonomy is deliberately coupled with robust oversight mechanisms to protect Member States and partners:

Governing Board deliberation and recommendations on activites, budget and strategy

CHOS oversight on strategy, budgets, performance and political leadership

Internal audit and risk management systems to detect and mitigate fiduciary and operational risks.

Results-based management and performance reporting aligned with AU oversight cycles.

External audits and partner due-diligence processes to confirm and improve internal controls and financial management, enabling direct financing modalities.

This balance of authority with controls is the institutional condition that allows Africa CDC to operate at emergency speed while maintaining trust among Ministers of Finance, Heads of State, and partners.

1.1.5. Legal interoperability: Africa CDC within the global health system

Africa CDC's Statute also mandates structured collaboration with the World Health Organization and other Global Health partners to ensure complementarity, and present a unified African position in global health governance. This legal interoperability allows Africa CDC to:

- Align continental emergency declarations with global mechanisms.
- Coordinate incident management without parallel command structures.
- Negotiate from a position of collective African authority.

1.2 Governance Architecture

Africa CDC's governance architecture is deliberately designed to resolve a central tension faced by all continental institutions: how to act fast in emergencies while remaining politically accountable to sovereign Member States. The model adopted by the African Union does not dilute authority across committees, nor does it centralise power without oversight. Instead, it creates a tiered system of political direction, technical judgement, and executive action, anchored in AU law and practice.

1.2.1. Governance logic: authority with accountability, not bureaucracy

Africa CDC's governance is built around a clear principle: decisions affecting continental health security must be evidence-driven, politically legitimate, and operationally executable. Governance bodies are therefore not ceremonial; each has a defined role in ensuring that Africa CDC's autonomy is exercised responsibly and predictably.

At its core, the governance system performs three functions:

1. Political stewardship ensuring Africa CDC's actions reflect collective AU priorities and protect national sovereignty.
2. Technical integrity ensuring decisions are grounded in science, risk analysis, and best practice.
3. Executive delivery enabling rapid, decisive action when delays would cost lives and stability.

This architecture is essential to credibility. Without it, Africa CDC would risk either paralysis (too many approvals) or overreach (too little accountability).

1.2.2. AU Assembly and Executive Council of African Union

The AU Assembly provides Africa CDC's ultimate political mandate through founding, autonomy, and policy decisions. The Executive Council exercises delegated oversight, including approval of institutional structures, staffing frameworks, and strategic directions. This ensures that Africa CDC's authority remains firmly anchored in Member State consensus.

Why it matters: This anchoring protects Africa CDC from being perceived as an external or donor-driven entity, but part of the Union, and ensures its legitimacy during politically sensitive emergency decisions.

1.2.3. The Committee of Heads of State and Government (CHSG) of Africa CDC.

The CHSG continued to anchor Africa CDC's mandate within the African Union framework, reinforcing continental ownership of health security and sovereignty at the highest political level. Elevating health as a peace and security, economic growth, and developmental instrument.

In 2025 alone, Africa CDC CHSG was instrumental in:

1. Advancing Pandemic Prevention, Preparedness and Response through their strong affirmation of support for continental coordination for pandemic and epidemic response, and the fight against emerging challenges such as antimicrobial resistance. In particular,

2. Supporting sustainable health financing in Africa and operationalisation of the African Epidemics Funds through promoting resource mobilisation to ensure a sustainable, coordinated, and transparent response to health emergencies in Africa.
3. Advancing the Assembly/AU/Dec.880(XXXVII) on establishing an accountability framework for the effective implementation of the Lusaka Agenda towards achieving Universal Health Coverage (UHC), requesting Africa CDC to bring a unify the voice of AU MS and representing Africa; and **AU/Dec.924 (XXXVIII)** which mandated Africa CDC, working in collaboration with the AUC, AUDA-NEPAD, AMA, AfCFTA and other AU Organs, in all public health aspects including those related to domestic and international health financing, local manufacturing of health commodities, African Pooled Procurement Mechanism, community engagement, digitization of health information systems, and various other innovations in health.
4. Encouraging the efforts towards advancing the local manufacturing of priority health commodities in Africa.

1.2.4. Africa CDC Governing Board: the deliberative body

The Governing Board is the central body that deliberates and weighs th evidence of activies, budgets and strategies, making recomemndations for approval. Ensuring that Africa CDC's autonomy translates into results without compromising accountability. Its core functions include:

- Approval of strategic plans, annual workplans, and budgets.
- Advice on financial management, audit outcomes, and risk mitigation.
- Monitoring institutional performance against agreed indicators.
- Providing strategic guidance to the Director General.

The Governing Board does not manage operations. Its role is to protect the institution's strategic direction and integrity, especially as Africa CDC's financial volume, political visibility, and operational footprint expand.

In 2025, the Governing Board continued to play a pivotal role in ensuring that Africa CDC was well-guided technically and politically as it advanced its work across the continent. This includes, but not limited to:

1. Reviewing and approving the framework for declaring a Public Health Emergency of Continental Security
2. Guiding continental coordinated efforts for multi-country outbreak response, such as MPOX and Cholera.
3. Guided Africa CDC's work to ensure African Health Security and Sovereignty and to advance health financing in the new era.

Why it matters: For Ministers of Finance and Heads of State, the Governing Board is the assurance mechanism that Africa CDC's growing autonomy is executed responsibly and does not create unmanaged fiscal or reputational risk.

1.2.5. Advisory Technical Council: safeguarding scientific credibility

The Advisory Technical Council (ATC) provides independent, expert advice to Africa CDC on technical, scientific, and policy matters. It plays a critical role in:

1. Reviewing evidence on emerging and ongoing health threats.
2. Advising on standards, guidelines, and policy positions.
3. Informing emergency escalation decisions.

The ATC does not make political decisions; it protects the integrity of the evidence on which those decisions rely.

In 2025, the ATC has been instrumental in guiding the Africa CDC on:

1. Reviewing and advising on the Africa CDC 2026 plan and budget, with a critical emphasis on alignment with Member States' priorities.
2. Technical guide on coordinating multi-country outbreak response and PPPR implementation in Africa.
3. Reviewing and providing technical guidance on key continental technical documents, including the Continental Immunisation Strategy.
4. Operationalisation of Africa CDC Regional Coordinating Centres and their linkages with existing regional mechanisms, such as RECs and Regional Health Organisations.

Why it matters: This separation between technical judgement and political authority ensures that Africa CDC's decisions remain credible domestically and internationally, especially when Africa must defend its positions in global forums.

1.2.6. Emergency Consultative Mechanism: governance under crisis conditions

During continental health emergencies, Africa CDC activates a dedicated emergency consultative mechanism, which brings together technical expertise and strategic leadership to advise the Director General. This mechanism ensures that emergency declarations and major response decisions are:

- Based on structured risk assessment.

- Reviewed by recognised experts.
- Communicated through AU political channels.

This design allows Africa CDC to shorten decision timelines without bypassing governance, a critical feature during fast-moving outbreaks.

Why it matters: Emergency governance must operate faster than routine governance, with a higher tolerance for risk given the consequence of inaction or delay. This mechanism provides that necessary balance.

1.2.7. Executive authority: the role of the Director General

The Director General (DG) is the chief executive authority responsible for translating governance decisions into action. Acting within the framework set by the AU, the Governing Board, and advisory bodies, the DG is empowered to:

- Declare and coordinate continental public health emergencies.
- Activate incident management and surge mechanisms.
- Deploy resources and personnel.
- Represent Africa in global health negotiations and coordination platforms.

This concentration of executive authority is intentional. In emergencies, clarity of command saves time and lives.

Why it matters: The Director General's authority comes with accountability—enabling decisive crisis action without governance compromise.

1.2.8. Governance beyond headquarters: regional and national interfaces

Africa CDC's governance architecture extends beyond headquarters. It is designed to function through:

- Regional Coordinating Centres (RCCs), which act as governance and coordination platforms at the regional level.
- Country offices working closely with National Public Health Institutes and Ministries, which retain sovereign responsibility for implementation.

This layered governance model ensures that continental decisions are adapted to regional realities and national systems rather than imposed uniformly.

1.2.9. Transparency, audit, and trust

Governance credibility ultimately depends on transparency. Africa CDC's architecture, therefore, incorporates:

- Internal and external audit mechanisms.
- Risk management and internal control systems.
- Regular performance reporting to AU organs and Member States.

These mechanisms allow Africa CDC to exercise autonomy while remaining open to scrutiny, an essential condition for sustained political support.

What must be protected going forward

For Africa CDC governance to remain fit for purpose, three safeguards are critical:

1. **Respect for role boundaries**: Political bodies set direction; technical bodies advise; executives deliver.
2. **Consistency across leadership transitions**: Governance rules must protect institutional continuity.
3. **Timely decision-making**: Governance processes must remain compatible with emergency response timelines.

1.3 Operating Model: Headquarters, Regional Coordinating Centres, and Member State–Centred Delivery

Africa CDC's operating model is designed to answer one overriding question posed by Heads of State and Ministers: how does a continental institution deliver results in sovereign countries without duplicating national authority or fragmenting action? The answer is a deliberately layered model that combines central strategic leadership, regional operational coordination, and country-owned implementation. This model allows Africa CDC to act at scale while remaining grounded in national systems.

1.3.1. Core operating principle: "Africa CDC without walls"

Africa CDC does not operate as a centralised implementer. Its operating doctrine is "Africa CDC without walls" a model in which authority, data, expertise, and

resources move rapidly to where they are needed, without creating parallel structures that undermine national ownership.

Three principles define this approach:

1. **Subsidiarity** delivery happens at the country level; Africa CDC intervenes only where collective action adds value.
2. **Regionalisation**, coordination, and surge support are organised through Africa's five regions to reflect epidemiological, political, and logistical realities under the coordination of the RCC's.
3. **Central coherence** strategy, standards, financing instruments, and external representation are anchored at headquarters to preserve unity of purpose.

This structure is not theoretical; it reflects the operational lessons of COVID-19, mpox, cholera, and other multi-country events where fragmented coordination delayed action and raised costs.

1.3.2. Headquarters: strategic nerve centre, not an implementing bureaucracy

Africa CDC Headquarters functions as the continental nerve centre. Its role is not to replace national delivery, but to perform functions that cannot be effectively executed at the country or regional level including cross-regional.

Key headquarters functions include:

- **Strategic leadership and policy direction**: Translating AU political decisions into continental strategies, standards, and operational frameworks, including AHSS, PPPR, Lusaka Agenda implementation, digital health governance, and manufacturing and procurement platforms.
- **Continental intelligence and early warning**: Aggregating surveillance data, event intelligence, and risk analysis to identify cross-border threats early and trigger escalation mechanisms when needed.
- **Emergency escalation and coordination authority**: Declaring continental health emergencies, activating incident management mechanisms, and aligning partners and Member States under a single response architecture.
- **Market shaping and pooled procurement instruments**: Managing continental tools such as pooled procurement, financing platforms, and manufacturing coordination that require scale and unified negotiation.
- **External representation and global negotiation**: Acting as Africa's technical and political interlocutor in global health forums, ensuring that African positions are coherent, evidence-based, and collectively endorsed.

Headquarters, therefore, concentrates decision-making authority, standard-setting, and political interface, while deliberately avoiding routine service delivery that belongs closer to communities.

1.3.3. Regional Coordinating Centres: the operational backbone

Africa CDC's Regional Coordinating Centres (RCCs) are the linchpin of its operating model. They translate continental strategy into region-specific operational coordination, recognising that Africa's regions differ in epidemiology, mobility patterns, infrastructure, and political economy.

RCCs serve five critical functions:

- 1. **Regional surveillance and risk coordination**: Supporting cross-border data sharing, joint risk assessments, and harmonised alerts within regions.
- **Operational coordination during emergencies**: Hosting or supporting regional incident coordination, facilitating surge deployments, and aligning partner support across countries.
- **Capacity strengthening and peer learning**: Enabling countries to share practices on PHEOCs, laboratories, genomics, workforce development, and community systems.
- **Interface with Regional Economic Communities (RECs)**: Aligning health security actions with trade, mobility, and border management realities.
- **Rapid proximity to Member States**: Reducing response latency by positioning coordination closer to where outbreaks occur.

RCCs are not independent institutions; they are extensions of Africa CDC's authority, embedded in regional political and operational ecosystems. Their value lies in speed, contextual intelligence, and trust.

1.3.4. Member State–centred delivery: sovereignty as the foundation

At the core of Africa CDC's operating model is a non-negotiable principle: delivery is owned by Member States. Africa CDC strengthens national systems; it does not substitute for them.

This country-centred approach operates through:

- **National Public Health Institutes (NPHIs)**: As the permanent institutional homes for surveillance, laboratories, emergency operations, and technical leadership.
- **Ministries of Health and Finance**: As the sovereign authorities for policy, budgeting, and implementation.
- **Community-level systems**: Including community health workers and local surveillance structures that provide early warning and last-mile reach for health services.

Africa CDC's interventions, such as technical assistance, surge deployments, financing instruments, and pooled procurement, are designed to strengthen national capacity so that countries emerge stronger after each emergency, not more dependent.

1.5.5. The execution flow: how the system works in practice

Africa CDC's operating model follows a predictable execution flow that leaders can rely on:

1. **Detection and intelligence;** events identified through national and regional surveillance.
2. **Risk assessment and escalation:** headquarters consolidates data and determines whether continental coordination is required.
3. **Response activation:** emergency mechanisms and incident management structures are triggered when thresholds are met.
4. **Regional coordination**: RCCs align countries and partners around operational priorities.
5. **Country delivery**: national authorities implement actions, supported by surge capacity, financing, and logistics at a regional and continental level.
6. **Monitoring and accountability**: progress tracked through unified reporting and performance frameworks.

T

his flow ensures that speed does not come at the expense of governance and that accountability is preserved even under crisis conditions.

1.3.6. Why this operating model matters politically

For Heads of State and Ministers, this model delivers three strategic advantages:

- **Faster response without loss of sovereignty**: Countries retain control while benefiting from continental coordination.
- **Reduced fragmentation and duplication**: Partners align behind nationally led plans within a continental framework.
- **Stronger negotiating power**: Africa speaks and acts as one when engaging global markets and institutions.
- **The power of collective action**: Including on operations that cross borders, benefit from collective action such as regional public goods.

This is the practical expression of Africa's Health Security and Sovereignty: not centralisation for its own sake, but structured solidarity that works.

1.3.7. What must be protected to keep the model effective?

To sustain this operating model, three conditions are critical:

1. **Fully functional RCCs across all regions**, with predictable financing and clear authority.
2. **Trust-based data sharing**, under agreed governance frameworks that protect sovereignty and confidentiality.
3. **Respect for role clarity**, avoiding drift toward parallel implementation structures, especially across multi-sectoral and partners' portfolios.

With the mandate (1.1), governance (1.2), and operating model (1.3) established, the report defines how Africa CDC serves as a continental health delivery instrument. In achieving its purpose, the key question is how Africa CDC has strengthened itself institutionally to carry out this responsibility, including its workforce, financial systems, internal controls, and accountability to Member States?

This will be discussed in Section II, related to Institutional Strengthening & Accountability, which demonstrates how Africa CDC matched expanded authority with expanded responsibility.

SECTION 2

Institutional Strengthening & Accountability

2.1 Workforce Growth, Capability, and Diversity

Africa CDC's ability to deliver its continental mandate depends fundamentally on people, their numbers, skills, diversity, and deployment readiness. In 2025, institutional strengthening focused on building a fit-for-purpose workforce capable of operating at emergency speed while sustaining long-term system building. Africa CDC expanded its workforce to 459 in 2025, up from 262 in 2023 (Figure 5), of which 35.3% (162) are women.

Africa CDC has deliberately redefined its workforce as a strategic asset central to sovereignty, rapid delivery, and effective outbreak response, rather than as an administrative support function. Operating in an environment marked by concurrent epidemics, cross-border threats, and limited fiscal space, the institution shifted from under-resourced coordination to execution ready staffing, from dependence on external consultants to strong in-house expertise, and from static headquarters roles to mobile, surge-capable deployment models. Following autonomy, workforce reform focused on filling critical, delivery-aligned positions within an initially fragile staffing structure, with growth carefully sequenced to strengthen operational capacity without creating administrative bloat.

In 2025, Africa CDC had significantly expanded staffing in key areas, including emergency preparedness and response, surveillance, laboratories, digital systems, financing, and procurement, prioritising roles that reduce response times and enhance country support. This strategy emphasised building deep public health capabilities, spanning epidemiology, laboratory science, emergency operations, public health financing, and digital health, through targeted recruitment, structured training, and real-world deployments, ensuring that staff competence is translated into tangible institutional strength.

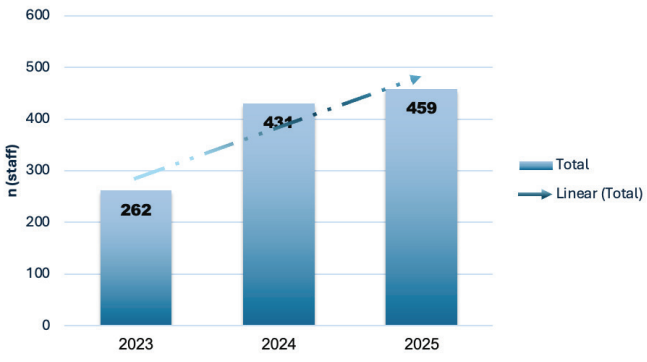


Figure 4: Trend of Africa CDC Workforce Expansion 2023 – 2025

2.1.1. Workforce as a strategic asset, not an administrative function

Africa CDC treats its workforce as a core instrument of sovereignty and delivery, not as a support function. The operating environment in which Africa CDC works, with multiple concurrent outbreaks, cross-border risks, and constrained fiscal space, demands a workforce that is technically credible, geographically distributed, and deployable at short notice.

This strategic framing drove three deliberate shifts:

- from under-staffed coordination to execution-ready staffing
- from reliance on external consultants to institutionalised in-house capability
- from static headquarters roles to mobile, surge-capable deployment models.

2.1.2. Scaling the institution: from fragile baseline to operational strength

At the outset of autonomy, Africa CDC faced a structural constraint: an approved staffing framework that was largely unfilled, limiting its ability to execute its mandate. Institutional reform, therefore, prioritised filling critical posts aligned to delivery, rather than expanding organisational layers.

By 2025:

- Africa CDC significantly increased staffing against its approved structure, prioritising emergency preparedness and response, surveillance, laboratories, digital systems, financing, and procurement.
- Recruitment focused on roles that directly reduce response time, strengthen country support, and enable fiduciary and operational autonomy.
- Staffing growth was sequenced to avoid overextension and ensure that systems, supervision, and accountability kept pace.

This approach ensured that workforce expansion translated into measurable institutional capacity rather than administrative bloat.

2.1.3. Capability: building depth where Africa needs it most

Africa CDC's workforce strategy prioritised critical public health capabilities that determine whether emergencies escalate or are contained early. These included:

- Epidemiology and surveillance, to improve early detection and cross-border risk assessment.
- Laboratory science and genomics, to strengthen variant tracking and diagnostic reach.
- Emergency operations and incident management, to coordinate multi-country responses.
- Public health financing and procurement, to shorten the time from decision to delivery.
- Digital health and data governance, to support real-time intelligence and interoperability between different health information exchange systems.

Capability development combined targeted recruitment, structured training, and operational exposure through deployments, ensuring staff competence was tested in real conditions, not only in planning environments.

2.1.4. Surge capacity: institutionalising rapid deployment

Africa CDC's mandate requires the ability to surge expertise into countries during crises without improvisation. This led to the consolidation of the African Volunteers Health Corps (AVoHC) as a standing surge mechanism.

In 2025:

- The AVoHC roster expanded to approximately 1,180 trained responders across multiple disciplines.
- Surge deployments became routine rather than exceptional, supporting outbreak response, laboratory scale-up, and emergency coordination.
- Deployment protocols were standardised to ensure speed, accountability, and alignment with national authorities.
- This institutionalisation of surge capacity transformed solidarity from a political statement into an operational reality.

2.1.5. Diversity and representation: legitimacy through inclusion

Africa CDC's workforce reflects the continent it serves. Diversity is not symbolic; it underpins legitimacy, trust, and effectiveness in a politically diverse environment.

Key dimensions of workforce diversity include:

- Geographic representation, ensuring that Africa CDC's staff composition spans AU regions and linguistic blocs.
- Gender balance, particularly in leadership and technical roles.
- Interdisciplinary expertise, bridging health, economics, logistics, digital systems, and policy.

This diversity strengthens Africa CDC's ability to collaborate credibly with Member States and to represent Africa collectively in global forums.

As of 31st December 2025, all African Union regions are represented at Africa CDC, with 44 AU Member States having formal representation. This diverse workforce brings a wide range of perspectives, experiences, and problem-solving approaches, significantly enhancing decision-making quality across the organisation.

Figure 5: Workforce Geographical Representation across AU Regions

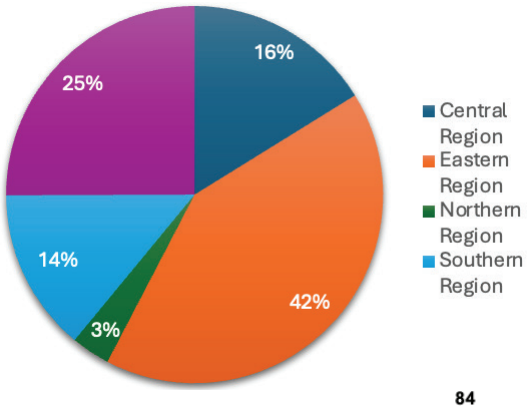
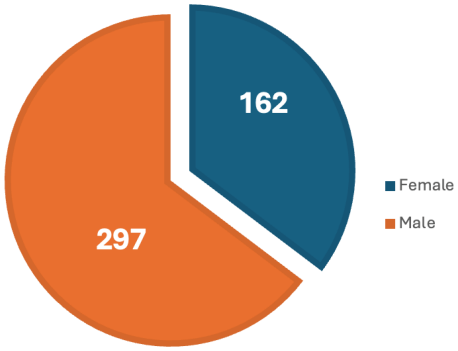


Figure 7: Gender Representation of Workforce Strength



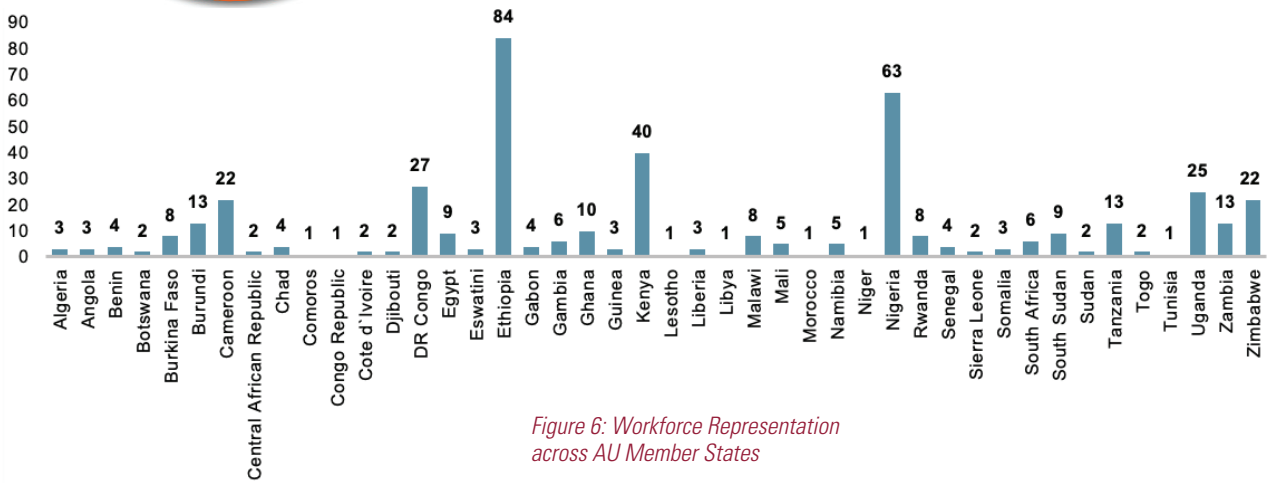


Figure 6: Workforce Representation across AU Member States

Beyond improved decision-making, workforce diversity has also contributed to greater innovation, stronger stakeholder engagement, enhanced risk management, and improved staff performance. These factors collectively lead to higher organisational effectiveness, resilience, and impact.

Africa CDC's talent acquisition strategy attracts a diverse workforce to work with the organisation across different capacities and modes of recruitment, including regular, fixed-term, ALD (Appointment based on Limited Duration), seconded staff, and consultants.

44 AU Member States are represented by staff members at Africa CDC.

2.1.6. Performance culture: accountability at individual and institutional levels

Workforce strengthening in 2025 was coupled with clear expectations for performance and accountability.

Africa CDC reinforced:

- Role clarity linked to strategic priorities
- Performance monitoring aligned with institutional objectives
- A shift from activity reporting to result accountability

This performance culture is essential for sustaining political trust, especially as the Africa CDC's autonomy and resource envelope expand.

To ensure meaningful performance management, in 2025 Africa CDC automated its staff performance appraisal system to accommodate all staff categories and provide ongoing support for its implementation. The system has been instrumental in learning and development initiatives, with staff submitting their personal development plans and supervisors identifying their staff's learning needs.

In 2022, Africa CDC had a nascent organisational structure with 82 staff, no competency framework, and HR policies that were fully dependent on the AU Commission. By November 2025, it had become a structured continental organisation with:

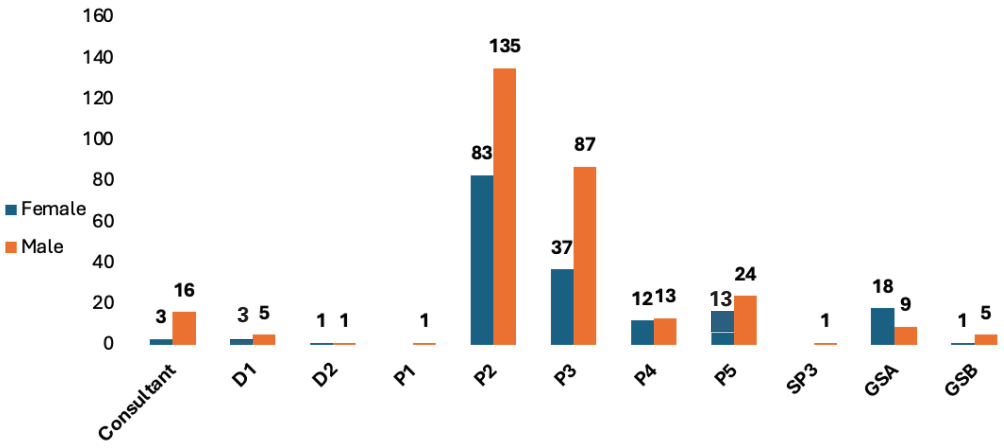


Figure 8: Gender Distribution by Grade

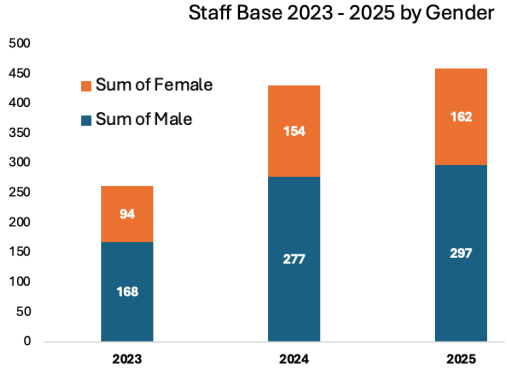


Figure 9: Staffing strength 2023-2025

- A modern Performance Management System and Competency Framework tied to the 2023–2027 Strategic Plan.
- Regular training, leadership development, and succession planning mechanisms anchored by the Africa CDC Academy.
- An Africa CDC "employee handbook" development that provides comprehensive references for staff policies, procedures, and expectations that guide employment, conduct, performance, and organisational operations. All employees are expected to read, understand, and comply with the guidance outlined.

These reforms have professionalised the Africa CDC and strengthened its credibility as a continental employer of choice.

Organisational Workforce Growth and Structure

Key result: Africa CDC doubled its workforce capacity in three years while maintaining gender balance and technical diversity.

Human Capital Development and Learning Systems

Africa CDC launched the Africa CDC Academy, a continental capacity-building centre that coordinates training across RCCs and Member States.

Between 2023 and 2025:

- **1,874 staff and Fellowship participants** completed technical or leadership courses.
- **Kofi Annan Global Health Leadership Program (KAGHLP)** graduated two cohorts and inducted a third (35 fellows per cohort).
- **Ministerial Executive Leadership Program (MELP)** trained 45 Ministers of Health and over one hundred senior officials.
- **African Epidemic Service (AES)** launched three training tracks: Applied Epidemiology, Public Health Informatics, and Laboratory Leadership, with initial cohorts of 10–20 fellows each.

These initiatives expanded Africa CDC's internal and external pipelines of public health leaders.

Regional Deployment and Field Support

As part of the decentralisation agenda, Africa CDC deployed sixty-eight staff to RCCs in Gabon, Kenya, Nigeria, and Zambia to coordinate field activities for surveillance, EPR, and laboratory programmes.

Example – Mpox Response 2024:

Over 100 technical experts and 400 community health workers were mobilised across 29 countries under RCC-coordinated frameworks, a first in CDC's history of continental operations. This shift towards regional presence has reduced response times for Member State requests by approximately 35 per cent compared with 2022 levels.

Table 1: Human Resource Key Performance Indicator Results (2022 - 2025)

Indicator	2022	2025	% Change	Data Source
Total staff	262	459	+75%	Africa CDC HR Database
Number of Female Staff	94 (36%)	162 (35%)	+72%	Africa CDC HR Database
Senior Leadership Female Representation (Heads of Divisions, Directors, and above)	1/15 (6.7%)	7/36 (19.4%)	+12.7 pp	Africa CDC HR Database
Total staff based at RCCs	62	128	+107%	Africa CDC HR Database
Total new hires	15	75	+400%	Africa CDC HR Database
Annual staff turnover rate	0	8 (1.7%)	New	Africa CDC HR Database
Africa CDC staff capacity built or trained in different core capacities for Individual Development Plans (IDPs) and Institutional Development	20	151	+655%	Africa CDC HR Database

Gender and Inclusion

Africa CDC mainstreamed gender equality into workforce planning through the Gender in Preparedness Framework (2024).

Key commitments and progress:

- Target: 40% female representation in workforce by 2027 –Achieved 35% in 2025.
- Gender focal points in each RCC and division.

Organisational Culture and Staff Well-Being

Africa CDC has introduced organisational culture reforms aimed at retaining talent, strengthening teamwork and team performance, and reinforcing a unified "mission-first" ethos across the institution.

Africa CDC established a Staff Counsellor position in 2025 to provide dedicated support for the psycho-social well-being, resilience, and overall mental health of its employees. In the third quarter, Management launched a series of structured listening sessions across the institution to better understand staff morale, team dynamics, and opportunities for improvement. Based on the feedback received, a comprehensive workplan has been developed and is now being implemented and monitored to strengthen workplace culture, staff well-being, and satisfaction.

These include career development discussions and mental health support for staff engaged in prolonged emergency operations.

2.1.7. What must be safeguarded going forward

To protect workforce effectiveness, three priorities require continued attention:

- Retention of critical skills, especially in high-demand technical areas.
- Further progress on female representation
- Continued investment in leadership and management capacity, not only technical expertise.
- Sustaining morale and integrity under high-pressure emergency conditions.

A capable workforce can only deliver if supported by sound financial systems and transparent governance. Subsection 2.2 will demonstrate how Africa CDC strengthened financial management, fiduciary controls, and transparency to match its expanded mandate and growing scale of operations.

2.2 Financial Management, Transparency, and Institutional Autonomy

As Africa CDC's mandate, political visibility, and resource envelope grew, Member States and partners expected proof that autonomy translates into faster delivery without compromising transparency, control, or accountability.

Table 2: Summary – Institutional Systems and Human Resources Capacity (2022 vs 2025)

Dimension	2022 Baseline	2025 Status	Progress Assessment
Staffing levels	82 staff	459 staff	Significant growth
HR governance	No manual or policy	Full HR and ethics manual adopted.	Achieved
Performance management	Absent	Results-Based Management (RBM), performance appraisals, and a quarterly review cycle are in place.	Achieved
Capacity building	Ad hoc trainings	Africa CDC academy and leadership programs are operational.	Achieved
Digital integrated systems	Manual records	ERP procured; deployment 2026.	30% of the project executed; technical specifications and SOPs finalised for system readiness.

2.2.1. Financial autonomy as an enabler of speed and credibility

Financial autonomy is not an end. For the Africa CDC, operational conditions enable continental decisions to translate into timely action, especially during emergencies when delays cost lives and undermine confidence.

By 2025, Africa CDC had operationalised core elements of financial autonomy:

- Direct receipt and management of funds aligned to approved programmes.
- Autonomous financial planning and execution within AU-approved frameworks.
- Ability to commit and disburse resources rapidly during emergencies.

Without this autonomy, Africa CDC would remain dependent on intermediaries, extending response timelines and diluting accountability. With it, Africa CDC can function as a true continental instrument while remaining accountable to Member States.

2.2.2. From fragmented funding to disciplined portfolio management

Africa CDC's financial strengthening focused on moving away from fragmented, project-by-project financing toward portfolio-level management aligned with institutional priorities.

Key features of this shift include:

- A consolidated budget framework aligned with the Strategic Plan and AHSS priorities.
- Integration of core and partner-financed activities under a single planning and reporting structure ("One Plan, One Budget, One Report").
- Clear linkages between financing, results, and AU oversight cycles.
- This approach reduces transaction costs for Member States and partners and strengthens Africa CDC's ability to demonstrate value for money at the institutional level, not only at the project level.

2.2.3. Transparency and control: systems that protect Member States

Africa CDC's expanded financial role is underpinned by strengthened internal controls and transparency mechanisms, designed to protect both the institution and its Member States from fiduciary and reputational risk.

By 2025, Africa CDC:

- Established and operationalised internal audit and oversight functions.
- Implemented enterprise risk management, including a formal risk register and mitigation tracking.
- Strengthened anti-fraud, ethics, and safeguarding frameworks.
- Subjected operations to multiple layers of audit (internal, external, and partner-specific).
- Established a transparent audit tracker which facilitated learning, compliance, and timely action and implementation of recommendations. In 2025, Africa CDC underwent nine audits, including the annual audit by the AU Board of External Auditors, two internal audits, an independent forensic audit, and five donor-specific audits.

To strengthen financial controls and reduce operational risk, the organisation implemented a cashless policy, ensured monthly bank reconciliations across all accounts, and accelerated the recovery of VAT and outstanding vendor balances. The 2024 Africa CDC Financial Statements were audited and verified by external auditors, confirming the integrity of the organisation's financial reporting.

In addition, closing reports were established for the COVID-19 Fund and the Mpox Special Account. The Africa Epidemic Fund (AfEF) Operational Guidelines were issued after consultation with the AU Committee of Fifteen Ministers, with the opening of the AfEF Account.

For Ministers of Finance, these systems provide assurance that Africa CDC's autonomy does not expose national or continental resources to unmanaged risk.

2.2.4. Emergency financing: shortening the distance from decision to action

One of the most visible dividends of financial reform is Africa CDC's ability to finance emergency responses more quickly.

In 2025:

- Africa CDC deployed a continental emergency financing instrument that significantly reduced the time between emergency decision and funds reaching operations.
- Emergency resources could be aligned rapidly with incident management structures, surge deployments, and procurement needs.

This capability transforms political declarations into operational reality and reinforces confidence in continental coordination.

2.2.5. Accountability to AU organs and Member States

Financial autonomy operates within a clear accountability framework:

- Regular financial and performance reporting to the CHOSG, Governing Board and AU oversight bodies.
- Alignment with AU budgetary and audit processes.
- Transparent communication of resource mobilisation, allocation, and utilisation.

This accountability anchors Africa CDC's legitimacy as an autonomous institution acting on behalf of Member States. Strong financial management is inseparable from modern internal systems, effective human resources, transparent procurement processes, integrated digital platforms, and robust risk management. Subsection 2.3 will outline how Africa CDC has reformed its internal systems to enable scale, enhance efficiency, and strengthen accountability across all delivery pillars.

2.3 Internal Reforms and Systems Strengthening

Africa CDC's expanded mandate and autonomy demanded more than additional resources; it required a fundamental redesign of internal systems to enable the institution to operate at scale, respond quickly, and withstand sustained scrutiny. In 2025, internal reform was treated as a strategic enabler of delivery, not merely an administrative task. Key reforms focused on four critical areas: establishing a Quality Management System and pursuing ISO 9001 certification; institutionalising risk management; operationalising Results-Based Management (RBM); and adopting the Decision Quality Framework.

Figure 10: Key Policy Documents Published Towards Africa's Financial Self-Reliance

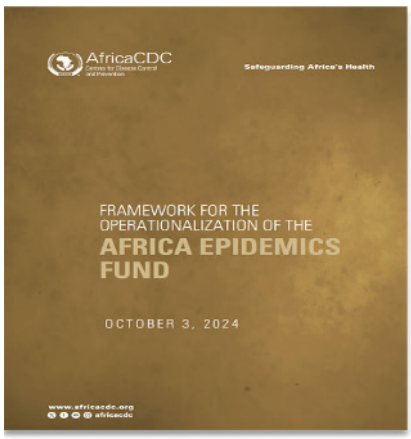


Figure 11: Transformation of Africa CDC internal systems for operational efficiency

Establishment of a Quality Management System and ISO 9001 Certification

Africa CDC began the establishment of a Quality Management System (QMS) aligned with ISO 9001:2015 standards. Starting with a diagnostic assessment of existing workflows, followed by the systematic development of standard operating procedures and institution-wide capacity building. Internal audits and pre-certification assessments have been initiated to strengthen process integrity and compliance readiness. The institution aim to be certification ready with formal ISO certification anticipated in early 2026 and regular audits scheduled thereafter every 1 to 2 years.

Institutionalisation of Risk Management

In 2025, Africa CDC established the Office of Internal Oversight (OIO), integrating audit, risk management, compliance, ethics, and investigations into a unified governance structure. The launch of an institutional Risk Register enhanced real-time monitoring of financial, operational, and reputational risks.

The institution completed its first stand-alone external audit, conducted by KPMG and the AU Board of External Auditors, and finalized compliance assessments across all RCCs and headquarters. This was supported by staff capacity building and the development of 8 key oversight tools and policies to institutionalize accountability and strengthen governance over the coming years.

Institutionalisation of Results-Based Management (RBM)

Africa CDC in 2024-2025, institutionalised RBM as the core framework for performance accountability, integrating project proposals, budgets, and annual work plans with Business Units, staff, and organizational performance. Progress is tracked through a comprehensive Performance Indicator Reference Sheet (PIRS) compendium, which is publicly available, and an internal database that tracks performance, monitors milestones and outcomes. Transparency was enhanced through public-facing tools, including the Mpox dashboard, weekly media briefings, and joint press statements. A "Report a Concern" grievance mechanism was also introduced to enable stakeholder feedback and redress.

Adoption of Decision Quality (DQ) Frameworks

Africa CDC operationalised the Organisational Decision Quality (ODQ) Framework in 2025 to strengthen programmatic delivery through evidence-based, accountable decision-making. The framework integrates standardised processes, a strengthened Programmatic Delivery Committee, decision-support tools, and ongoing capacity-building. All programmatic decisions are assessed against six quality dimensions, ensuring alignment with the institution's mandate and global standards. In 2026, the ODQ Handbook and tailored continuous training for divisions and RCCs will support full institutionalisation.

From Dependence to Financial Independence

In 2022, Africa CDC's budgeting, procurement, and accounting processes operated fully within the African Union Commission's centralised financial management framework. While this ensured alignment with AU-wide systems and standards, it also presented operational challenges, including reduced flexibility during emergencies and limited visibility for some partners regarding fund utilisation.

By November 2025, Africa CDC had transformed into a financially autonomous institution capable of receiving, managing, and reporting directly on donor resources, including those of the World Bank, EU HERA, Gavi, CEPI, AfDB, UK FCDO, among others. This achievement marks

the most profound shift in Africa CDC's institutional history.

The Africa CDC completed the due diligence review by the UK Foreign, Commonwealth and Development Office (FCDO). This enabled the UK to proceed with direct disbursements to the Africa CDC. Additional accreditations were initiated with the Pandemic Fund, and in 2026, accreditations will be initiated with the EU and the Green Climate Fund.

Integrated Finance Architecture

Africa CDC instituted an Integrated Finance System (IFS) that aligns budgeting, treasury, accounting, grants, and procurement within a single governance framework.

Financial Performance and Budget Execution

In 2025, Africa CDC achieved its highest financial performance, with record revenue and budget implementation. This was achieved through a drive-for-results culture supported by monthly and quarterly management reviews of progress on planned activities and budget execution.

World Bank Project Performance

The World Bank Project is a core part of Africa CDC's institutional strengthening. Of the 2025 expenditure, approximately $35 million was World Bank funds. The following shows the financial performance of the grant since 2022.

The disbursement trajectory shows a marked acceleration from FY2025 onward, reaching 43.8% ($44.2M) by the end of the year. This shift follows operational enhancements implemented after the World Bank's recommendations in mid-2024, including expanded use of direct payments and simplified procurement. These measures complemented CDC's strengthened financial autonomy and execution capacity, resulting in faster conversion of approved activities into disbursements. Disbursement is projected to reach 70% in 2026 and 100% by 2027.

Percentages reflect cumulative disbursement figures reported in the World Bank ISR and may differ from cash-based figures in the financial annexes.

Budget Utilisation and Expenditure Patterns

In 2025, Africa CDC executed **US$143.2 million of its 151 million** mobilised and approved budget, its highest execution rate since inception.

Grants Management and Donor Diversification

Africa CDC's grants portfolio grew from US $52 million in 2022 to US $463 million by 2025, across 66 active grants. Key sources include the World Bank (21%), AfDB (6%), Governments (8%), Philanthropies (52%), Gavi (3%), Global Fund (1%), EU (4%), and multilateral institutions (5%).

To manage this expanding portfolio, Africa CDC implemented a Grants Lifecycle Management Framework,

Table 3: Milestones in Financial Architecture Development (2022–2025)

Stage	Period	Key Actions Implemented	Resulting Outcome
Baseline (2022)	Before Project Effectiveness	All Financial Operations Processed Through AUC; No Independent Accounts or Audit Mechanisms.	Delayed Disbursements and Limited Budgetary Flexibility.
Transition Phase (2023)	Q1 – Q4 2023	Created Finance Directorate with Dedicated Budget, Treasury, And Grants Units;	Financial Reporting Standards Aligned With AU
Operational Autonomy (2024)	Q1 – Q4 2024	Opened Africa CDC Bank Accounts with Authorised Signatories for Donor Receipts; Implemented Financial Management Manual and Standard Operating Procedures (Sops).	First Direct Donor Transfers from the World Bank Were Recorded.
Institutionalisation (2025)	Q1 – Q4 2025	Introduced Enterprise Risk Management (ERM), Including an Organisation-wide Risk Registry; Established an Office of Internal Audit and Oversight; Establishe ESG, Safeguarding, Anti-fraudi and corruption policies; Updated the Internal Control Framework; Procured an Enterprise Resource Planning (ERP) Platform for Automation of Finance, HR, And Procurement.	Financial Data Integration and Quarterly Performance-based Reporting Were Initiated.

Source: Mid-Year Report 2025, pp. 45–49, and Annual Report 2024, pp. 38–40.

Overall Africa CDC financial performance in 2025

Budget Category	Approved	Budget Execution	%
Operational Budget	5,691,876	5,691,876	100%
Program Budget	56,488,228	54,665,766	97%
Technical Assistance (TA)	88,816,742	82,794,594	93%
Total	**150,996,847**	**143,152,236**	**95%**

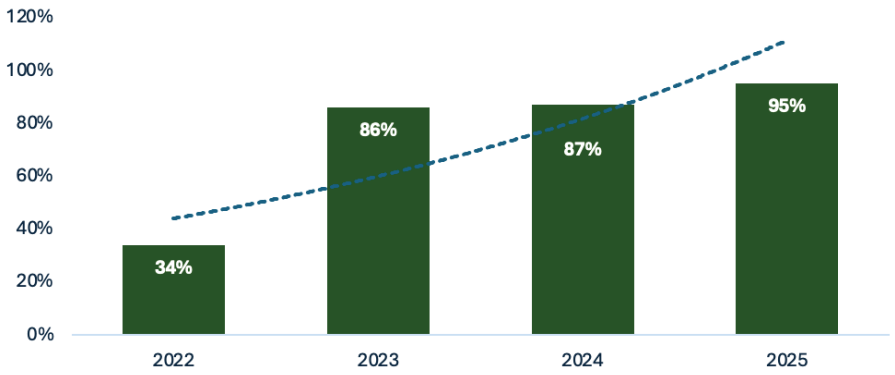


Figure 12: Africa CDC Budget Trend 2022 – 2025

standardising project approval, disbursement, and M&E processes across divisions and RCCs. All donor agreements now include country-level accountability clauses and joint reporting mechanisms.

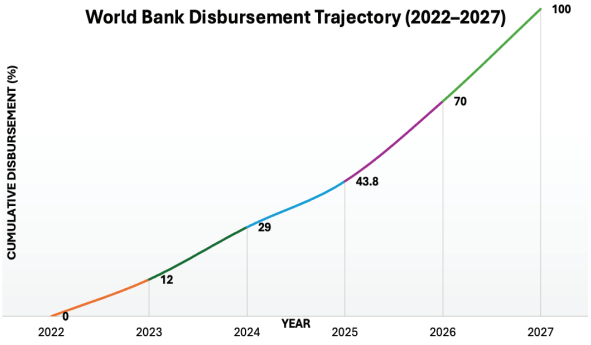


Figure 13: World Bank Disbursement Trajectory (2022 - 2025) (Adapted from World Bank ISR (August 2025) and Africa CDC Finance Dashboard)

Internal Controls and Audit Mechanisms

Africa CDC strengthened fiduciary assurance through three complementary instruments:

1. **Office of Internal Audit (OIA)** – established 2025; **Risk Register** – institutionalised; tracks financial, operational, and reputational risks with mitigation actions.

External Audit Engagement – Africa CDC's 2025 financial statements under review by the AU Board of External Auditors and an independent firm (KPMG).

Value for Money and Efficiency Gains

Africa CDC's transition to direct procurement and pooled purchasing generated measurable savings:

Financial Governance and Accountability

Africa CDC adopted a Financial Governance Charter (2024) defining the roles of the Director General, Deputy DG, and Director of Finance in budget approval and oversight. The Charter mandates quarterly financial review meetings and annual budget hearings with the Governing Board.

Additionally, the institution launched an mpox Financial Transparency Dashboard (2025) that tracks donor commitments and actual disbursements. This platform feeds into the G20 Joint Health and Finance Task Force monitoring system, a first for an African institution.

What must be protected and strengthened?

To sustain financial credibility, three priorities require continued attention:

1. **Consistency in financial reporting standards** across all funding streams.
2. **Ongoing investment in financial systems and staff capacity** as volumes grow.

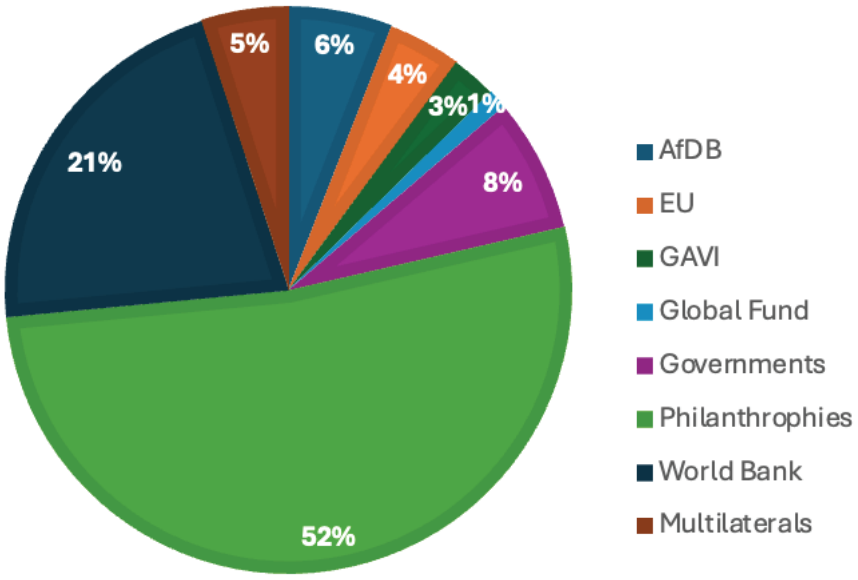


Figure 14: Composition of Africa CDC Grant Portfolio (2025)

Table 4: Milestones in Financial Architecture Development (2022–2025):

Parameter	Baseline (Oct 2022)	Status (Aug 2025)	Target (July 2027)	Remarks
IDA Grant (US $ million)	0	**44.20 of 101.93 (43.76 %)**	100 %+	Accelerated post-MTR through direct payment and procurement plan revision.
PDO Rating	N/A	Satisfactory	Satisfactory	Improved from Moderately Satisfactory (2023).
Intermediate Results Indicators (achieved/total)	0 / 14	10 / 14	14 / 14	90 % completion expected by 2026.
Financial Reporting Compliance	N/A	Quarterly Financial Monitoring Reports (FMRs) on schedule.	Full automation via ERP.	Timely submission confirmed by Bank TTL.

Table 6: Audit and Control Enhancements

Instrument	Adopted	Outcome
Financial Management SOPs	2024	Standardise financial processes across HQ and RCCs.
Enterprise Risk Management	2025	Organisation-wide risk registry and risk management included in quarterly monitoring.
Independent Audits (External)	2025	A complete audit scope, including internal audits, external audits, and forensic examination
ERP Procurement	2025	Automation of Finance and HR modules by 2026.

Table 7: Efficient gain through pooled procurement

Efficiency Metric	2022	2025	(%) Chang	Comment
Average procurement lead time (days)	180	92	–49 %	Post-ERP process simplification and supplier frameworks.
Average payment processing time (days)	45	25	–46.8%	Direct payment mechanism approved by WB 2024.
Funds absorption rate (World Bank grant)	0 %	43.8 %	New	Acceleration after autonomy.

Table 8: Summary – Financial Maturity Assessment (2022 vs 2025)

Dimension	2022 Baseline	2025 Status	Progress Assessment
Financial autonomy	No independent accounts.	Own bank accounts and direct receipts operational.	Achieved
Budget execution capacity	34 %	95%	Achieved
Disbursement efficiency (World Bank)	0 %	43.8 %	On track
Risk management	Absent	Risk Register and OIA operational.	Achieved
Audit readiness	None	External audit in progress.	Achieved
Automation	Manual reporting	ERP procured and in configuration.	Substantial

3. **Clear political backing for autonomy**, especially during emergencies when speed is essential.

Strong financial management is inseparable from modern internal systems, including human resources, procurement, digital platforms, and risk management. Subsection 2.3 will show how Africa CDC reformed its internal systems to support scale, speed, and accountability across all delivery pillars.

2.3. Reform of Internal Systems

2.3.1. Reform logic: systems must serve execution, not procedure

Africa CDC's internal reforms were guided by a few question: Do existing systems accelerate or delay delivery? Do they improve transparency? Do they drive efficiency? Where systems slowed decision-making, obscured accountability, or fragmented authority, they were redesigned. The objective was to replace legacy, compliance-heavy processes with fit-for-purpose systems aligned to emergency-grade operations, while remaining fully compliant with AU rules and international standards.

This reform logic prioritised:

- clarity of roles and decision rights
- predictability of processes under pressure
- transparency for oversight bodies and partners.

As part of this effort, Africa CDC strengthened its institutional safeguards, including financial controls, risk management, audit responsiveness, conflict-of-interest measures, grievance redress, and protection against fraud and misuse of resources. These reforms were designed not only to improve operational efficiency but to reinforce the integrity, transparency, and accountability expected of a continental public health agency.

Table 9: Financial and Grants Management Key Performance Indicator Results 2022-2025

Indicator	2022	2025	% Change	Source
Growth of partnership portfolio with functional frameworks	8	46	+475%	MOU Tracking Database
Total value (in USD) of new financial resources mobilised	$ 52,000,000	$463,000,000	+890%	Grant Management Database
Africa CDC's Partnership and Resource Mobilisation Strategy developed	None	80% completed (under validation; rollout in 2026)	New	Africa CDC PIRS Database (2025)

The reforms included a roll-out of the following initiatives:

- Management Structure for coordination, decision-making, risk management, teamwork, and performance
- Performance management of workplans, results and finances
- Strengthened Internal Control Framework
- Office of Internal Oversight
- Enterprise Risk Management, including risk registry and risk champions
- Program Implementation Unit (PIU)
- Environmental, Social, and Governance (ESG) Policy
- Anti-fraud and anti-corruption measures, including whistleblower protections and digital tracking.
- Safeguarding Policy

2.3.2. Organisational structure: aligning the form with function

Africa CDC implemented a revised organisational structure approved by AU oversight bodies to reflect its evolving mandate. The structure was designed around delivery functions, not administrative silos, and organised to support the AHSS agenda and PPPR responsibilities.

Key features include:

- clearer separation between strategic leadership, technical delivery, and enabling functions.
- consolidation of overlapping functions to reduce fragmentation
- structured interfaces between headquarters, Regional Coordinating Centres, and country-facing teams.

Phased implementation ensured that staffing growth, supervision, and accountability mechanisms remained aligned.

2.3.3. Human resources systems: from staffing to performance management

Internal HR reforms moved beyond recruitment to address performance, integrity, and institutional culture.

Africa CDC strengthened:

- job architecture linked to strategic priorities
- performance management systems that connect individual objectives to institutional results
- codes of conduct, ethics, and safeguarding mechanisms to protect institutional credibility
- staff development pathways to retain critical skills and reduce reliance on short-term consultancy.

These reforms underpin a professional workforce capable of operating in high-pressure environments while upholding AU values.

2.3.4 Performance Management and Results-Based Culture

In 2024, Africa CDC introduced a comprehensive Results-Based Management (RBM) system that links individual performance to organisational goals. A set of organisational results linking all continental programmes and partners' contributions is developed, published and regularly reviewed to ensure transparency and accountability. The application of the RBM framework within institutional practices ensures that the organisation moves from project- or programme-based to result-based planning, implementation, tracking and reporting.

Core elements include:

1. **Quarterly Performance Reviews** integrated into the Institutional Dashboard.
2. **Annual performance monitoring** for Directors and RCC Heads aligned with the strategic objectives of the Strategic Plan.

3. **Midterm and End Term Evaluation** of the Strategic Plan and its associated indicators in the PIRS.
4. **Developing an organisational-wide learning agenda** to track lessons and ensure continuous improvement in the delivery of results.
5. **Incentive and Recognition System** rewarding innovation, gender leadership, and collaboration.
6. **Continuous capacity building and change management on RBM** completed by all Directors and technical leads in 2024.
7. **Introducing Organisational Decision Quality (ODQ)** to ensure quality programmatic delivery based on quality and evidence-based decisions.

HR Policies and Ethics Framework

Africa CDC adopted a set of foundational governance and HR policies in 2023–2024 to reinforce ethical and transparent operations. All staff receive mandatory ethics and AU values orientation at onboarding and upon signing the AU Oath of Office.

2.3.4. Procurement and operations: enabling speed with control

Procurement and operational systems were reformed to support rapid yet accountable execution, particularly during emergencies.

Improvements included:

- streamlined procurement workflows with defined thresholds and approval pathways.
- clearer delegation of authority to reduce bottlenecks.
- strengthened contract management and vendor oversight.
- alignment of procurement planning with programme and emergency needs.

The result is an operations backbone that can support surge deployments, emergency purchasing, and large-scale programmes without compromising fiduciary standards.

In 2025, 92.3% of planned procurements were successfully completed, totalling USD 25.5 million in contract value. In addition, over 1,100 operational procurements valued at USD 11 million were executed in full compliance with applicable procurement policies and standards. To support programme implementation and emergency response operations, 6,900 travel tickets were issued, totalling USD 8.2 million. To strengthen consistency, transparency, and accountability, Africa CDC has initiated certification of its supply chain systems and the rollout of an e-procurement platform, scheduled to become fully operational in 2026.

Beyond operational procurement, Africa CDC, through its Supply Chain Division, facilitated the procurement and delivery of vaccines, cold chain equipment, diagnostics, and in-country logistics (ICL) support, totalling an estimated USD 69.7 million and benefiting approximately 35 Member States. As part of its capacity-strengthening mandate, Africa CDC also trained health and humanitarian supply chain professionals to enhance national and regional preparedness and response capabilities.

In parallel, a continental supply chain maturity dashboard was developed and is fully operational, providing a snapshot of supply chain capacity across Member States. The insights generated will inform tailored technical

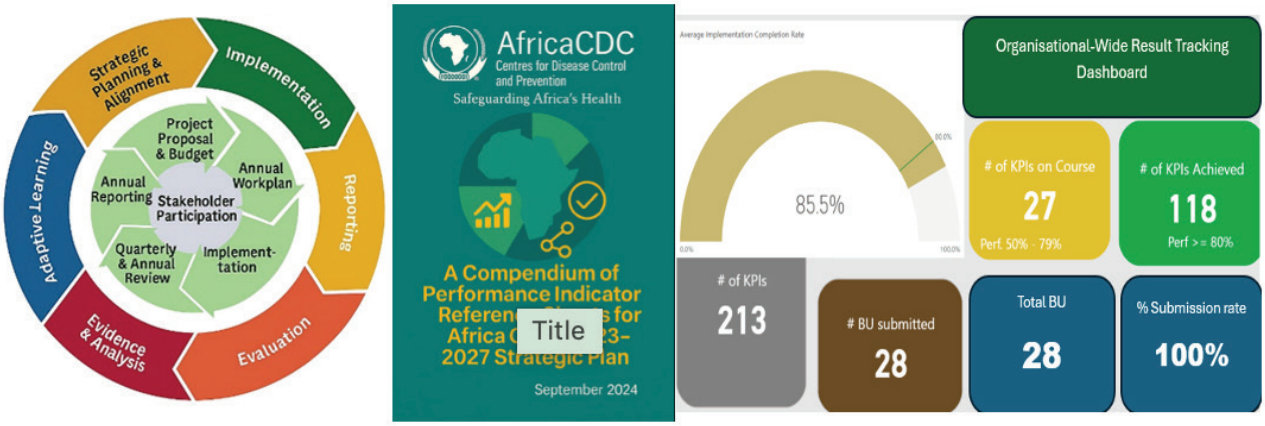


Figure 15: from the left, Organisational-Wide RBM cycle, compendium of organisational indicators and iterative monitoring dashboard.

support based on identified gaps. Africa CDC has also led strategic initiatives such as MedFlow, which aims to identify and address bottlenecks in health and humanitarian logistics by convening heads of customs, ministries of health, and other key stakeholders to jointly diagnose challenges and recommend practical solutions.

2.3.5. Digital and information systems: toward real-time institutional intelligence

Africa CDC invested in modernising its digital backbone to enable real-time visibility over operations, finances, and performance.

Key advances include:

- improved data integration across programmes and regions
- digital tools to support surveillance, emergency coordination, and reporting.
- strengthened information security and data governance frameworks.

These systems reduce information asymmetry, support faster decision-making, and improve accountability to Member States.

Institutional Business Process Automation and Digital Integration

Africa CDC has embarked on a phased approach to automate institutional business processes and integrate digital systems to enhance efficiency, transparency, and data-driven operations. As an interim measure, a suite of digital platforms has been deployed to streamline high-volume internal transactions and operational workflows while a long-term Enterprise Resource Planning (ERP) solution is being developed.

Key Results:

As of 2025, the interim systems were designed to quickly fill critical operational gaps, reduce manual workload, and deliver immediate efficiency gains while the broader ERP is still under design and procurement. This phased strategy ensures that divisions can begin benefiting from automation and improved data visibility without waiting for the full ERP rollout. To address immediate operational needs, a central business platform comprising modules such as the Staff Portal and Approvals Management (APM) was introduced. The system manages:

- Staff profiles
- Employment contracts
- Performance Planning Agreements (PPAs)
- Leave management.
- Weekly task tracking and reports
- Quarterly travel matrix
- Activity Request Form (ARF)
- Request for Services (RQS)
- Travel memos approvals (special, single and change requests)

This digitisation has replaced multiple manual processes, increased efficiency, and reduced turnaround time for key administrative functions.

In addition, 11 specialised digital systems were developed to support divisional priorities, including: research prioritisation tracking; CPHIA payments and registration; legal and registry services; financial operations; emergency preparedness and response; local manufacturing workflows; complaints management; asset management; digital museum archiving and internal knowledge sharing via intranet.

Insights from operating these interim systems will directly inform the design, configuration, and migration pathways of the ERP, ensuring a smooth, efficient transition to a fully integrated enterprise platform.

ERP as a Game-Changer

The vision is to establish a comprehensive ERP system that will serve as the digital backbone for Africa CDC, seamlessly integrating finance, HR, procurement, logistics, operations and project management. The ERP will also link headquarters and all RCCs, enabling real-time reporting, programme tracking, and evidence-based decision-making.

Expected Benefits (2026 onward)

- Fully automated salary and allowance management
- Paperless recruitment, leave, and HR operations.
- Real-time linkage between HR performance and budget execution
- Enhanced accountability, transparency, and organisational efficiency
- Unified data systems supporting strategic planning and oversight across all levels.

2.3.6. Risk management and internal controls: institutionalising foresight

Internal reforms placed strong emphasis on risk management, recognising that scale and visibility increase exposure.

- enterprise risk management processes with active risk registers
- internal control frameworks embedded in routine operations.
- mechanisms to track and close audit findings systematically.

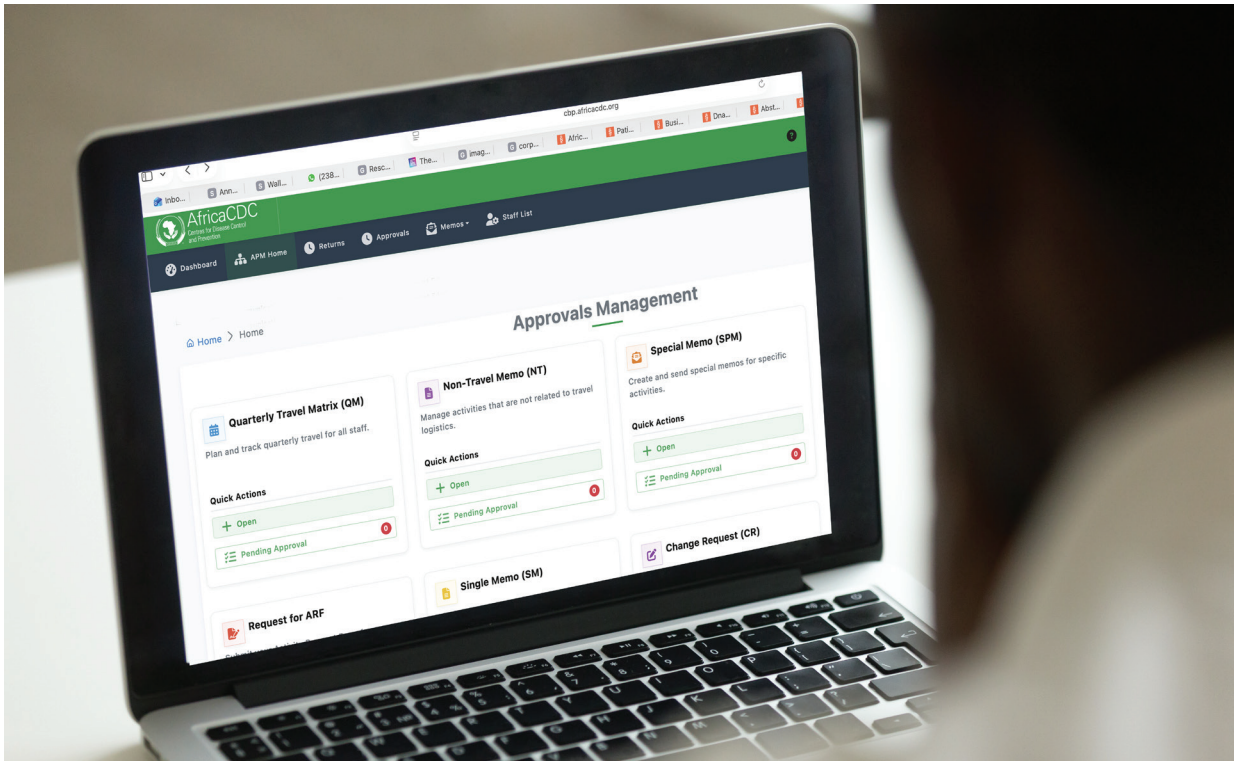


Figure 16: Dashboard of the Africa CDC Central Business Platform

This shift from reactive compliance to proactive risk management protects the institution's autonomy and reputation.

2.3.7. Why these reforms matter politically

For Heads of State and Ministers, internal reform is not an internal matter; it is a sovereignty safeguard. Systems that enable fast, accountable execution ensure that political decisions taken at the AU level are faithfully and credibly implemented. Conversely, weak systems would undermine confidence and invite external control.

With internal systems strengthened, the final element of institutional credibility is external accountability. Subsection 2.4 will explain how Africa CDC reports to, engages with, and remains answerable to Member States and AU organs, closing the accountability loop that sustains trust in continental action.

2.4 Accountability to Member States

Africa CDC's legitimacy ultimately rests on accountability to the governments and people of Africa. Autonomy without accountability would weaken trust; accountability without autonomy would paralyse action. In 2025, Africa CDC consolidated a model of accountability that allows the institution to act at emergency speed while remaining answerable to Member States through clear political, financial, and performance channels.

2.4.1. Accountability as a political obligation, not a reporting exercise

Africa CDC understands accountability as a political obligation to Member States, not merely compliance with reporting requirements. As an autonomous organ of the African Union, Africa CDC is accountable for:

- how it exercises delegated authority
- how it uses collective resources
- how it translates continental decisions into country-level impact.

This framing ensures that accountability reinforces sovereignty rather than constraining it.

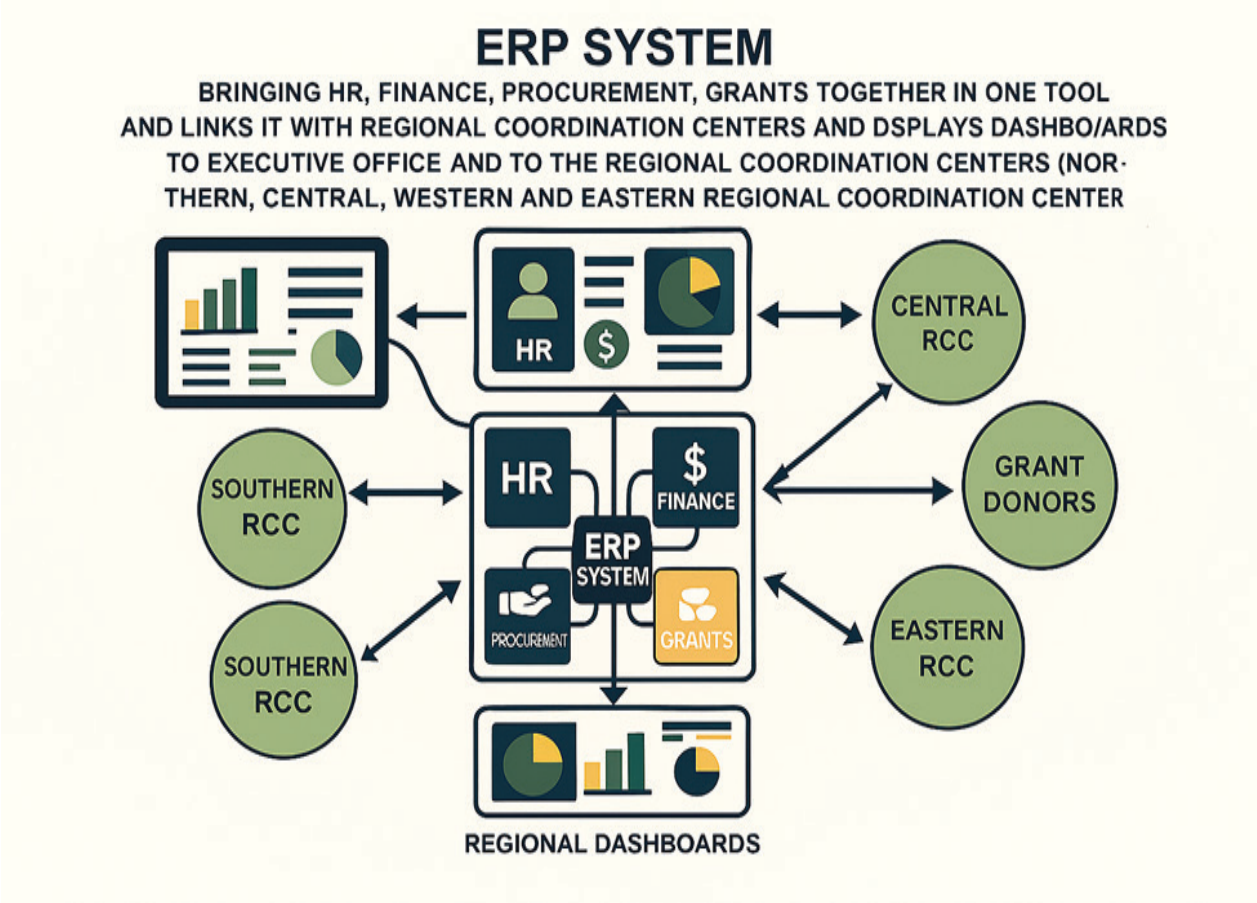


Figure 17: Africa CDC Digital Workforce Ecosystem (2025).

2.4.2. Formal accountability to AU decision-making organs

Africa CDC formally and regularly reports to AU statutory organs, ensuring its actions remain aligned with the collective political direction.

Key accountability pathways include:

- Reporting to the AU Assembly and Executive Council through structured updates on mandate delivery, emergency actions, and strategic priorities.
- Oversight by the Governing Board, including review of annual plans, budgets, financial statements, audit findings, and institutional risks.
- Engagement with Permanent Representatives and relevant AU committees, enabling continuous political dialogue and feedback.

This multi-layered reporting ensures that Africa CDC's authority remains anchored in Member State consensus.

2.4.3. Performance accountability: result-based

Africa CDC's accountability framework emphasises results over activities. The institution reports against agreed strategic objectives and indicators, enabling Member States to assess:

- whether Africa CDC's actions reduced response time and fragmentation
- whether continental tools strengthened national capacity
- whether resources are translated into measurable outcomes.

The "One Plan, One Budget, One Report" discipline enables leaders to see the full picture across emergency response, preparedness, financing, and system strengthening rather than fragmented project narratives.

2.4.4. Financial accountability and fiduciary assurance

Financial accountability is a central pillar of trust between the Africa CDC and Member States.

Africa CDC ensures this through:

- transparent financial reporting aligned with AU standards.
- independent audits and systematic follow-up on

audit recommendations
- disclosure of resource mobilisation, allocation, and utilisation
- integration of financial risk management into institutional decision-making.

For Ministers of Finance, these mechanisms provide assurance that Africa CDC's autonomy strengthens, rather than weakens, collective fiscal responsibility.

2.4.5. Accountability through engagement, not distance

Africa CDC's accountability model is interactive, not distant. It includes:

- continuous engagement with Ministries of Health and Finance
- structured consultations during emergencies and major policy shifts
- feedback loops through regional and continental forums.

This approach ensures that accountability is lived and responsive, rather than episodic and retrospective.

2.4.6. Transparency to partners as a function of Member State accountability

Africa CDC's transparency with partners is not donor-driven; it is a consequence of accountability to Member States. By maintaining high standards of transparency and reporting, Africa CDC protects Member States from reputational and fiduciary risk and strengthens Africa's collective negotiating position.

2.4.7. Why accountability strengthens sovereignty

Effective accountability enables the Africa CDC to:

- act decisively without fear of political backlash.
- retain the confidence of Member States during crises.
- resist fragmentation and external capture.
- sustain legitimacy as Africa's continental public health authority.

In this sense, accountability is not a constraint it is the institutional condition that makes sovereignty operational.

With institutional strengthening and accountability established, the report now turns outward to context: Why does Africa require a Health Security and Sovereignty agenda now?

African Leaders Champion the Call to Fight Cholera

SECTION 3

Africa's Health Landscape in 2025
Why AHSS Matters Now

Africa's health context in 2025 explains why the Africa Health Security and Sovereignty (AHSS) agenda is no longer optional. The continent is navigating a convergence of epidemiological risk, fiscal stress, and geopolitical fragility that turns health shocks into macroeconomic, security, and legitimacy shocks. This section sets the evidence-based case for AHSS as a strategic response to that reality.

3.1 Epidemiological Overview: Persistent and Emerging Risks

Africa's disease burden in 2025 is characterised by simultaneity and scale. Longstanding endemic threats, such as cholera, measles, malaria, meningitis, and yellow fever, coexist with emerging and re-emerging pathogens, including mpox and viral haemorrhagic fevers. Climate variability, rapid urbanisation, and population mobility intensify transmission dynamics, while fragile border health systems allow local outbreaks to become regional threats. A dramatic increase of public health events is happening in Africa from 153 reported in 2022 to 242 and 213 reported in 2024 and 2025 respectively (*Figure 22*).

Crucially, outbreaks now overlap in time. Multiple countries face concurrent public health events, stretching surveillance, laboratory, and response capacity. This pattern undermines the effectiveness of episodic, country-by-country responses and validates the need for continental intelligence, surge capacity, and pooled tools.

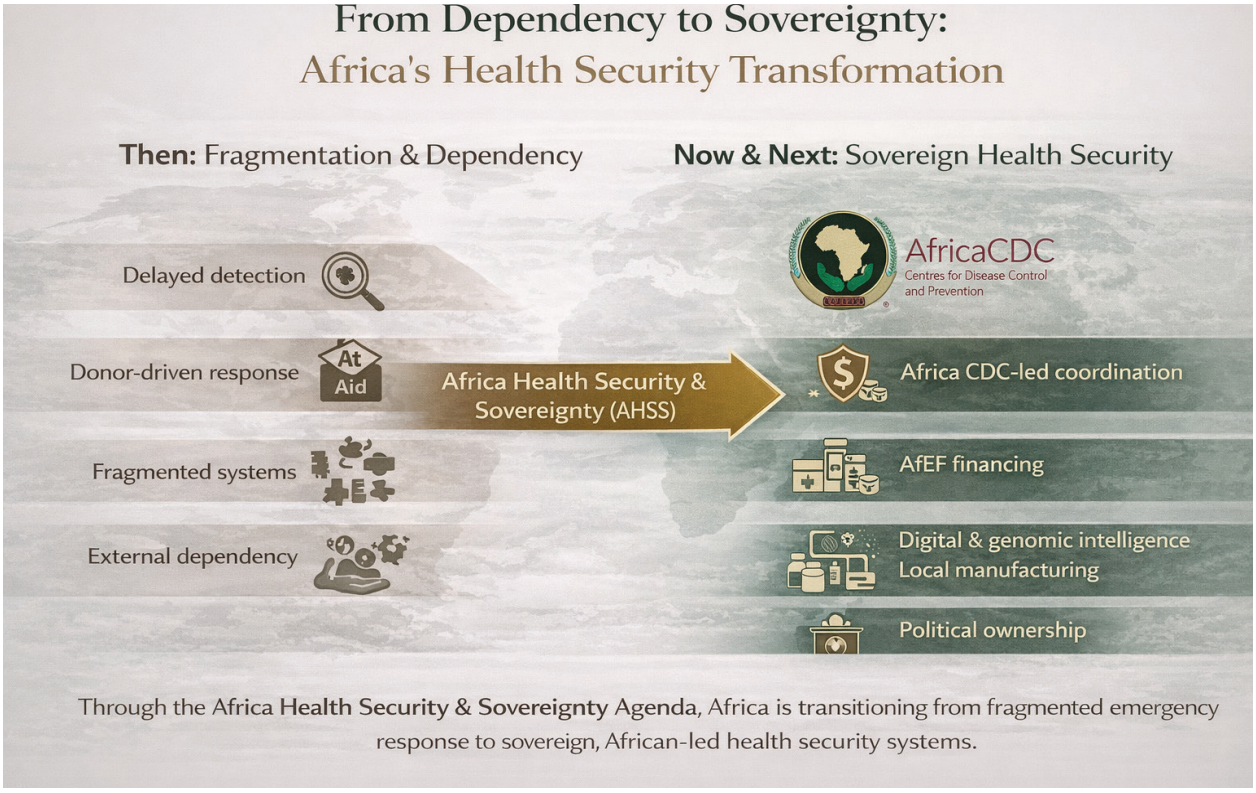


Figure 18: From Dependency to Sovereignty: Africa's Health Security Transformation.

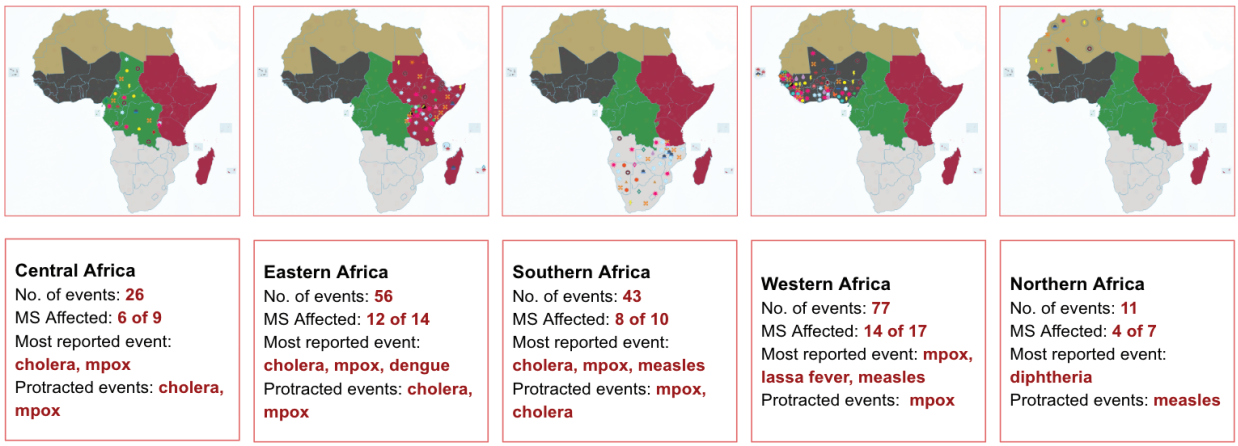


Figure 19: Multi-hazard outbreak map (2025) showing concurrent epidemics by region (Africa CDC surveillance dashboards).

3.2 Financing Context: Shrinking Fiscal Space and Rising Household Burden

Africa's health financing environment in 2025 is structurally constrained. Public budgets face competing demands from debt servicing, energy, food security, and security expenditures. External development assistance is increasingly unpredictable and, in several contexts, declining in real terms. As a result, households continue to shoulder a disproportionate share of health costs through out-of-pocket payments, exposing families to financial shock during health emergencies.

This financing profile weakens preparedness and amplifies inequity. When outbreaks occur, delayed financing leads to delayed response, raising total costs and avoidable mortality. The evidence underscores a central AHSS premise: without domestic and innovative financing mechanisms anchored in national systems, health security remains reactive and fragile. Through its Africa's Health Financing in a New Era concept note, Africa CDC recommended strengthening domestic financing, introducing innovative financing mechanisms, and harnessing blended financing to address the health financing gap on the continent.

3.3 Geopolitical and Supply-Chain Vulnerabilities

Health security in 2025 is inseparable from geopolitics. Global supply chains for vaccines, diagnostics, and medical commodities remain concentrated and vulnerable to export restrictions, price volatility, and strategic prioritisation by producing countries. During recent emergencies, Africa experienced delayed access, fragmented allocation, and price dispersion despite bearing a substantial share of disease burden.

These vulnerabilities are compounded by logistics bottlenecks, limited cold-chain capacity, and fragmented procurement. The result is strategic dependency at precisely the moment when rapid access is most critical. AHSS responds directly to this risk by advancing pooled procurement, regional manufacturing, regulatory reliance, and market-shaping instruments that reduce exposure to external shocks.

3.4 Implications for Africa's Security and Sovereignty

Health shocks now carry security implications. Large outbreaks disrupt labour markets, trade corridors, education systems, and public confidence in institutions. In fragile settings, they exacerbate instability; in stable settings, they impose unplanned fiscal reallocations and growth losses.

From a sovereignty perspective, dependence on exter-

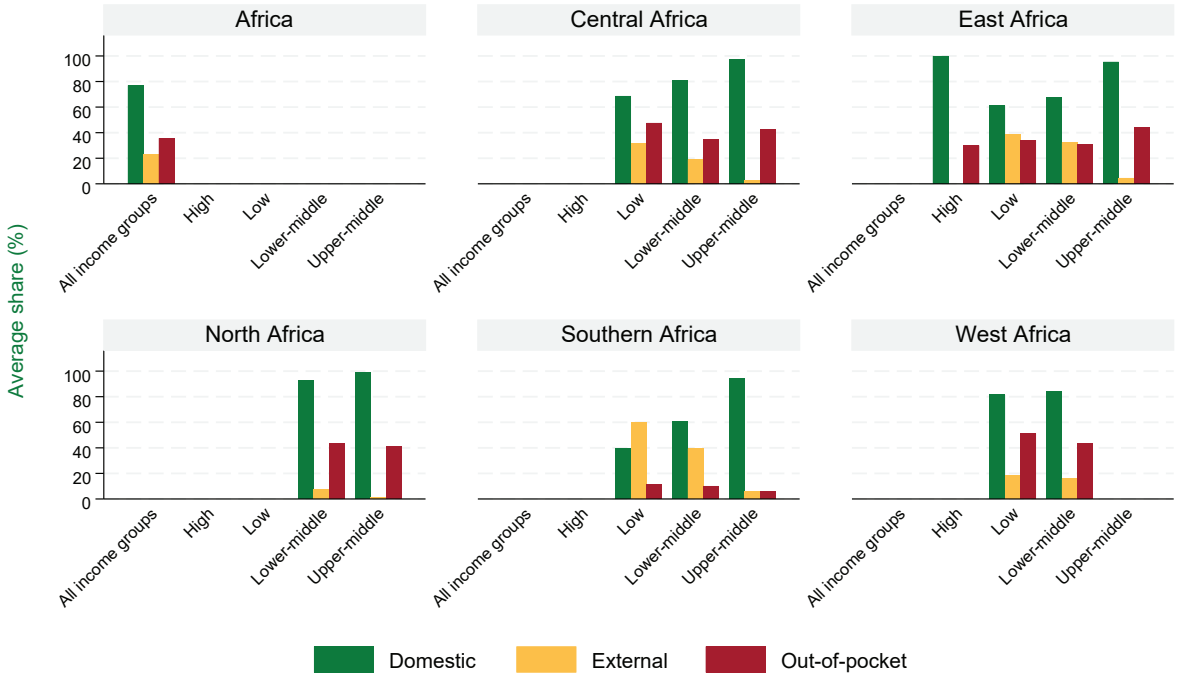


Figure 20: Composition of health spending by source (government / DAH / out-of-pocket/prepaid), Africa and sub-regions (Source: WHO 2025)

nal triggers, financing, and allocation decisions weakens national agency. When countries cannot determine when to escalate, how to finance a response, or where to source countermeasures, political authority erodes. AHSS reframes health security as a core function of the state and the Union, comparable to border security or financial stability.

3.5 Why AHSS is the Strategic Response

AHSS addresses the 2025 reality through five integrated moves:

1. **Continental leadership in global health architecture** to ensure Africa sets agendas rather than reacts to them.
2. **Preparedness, prevention, and response (PPPR)** anchored in continental surveillance, surge, and emergency financing.
3. **Sustainable health financing** that reduces dependence and protects households.
4. **Digital transformation and data sovereignty** for real-time intelligence and interoperability.
5. **Local manufacturing and pooled procurement** to secure access and stabilise markets.

Together, these pillars convert fragmentation into structured solidarity and vulnerability into operational sovereignty. With the case for AHSS established by epidemiological, fiscal/economic, and geopolitical evidence, the report now turns to delivery. Section IV presents the results by AHSS pillar, demonstrating how Africa CDC translated strategy into measurable outcomes for Member States, what worked, what changed on the ground, and what remains to be done.

Section IV presents result by AHSS pillar, demonstrating how Africa CDC translated strategy into measurable outcomes for Member States what worked, what changed on the ground, and what remains to be done.

5 Pillars

AFRICA'S HEALTH SECURITY AND SOVEREIGNTY AGENDA

1. **Reformed and Inclusive Global Health Architecture**
2. **Institutionalise Continental PPPR Agenda**
3. **Predictable, Domestic, Innovative and Blended Financing**
4. **Digital Transformation**
5. **Local Manufacturing**

SECTION 4

Delivering the AHSS Agenda
Results by Pillar

4.1 Pillar 1: Strengthening Global Health Architecture & African Leadership

4.1.1. Why This Pillar Matters

For decades, global health governance has been shaped outside Africa, even when decisions directly affected African lives, economies, and stability. This asymmetry was most evident during crises, when Africa faced delayed access to countermeasures, fragmented guidance, and limited influence over global decision-making.

AHSS Pillar 1 addresses this structural imbalance. Its objective is not symbolic representation but institutional leadership: ensuring that Africa has the authority, credibility, and operational capacity to shape global health rules, influence resource allocation, and coordinate responses that reflect African realities. In 2025, this pillar focused on positioning countries in leadership roles, with Africa CDC as the continental coordinator and anchor of the African voice, coordinating with global organisations that support countries and regional entities.

4.1.2. Key Results in 2025

Africa CDC achieved a qualitative shift from participation to coordination and leadership across global and continental platforms.

Africa CDC's Role in Positioning Africa within the Global Health Architecture

Africa CDC has strategically repositioned Africa from a passive recipient to an active architect in global health governance. Key achievements include:

Strategic Frameworks for Sovereign Engagement: The launch of the **Africa Health Security and Sovereignty (AHSS) Agenda** has reframed Africa's priorities around health sovereignty, local manufacturing, digital innovation, and domestic financing. This agenda directly challenges traditional dependency models and asserts African agency in setting the global health agenda.

Diplomatic Anchoring of Continental Reforms: Africa CDC serves as the **Continental Secretariat for the Lusaka Agenda**, a landmark AU-endorsed framework. In this role, Africa CDC coordinates with major Global Health Initiatives (e.g., GAVI, the Global Fund) to align their investments with African priorities, thereby strengthening the continent's collective leverage and coherence in global forums.

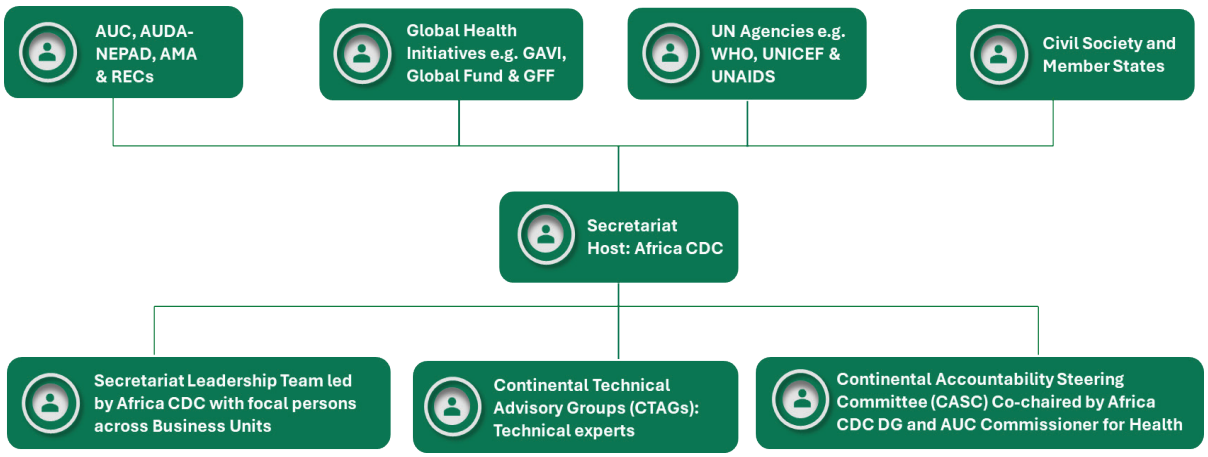


Figure 22: Implementation framework for the Lusaka Agenda

- **Leadership in Global Negotiations:** Africa CDC provided the technical and diplomatic anchor for Africa's unified engagement in critical multilateral processes. This was exemplified in the **WHO Pandemic Agreement negotiations**, where Africa CDC coordinated the African Common Position to embed principles of equity, solidarity, and sovereignty. The agency also led continental deliberations on **Pathogen Access and Benefit-Sharing (PABS)**, ensuring African scientific and economic interests are protected in the new global regime.
- **Convening High-Level Reform Dialogues:** The **Sandton High-Level Convening on Global Health Reforms** (November 2025) was an Africa-led platform to co-design actionable proposals for reforming the fragmented global health architecture. This initiative positioned Africa as a sovereign co-architect seeking equitable partnerships and mutual accountability.
- **Strategic Institutional Partnerships:** Landmark agreements, such as the elevated **WHO-Africa CDC Partnership Framework**, transform the relationship from operational coordination to strategic alignment. Partnerships with **ECDC, RKI, and Global Health EDCTP3** are strategically managed through Africa CDC as the institutional gateway, ensuring cooperation aligns with continental priorities like workforce development, research, and manufacturing.

Africa CDC's Leadership in Coordinating Continental Public Health Efforts.

Africa CDC has consolidated its role as the continent's central technical and coordinating public health authority, translating political mandates into concerted action. Key achievements include:

Operationalisation of Governance Structures: Africa CDC has fully operationalised its statutory organs, the **Advisory and Technical Council (ATC)**, **Governing Board (GB)**, and **Committee of Heads of State and Government (CHSG)**. These bodies have adopted critical frameworks, including the **Public Health Emergencies of Continental Security (PHECS)** declaration mechanism and the Continental Immunisation Strategy, and providing clear governance for collective action on continental health sovereignty.

- **Unified Continental Voice and Political Leadership:** By working closely with AU policy organs, Africa CDC ensures a **unified African position** in global forums like the World Health Assembly, G7, and G20. The CHSG has consistently anchored health as a top-tier political issue, expanding Africa CDC's mandate to represent Member States on the governance boards of major global health mechanisms. As directed by the African Union, Africa CDC played a central role in advancing African priorities within ongoing global discussions on pandemic preparedness, financing, and coordination mechanisms. African perspectives, particularly on equity, regional manufacturing, pooled procurement, and emergency financing, were increasingly reflected in global policy debates.
- **Driving Cross-Sectoral Integration:** Africa CDC exercises diplomatic leadership on interconnected challenges through a **One Health approach**. It co-chairs the African Union Task Force on Antimicrobial Resistance (AMR) and launched the **Climate Change and Health Strategic Framework**, fostering multisectoral collaboration and advocating for Africa-specific responses in global climate-health discourse.
- **Building Sustainable Diplomatic Capacity:** The launch of the **Global Health Diplomacy Fellowship** addresses a critical structural gap by systematically training a cadre of African diplomats and policy leaders. This initiative aims to institutionalise health diplomacy skills across the continent, ensuring sustained African leadership in future negotiations.
- **Integrating Technical and Political Advocacy:** Africa CDC effectively **translates data into diplomatic leverage**. By maintaining continent-wide surveillance and using political scorecards and dashboards, it provides an evidence base for African positions and elevates health security outcomes to the level of Heads of State, turning information into a tool for accountability and strategic negotiation.
- **Institutional leadership in emergency governance:** Africa CDC exercised its continental authority to declare a Public Health Emergency of Continental Security (PHECS) during the mpox outbreak, triggering unified African action and synchronising escalation with global mechanisms. This action demonstrated Africa's ability to lead emergency governance internally, rather than relying solely on external declarations.
- **Strengthened continental political leadership:** Africa CDC worked closely with AU political leadership and designated champions to elevate health security as a strategic and economic issue, not a sectoral concern. Health security was positioned alongside trade, industrialisation, and digital transformation in continental political discourse.

Building Diplomatic Capacity through the Global Health Diplomacy Fellowship.

Launched in 2025, the Africa CDC Global Health Diplomacy Fellowship aims to strengthen the continent's capacity to advance African health priorities in global forums. Key Achievement include:

- **Steering Committee for the fellowship inaugurated:** The inaugural Steering Committee e-meeting was held in Cape Town, South Africa, in September 2025. During the meeting, the committee finalised the curriculum, nominated subject matter experts, and agreed on the M&E documentation and the fellowship prospectus.
- **Developing the fellowship prospectus:** The prospectus has been finalised and will be circulated to all Member States, inviting eligible candidates to apply for the fellowship. In 2026, the first cohort of the Global Health Diplomacy Fellowship will be admitted.

4.1.3. Country & Political Impact

The impact of Pillar 1 is measured not only in statements, but in changed dynamics for Member States:

- **Alignment:** External aid with national plans, increasing domestic health investment, using country systems, and strengthening primary care/health systems for Universal Health Coverage
- **Greater negotiating leverage:** Countries engaged global partners through a continental platform rather than as isolated actors, improving coherence and bargaining power.
- **Reduced policy confusion:** Unified continental guidance reduced contradictory advice during emergencies.
- **Faster political alignment:** Africa CDC–led positions, informed by Heads of State and Ministers, during crises, shortening the time between recognition of risk and collective action.
- **Enhanced legitimacy of national decisions:** National emergency actions gained political cover and credibility when anchored in continental consensus.

For Ministers of Health and Finance alike, Africa CDC's leadership reduces transaction costs and political risk in engaging with the global system.

4.1.4 What's Next

To consolidate gains under Pillar 1, Africa CDC will focus on:

1. **Unifying the voice of Member States:** Representing Africa within global health initiatives
2. **Institutionalising Africa's leadership role** Embedding Africa CDC's authority formally within reformed global health governance arrangements, ensuring continuity beyond individual crises.
3. **Deepening political coordination** Strengthening structured engagement with AU Heads of State and Ministers to maintain health security as a standing political priority.
4. **Aligning global reforms with African systems** Ensuring that new global mechanisms reinforce rather than bypass continental and national institutions.
5. **Protecting unity of voice** Maintaining coherence across Africa's diverse political and epidemiological contexts while allowing flexibility for national implementation.

With Africa's leadership position in global health governance increasingly established, the next test is operational: Can Africa prevent, detect, and respond to pandemics faster and more effectively at scale and under pressure?

Figure 23: Overview of the scholarship in global health diplomacy

Figure 24: Africa CDC as Africa's Continental Early Warning & Decision Nerve Centre

4.2 Pillar 2: Pandemic Prevention, Preparedness & Response (PPPR)

4.2.1 Why This Pillar Matters

Pandemics and epidemics are no longer rare or isolated shocks; they are systemic and recurrent risks with far-reaching consequences for health, economies, social cohesion, and state legitimacy. For Africa, the cost of delayed detection and a fragmented response is measured not only in lives lost but also in socioeconomic impacts, including disrupted trade, constrained fiscal space, eroded development gains, and weakened public trust in public institutions.

Africa Health Security and Sovereignty (AHSS) Pillar 2 responds to this reality by advancing a decisive paradigm shift from reactive crisis management to anticipatory preparedness and coordinated response. This pillar is anchored in strengthened national public health systems and reinforced by interoperable continental mechanisms, ensuring that threats are detected early, decisions are taken collectively, and responses are deployed rapidly, predictably, and at scale.

The strategic objective is clear: no African country should be left alone to face PHE, and no outbreak should escalate because of delayed coordination, fragmented financing, or lack of access to expertise.

This objective has been operationalised through the establishment of the Incident Management Support Team (IMST), Africa's new model for multi-country epidemic response, designed to harmonise action across the community, national, regional, and continental levels.

Under the IMST model, responses are guided by the 4-One Principles: *one team, one plan, one budget, and one monitoring and evaluation framework*. This approach ensures unity of command, clarity of roles, accountability, and efficiency, replacing ad-hoc, parallel, and donor-driven arrangements with a single, Africa-led operational architecture. The model reinforces the principle that countries lead, regions coordinate, and global partners support and align technical assistance and resources behind national priorities.

The relevance of Pillar 2 was clearly demonstrated during the continental mpox response, which marked the first full activation of the IMST at scale. Following more than one year of intensified operations on mpox response, Africa CDC leveraged the set structure to address cholera as the primary continental priority, in response to the Call to Action by African Union Heads of State and Government, under the leadership of the AU Champion, H.E. Hichilema, President of Zambia. This transition underscored a critical shift: Africa CDC's preparedness and response systems are no longer disease-specific or temporary, but flexible, multi-hazard, and institutionalised.

The President of Zambia and AU Champion for Cholera, H.E. Hakainde Hichilema, delivered an inspiring address on Africa's local manufacturing agenda during the WHO AFRO Regional Committee Meeting held in Lusaka, Zambia

AHSS Pillar 2, therefore, constitutes the operational backbone of Africa's capacity to detect, respond to, and recover from public health emergencies. Over the past decade, Africa has experienced an estimated 150–200 outbreaks annually, a burden intensified by climate change, rapid urbanisation, population mobility, fragile health systems, and persistent inequities in access to medical countermeasures.

In 2025 alone, 213 public health events were reported, with the highest in the Western Africa region, including 65 high-risk events, 138 moderate-risk events, and 10 low-risk events. In this context, fragmented, short-term, or donor-dependent arrangements are no longer viable.

What is required and what Pillar 2 delivers is a permanent, institutionalised, continent-wide preparedness and response mechanism, anchored in African leadership, capable of rapid coordination and surge, and designed to build the foundations of true health security and sovereignty. Through the IMST and the 4-One Principles, Africa CDC has begun to translate continental political resolve into measurable action and impact, ensuring that future outbreaks are met with speed, coherence, and collective strength.

In 2025, Africa CDC demonstrated that this shift is underway. Under the authority of Assembly Decisions AU/Dec.835 (XXXV) and AU/Dec.924 (XXXVIII), the institution moved decisively from reactive crisis management to initiative-taking, structured, and sovereign preparedness. The cornerstone of this architecture is the IMST, co-chaired by Africa CDC and WHO but politically directed by the African Union. IMST provides a single continental platform through which outbreaks are detected, assessed, decisions are escalated, and coordinated allowing a unified approach to continental emergency response coordination while building resilience of response capabilities in Member States. Its activation during multi-country mpox, cholera, Marburg Virus Disease and Ebola events in 2025 showed unprecedented coherence and speed. Thirty-two Member States engaged directly in the mpox and Cholera IMST, sharing real-time data, harmonizing surveillance protocols, aligning vaccination strategies, and coordinating risk communication.

The mpox response is emblematic of what institutionalized preparedness means in practice. By the end of 2025, thirty-one Member States had reported mpox outbreaks with more than 183,000 suspected cases and 1,924 deaths. Through IMST-coordinated efforts, Africa CDC secured 4.8 million mpox vaccine doses and supported the administration of 1.13 million doses in thirteen countries ensuring access to vaccines are not determined by GDP but by burden of disease. Testing capacity was expanded to reach more than 98 percent of affected countries, with laboratory decentralization in the most heavily impacted areas. Over 2,000 community health workers and technical experts were deployed to support surveillance, case management, and risk communication, and a DHIS2-based continental mpox surveillance module was co-developed with Member States to standardize reporting and accelerate real-time data flows. As a result, hospital infection was reduced by 50%, twenty-nine countries are now experiencing drastic declines in cases like Sierra Leone, one of the highest burdened countries, has now reported zero cases for more than a month. A differentiated transition roadmap was also developed, classifying countries by epidemiological context and embedding mpox into routine public health emer-

gency managment systems of countries rather than treating it as an exceptional event.

Cholera provided a second major test of Africa's evolving emergency architecture. In 2025, twenty Member States faced significant cholera outbreaks driven by climate-influenced water and sanitation failures and rapid urbanization. Under the leadership of H.E. President Hakainde Hichilema, AU Champion for Cholera Response, Africa CDC convened affected countries and partners to operationalize the Continental Cholera Response Plan 1.0, launched in Lusaka in August 2025. The plan integrates cholera into the IMST structure, establishes national presidential taskforces, and aligns accelerated action toward cholera elimination by 2030 with Agenda 2063. It combines enhanced surveillance, WASH interventions, case management, oral cholera vaccine deployment, and cross-border coordination while driving local manufacturing of Medical Countermeasures (MCM). Countries reported faster detection, more streamlined resource mobilization, and more coherent communication strategies, with significant reductions in the time between outbreak confirmation, IMST activation, and operational response.

Central to this pillar is surveillance and early warning. The 213 Public Health Events reported in 2025 is a sign that surveillance systems are becoming more sensitive. Event-Based Surveillance (EBS) was expanded to 38 Member States, with 35 adopting Africa CDC guidance and fifteen fully launching EBS implementation. To support this, Africa CDC trained 195 surveillance experts and 2,678 community health workers in four pilot countries specifically on event-based detection. Taken together with cumulative efforts since 2021, a total of 1,099 surveillance officers and 3,476 community health workers across 38 countries have been capacitated to detect and report unusual events, ranging from atypical clinical patterns and animal deaths to climate anomalies and social media signals, well before they escalate into crises.

The expansion of early warning has not been limited to human health signals. Africa CDC advanced the One Health agenda by coordinating multi-sectoral technical working groups that updated national signal lists, integrated zoonotic surveillance into routine systems, and piloted environmental and wastewater surveillance. These innovations are critical as climate change accelerates vector-borne diseases, floods, droughts, and heat-related health events.

The launch of the AU Climate and Health Strategy, the updated AMR Framework (Version 2.0), and the draft Continental Wastewater Surveillance Framework positions Africa to detect climate-driven threats earlier and with greater precision. In parallel, the Epidemic Intelligence Management System (EMS) was deployed in seven countries, enabling real-time data capture, analytics and forecasting that allow countries to anticipate outbreaks months in advance rather than merely reacting once case numbers surge.

The role of Regional Coordinating Centres (RCCs) has been critical in embedding this architecture across the continent. In Southern Africa, preparedness capacities were significantly strengthened through the provision of USD 1 million worth of cold-chain and PHEOC support equipment to Lesotho and Zambia. This investment enhanced vaccine readiness, rapid-response capability, and temperature-controlled storage for emergency commodities. Technical assistance provided to Eswatini and Zimbabwe accelerated progress towards establishing National Public Health Institutes (NPHIs), while

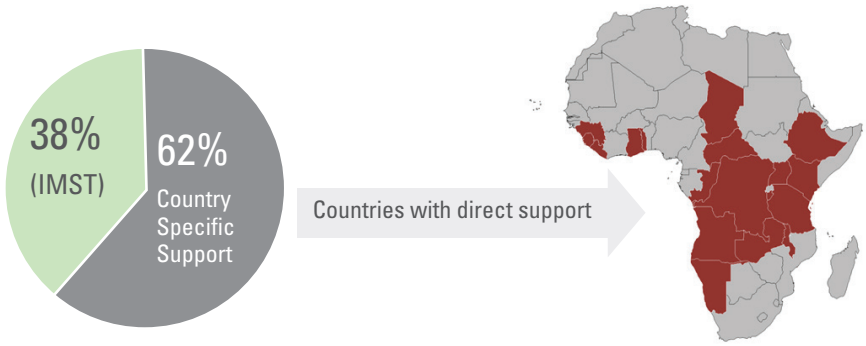


Figure 26: Emergency response support across the continent

multiple Rapid Response Team deployments supported the management of concurrent outbreaks across the region.

The Southern Africa Regional Emergency Operations Centre was activated on three occasions to coordinate responses to cholera outbreaks in Zambia and Zimbabwe, as well as to Mpox. The establishment of functional Emergency Operations Centres, the activation of Incident Management Support Teams (IMSTs), and strengthened regional coordination mechanisms collectively contributed to the effective containment of cholera outbreaks. Frontline service delivery was further enhanced in Malawi and Zambia through the capacity-building of 600 community health workers, who were equipped with high-quality deployment kits. In parallel, 100 medical experts were trained in case management and infection prevention and control (IPC), and essential IPC supplies were provided to strengthen clinical readiness. Rapid detection and response capacities were reinforced in Botswana, Eswatini, and Namibia through the implementation of standardised EBS systems. National emergency preparedness was further consolidated through the establishment and full equipping of PHEOCs in Lesotho and Zambia.

In Eastern Africa, the RCC provided first-time support for Joint External Evaluations (JEEs) in Eritrea and Mauritius and deployed experts to Sudan amid complex emergencies. At country level, tangible impact was demonstrated, particularly in Somalia, through the deployment of 105 female community health workers, training of 28 healthcare workers in infection prevention and control and simulation exercises, capacity building of 23 National Institute of Health staff, development of the NIH Strategic Plan and M&E Framework, and establishment of an Alert Desk within the Public Health Emergency Operations Centre through the KOICA funding support. Under the Saving Lives and Livelihoods (SLL) initiative, the RCC strengthened border surveillance, laboratory systems, and outbreak response readiness, including cold-chain and PHEOC equipment.

Central Africa advanced significantly with the equipping of the PHEOCs in four member states, namely the Central African Republic, Chad, the DRC, and São Tomé and Príncipe. The region also supported the launch of a regional integrated sample transport strategy and the strengthening of surveillance infrastructure. Formative supervision of SLL Phase II in six Member States resulted in measurable improvements in data quality, strengthened partnerships with implementing partners, enhanced pharmacovigilance, and improved risk communication and community engagement. The RCC also strengthened vaccine logistics and supply chains through targeted investments, including vehicles and 55 motorcycles in Burundi, 100 motorcycles in Cameroon, and cold-chain equipment in Chad.

In Northern Africa, the advancement of RISLNET brought together Directors of Surveillance, Laboratories and NPHIs to develop a joint regional workplan for early warning and cross-border preparedness. Regional priorities for 2026 were jointly identified, while surveillance baseline assessments were completed in three Member States, supporting evidence-based planning. Bottlenecks affecting the implementation of the SLL project were addressed through the alignment of priorities and more efficient resource utilisation, alongside the initiation of an exchange program to map capacities across Member States.

The Western Africa RCC also enhanced technical capacity and preparedness across the region by training over 200 public health officers from Member States in cross-border surveillance, early warning systems, and risk communication. These investments strengthened regional readiness, supported earlier outbreak detection, and improved coordinated response to public health threats across its Member States.

Taken together, these developments confirm that Africa's emergency preparedness and response architecture is no longer conceptual, but fully operational. Surveillance systems now feed seamlessly into IMST activation; the IMST mobilises the African Volunteers Health Corps (AVoHC) and operates through national Public Health Emergency Operations Centres (PHEOCs); PHEOCs coordinate with National Public Health Institutes (NPHIs) and Ministries of Health to drive country-led response.

In parallel, the Africa Epidemics Fund (AfEF) provides rapid and predictable financing, Regional Collaborating Centres (RCCs) ensure regional coordination and peer support, and the Africa CDC Secretariat in Addis Ababa integrates these elements through continental analytics, forecasting, and policy guidance. This end-to-end, Africa-led system has been repeatedly tested throughout 2025 across multiple outbreaks and has demonstrated its capacity to deliver faster, more coordinated, and more effective responses at scale.

As Africa looks towards 2026 and beyond, this pillar is set for deeper consolidation. Priorities include establishing regional surge hubs under each RCC, expanding functional PHEOCs to all 55 Member States, creating specialised teams for climate-related emergencies, fully operationalising the AVoHC-EMT clinical deployment model, and ensuring the sustainable capitalisation of Afef.

The vision is clear: Africa will detect, analyse, decide, and act through its own institutions, workforce, financing and leadership, no longer responding to emergencies on others' terms.

4.2.2 Overall Key Results in 2025.

In 2025, Africa CDC demonstrated that Africa Health Security and Sovereignty is no longer a vision in progress, but a reality taking shape through delivery. Across the continent, the full pandemic prevention, preparedness, detection, and response continuum was strengthened through permanent, scalable systems designed to protect lives, safeguard economies, and reinforce trust in public institutions. These achievements reflect a decisive shift toward African-led solutions, fully aligned with the African Union's vision of a resilient, integrated, and self-reliant continent.

Africa's early warning and surveillance capabilities reached new levels of effectiveness and credibility. Africa CDC monitored 213 public health events reported from 44 African Union Member States, including low-risk signals, reflecting improved transparency, detection, and confidence in continental systems.

Expanded genomic surveillance capacity enabled earlier identification of variants and transmission patterns, while improved integration of epidemiological, laboratory, and event-based data enhanced situational awareness at national, regional, and continental levels. Together, these advances supported faster, evidence-informed escalation decisions and strengthened collective risk intelligence across the continent.

Preparedness infrastructure was significantly consolidated, reinforcing Africa's ability to act before crises escalate. The expansion and operationalisation of Public Health Emergency Operations Centres strengthened readiness at both national and regional levels, transforming preparedness from an ad hoc function into a permanent institutional capability. Standardised preparedness frameworks improved interoperability among countries during cross-border events, while simulation exercises and preparedness assessments generated practical insights that informed targeted investments and capacity building. Preparedness was no longer episodic but embedded within national systems.

Africa CDC also delivered a rapid, coordinated response at scale, anchored in continental solidarity and national leadership. The Public Health Emergency of Continental Security (PHECS) mechanism was operationalised to trigger timely collective action when threats exceeded national capacity. Through the IMST model, Africa CDC coordinated multi-country responses under a unified operational framework, aligning partners, expertise, and resources behind country-led priorities. The AVoHC provided reliable surge capacity, enabling the swift deployment of skilled epidemiologists, laboratorians, and emergency managers to where they were most needed.

These operational achievements were made possible by strengthened emergency financing mechanisms that translated political commitment into immediate action. By shortening the time from decision-making to operational deployment, continental financing enabled earlier containment, reduced downstream costs, and protected fragile health systems from being overwhelmed. By integrating surveillance, preparedness, response,

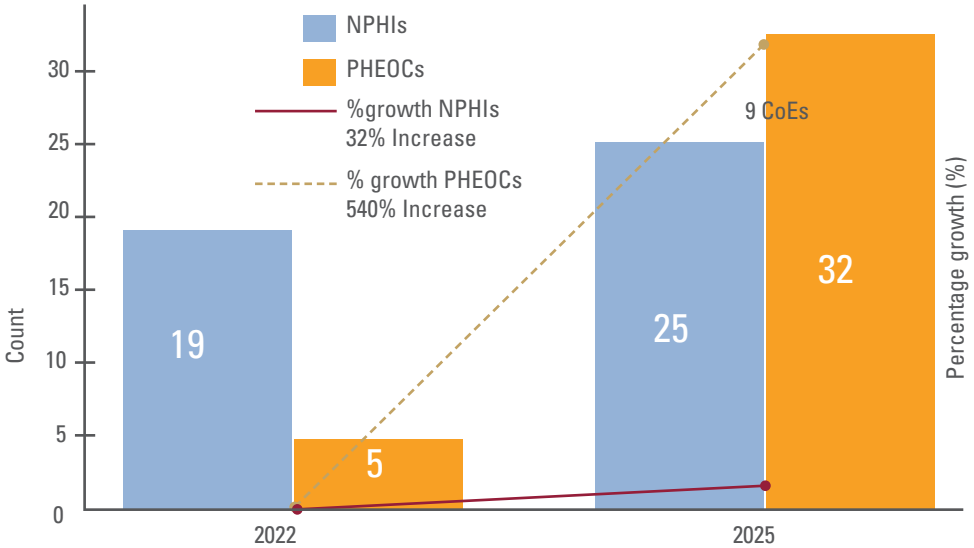


Figure 27: Expansion of Functional National Public Health Institutes and Public Health Emergency Operations Centres (2022–2025)

and financing within a single architecture, Africa CDC demonstrated that sovereignty in health security is built on systems that deliver decisively, equitably, and at scale.

4.2.3. Key Results per component for PPPR in 2025

National Public Health Institutes - NPHI

Robust national institutions are the foundation on which Africa's new emergency preparedness and response architecture is built. For too long, outbreak response across the continent relied on ad hoc committees and temporary coordination mechanisms that dissolved once crises subsided, leaving little institutional memory and limited capacity to respond more effectively to the next emergency.

In 2025, this paradigm continued to shift decisively. Africa CDC accelerated the development of National Public Health Institutes as permanent, professional institutions designed to sustain institutional knowledge, maintain preparedness, and lead responses over time. By the end of 2025, twenty-seven (27) African Union Member States had fully operational National Public Health Institutes, while a further nineteen (19) were at various stages of establishment. Africa CDC supported this progress through targeted investments in governance and institutional development, digital and ICT systems, and a leadership programme, reaching 124 senior officials from NPHIs and Ministries of Health.

These efforts were not theoretical. NPHIs were repeatedly evaluated during multiple outbreaks in the year and demonstrated their ability to coordinate surveillance, laboratories, emergency operations, and risk communication in real time, providing continuity, authority, and accountability where ad hoc arrangements had previously failed.

Today, National Public Health Institutes serve as the national backbone of pandemic prevention, preparedness, and response systems. They provide a permanent home for core public health functions and ensure that continental mechanisms, such as the Incident Management Support Team, are anchored in robust domestic structures rather than temporary crisis arrangements. Through this transition from improvised response to institutionalised leadership, Africa has begun to secure not only faster, more effective outbreak control, but also a durable foundation for health security and sovereignty that will strengthen with each challenge faced and overcome.

Workforce & Leadership

In 2022, Africa's public health workforce landscape was characterised by fragmentation and scarcity. Africa CDC's technical workforce was small and highly centralised, with fewer than 200 trained epidemiologists across the continent and a limited leadership development pipeline. Most Member States lacked Field Epidemiology Training Programs or structured public health leadership initiatives, leaving outbreak response

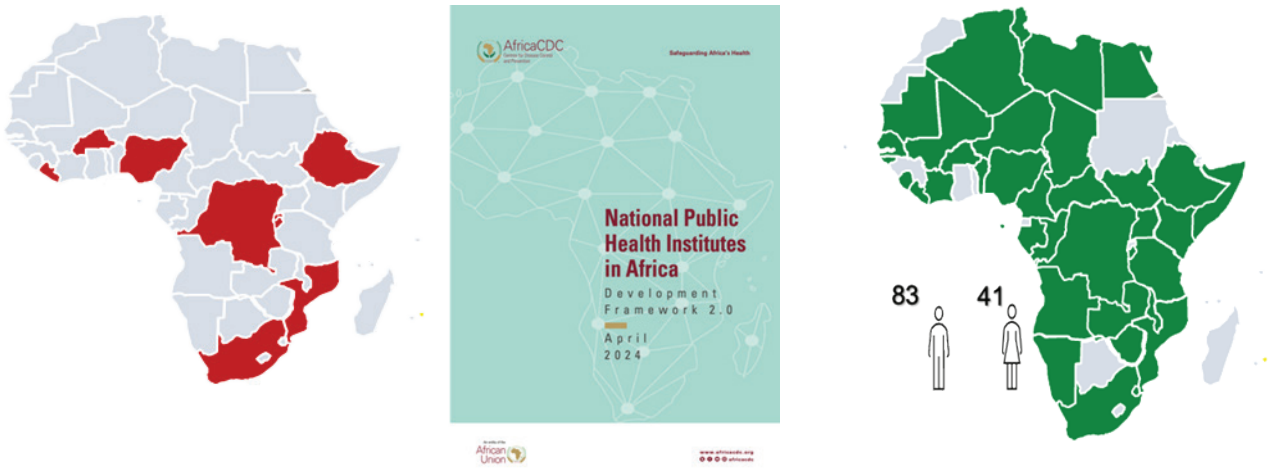


Figure 28: left to right (Designation of 9 NPHI regional Centres of Excellence, revised NPHI development framework, and Training on change management and leadership for NPHI`s)

dependent on short-term deployments, external expertise, and ad hoc arrangements. This reality constrained preparedness, slowed response, and weakened institutional memory.

Between 2023 and 2025, Africa CDC led a decisive shift from episodic capacity building to the deliberate construction of a continental public health workforce ecosystem, aligned with Africa Health Security and Sovereignty. With support from the World Bank and strategic partners, Africa CDC operationalised the Africa CDC Framework for Workforce Development and rolled out a set of flagship programs to build skills and leadership, and to deployable surge capacity at scale.

Field epidemiology capacity expanded rapidly. Through the Field Epidemiology Training Program, 303 epidemiologists and surveillance officers were trained across 21 Member States between 2023 and 2025. These investments translated directly into action: 48 experts were deployed through the African Volunteers Health Corps to support responses to mpox, cholera, and Marburg virus disease. Workforce development was deliberately inclusive, with the Gender in Preparedness framework mainstreamed across programmes, resulting in 40 per cent female participation.

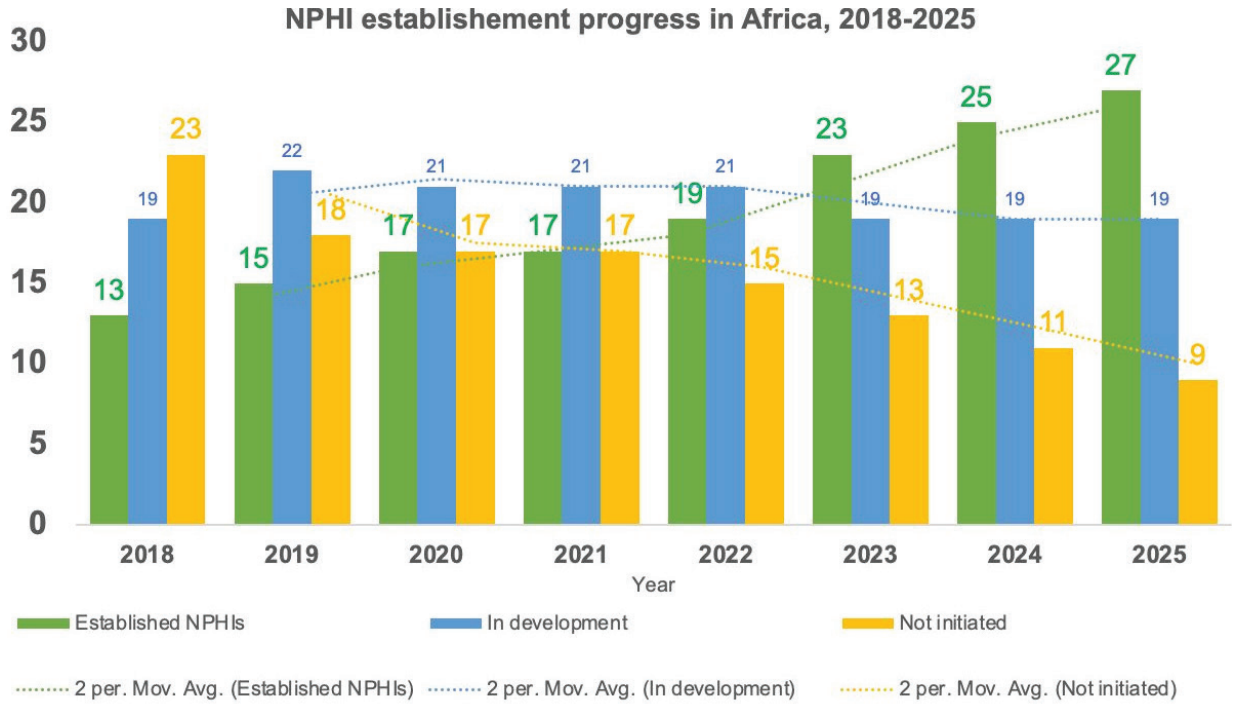


Figure 29: NPHI Growth over time in Africa (2018 - 2025)

Table 10: Workforce Development Indicators (2022 -2025)

Indicator	2022	2025	% Change	Source
Public health workers trained in core public health priorities across Member States	0	4,870	New	Africa CDC PIRS Database
Total beneficiaries of Africa CDC's workforce development initiatives through scholarships and fellowships	0	161 (AES – 31, KAGHL 25, FETP adv-60, PHEM-19, manufacturing 20)	New	Africa CDC PIRS Database
Field Epidemiology Training Program (FETP)	120	303	+152 %	Mpox Mid-Term Report (2025)
Biomanufacturing and R&D Training	0	16	New	Africa CDC PIRS Database
Mental Health Experts equipped with Leadership skills to advance Mental Health Policy, Programs and Systems	0	197	New	Africa CDC PIRS Database
RECs and Member States supported to strengthen South-to-South collaboration and learning exchanges across key public health areas (CHWs), infectious diseases, NTDs, RMNCAH, NCDs and Mental Health	0	10	New	Africa CDC PIRS Database
Training programs developed for African health products manufacturers	0	1	New	Africa CDC PIRS Database
Workforce Framework & Gender Policy	Yes, developed	Implemented, but to be adopted	N/A	Africa CDC PIRS Database
Africa CDC workforce programs development with gender mainstreaming	0	Gender Equity and Integration Training Series by Africa CDC & AUC WGYD	New	Africa CDC PIRS Database
Continental policies and guidelines developed to support the attraction, development, and retention of Africa's public health workforce	0	Africa CDC Health Workforce Compact validated	New	Africa CDC PIRS Database
Health Youth Champions trained in digital health programmes and initiatives across Member States	0	765	New	Africa CDC PIRS Database

Kofi Annan Fellowship in Global Health Leadership **109 Fellows from 31 Member States** enrolled and graduated 2019 -2025

Enrolled **47 Fellows from 24 Member States** in to the Africa Epidemic Service Program Epidemiology and PHI Tracks

Figure 30: Workforce Development Indicators (2022 –2025)

To professionalise and sustain epidemic response capacity, Africa CDC established the African Epidemic Service, a two-year fellowship programme structured around three strategic tracks: Applied Epidemiology, Laboratory Leadership, and Public Health Informatics. To date, 47 fellows have been recruited across two tracks, including 26 in epidemiology and 21 in public health informatics. The first cohort of ten epidemiology fellows is expected to complete training in July 2026, marking the emergence of a new cadre of continentally trained, deployment-ready public health professionals.

Another major milestone was the launch of the Africa CDC Public Health Emergency Management Fellowship in March 2023. The programme has now graduated 27 expert-level public health professionals from 22 Member States, including 19 fellows from 16 countries in 2025 alone. These graduates now form a critical leadership pool for Public Health Emergency Operations Centres and national response structures. In parallel, Africa CDC and partners continued to deliver short courses, simulations, and targeted training for emergency operations staff, reinforcing readiness across national systems.

Leadership development was elevated as a strategic priority. Through the Kofi Annan Global Health Leadership Program, 84 fellows have graduated across 4 cohorts since 2019, many now holding senior leadership roles that advance national and continental health priorities. A fifth cohort of twenty-five fellows is currently in training. Complementary initiatives trained 70 mid-career professionals between 2023 and 2025, while the Ministerial Executive Leadership Program equipped 45 Ministers of Health and more than 100 senior officials with the skills to lead complex health reforms. The Mental Health Leadership Program further strengthened leadership capacity by training 250 experts to guide mental health policy and programming.

Recognising that resilient health systems are built from the community upwards, Africa CDC also invested in community health workers as a frontline extension of epidemic intelligence and response. A total of 1,436 community health workers were trained and deployed across Uganda, Burundi, and the Democratic Republic of the Congo to support surveillance and infection prevention and control, supported by regional train-the-trainer modules coordinated through Regional Collaborating Centres in Eastern and Central Africa.

These efforts unfolded against a stark demographic and economic reality. By 2030, the global health workforce shortage is projected to reach eleven million, with more than half of this deficit affecting Africa. In response, African Union Heads of State and Government established the Health Workforce Task Team in 2022 as the continental coordination mechanism for workforce development, mandating Africa CDC to serve as its secretariat. Under this mandate, Africa CDC delivered a comprehensive baseline review, an investment case outlining financing needs and returns on investment, and an African Health Workforce Compact, with an accompanying implementation and monitoring framework.

Figure 31: Combined PHEM fellowship coverage (2023-2025

Building on these foundations, the African Health Workforce Compact was operationalised at the inaugural AU Health Workforce Task Team meeting. Co-chairs were appointed, and implementation commenced across seven workstreams covering governance, financing, training harmonisation, retention and migration, research and innovation, data and monitoring, and technical assistance to Member States.

The impact of this transformation is tangible. Africa CDC now manages the largest continental public health workforce network in its history. Within twelve months of the mpox Public Health Emergency of Continental Security declaration, more than 1,400 frontline workers and 300 epidemiologists were mobilised across five regions, a continental first. This achievement signals a fundamental shift: Africa is no longer building workforce capacity in anticipation of crises, but deploying it at scale, in real time, through institutions designed to endure.

Laboratory Systems and Networks

In 2025, Africa CDC consolidated Africa's collective capacity to detect, respond to, and contain public health threats by strengthening laboratory systems across all 50 African Union Member States. Through training more than 1,200 professionals and decentralising and equipping over 120 laboratories, supported by more than USD 8 million in strategic investments, Africa took decisive steps towards health security anchored in its own institutions. These achievements embody Africa Health Security and Sovereignty (AHSS), advance Agenda 2063, and establish a durable laboratory backbone that enables African leadership in Pandemic Fund–supported preparedness, response, and resilience.

Laboratory systems play a significant role in the early detection of public health emergencies. Multi-disease laboratory detection and sequencing capacity has been established in many AU Member States, which are critical for addressing emerging and re-emerging infectious diseases. Laboratory diagnostic capabilities have been decentralised to regional and sub-regional levels to facilitate surveillance and the detection of outbreaks in communities. To increase access to diagnostics for Africa's priority diseases, we have established continental mechanisms for evaluating and rapidly adopting technologies, including locally manufactured products. Africa CDC supported the evaluation of a locally manufactured PCR test kit from Morocco and procured and distributed it in Uganda, DRC, and Burundi. The biobanking network, which involves all regions of Africa, and the Africa CDC Diagnostic Advisory Committee (DAC) play an extremely critical role in this regard. Genome sequencing capacity has expanded significantly from just seven countries in 2019 to 46 Member States in 2025, and the application of genome sequencing has ex-

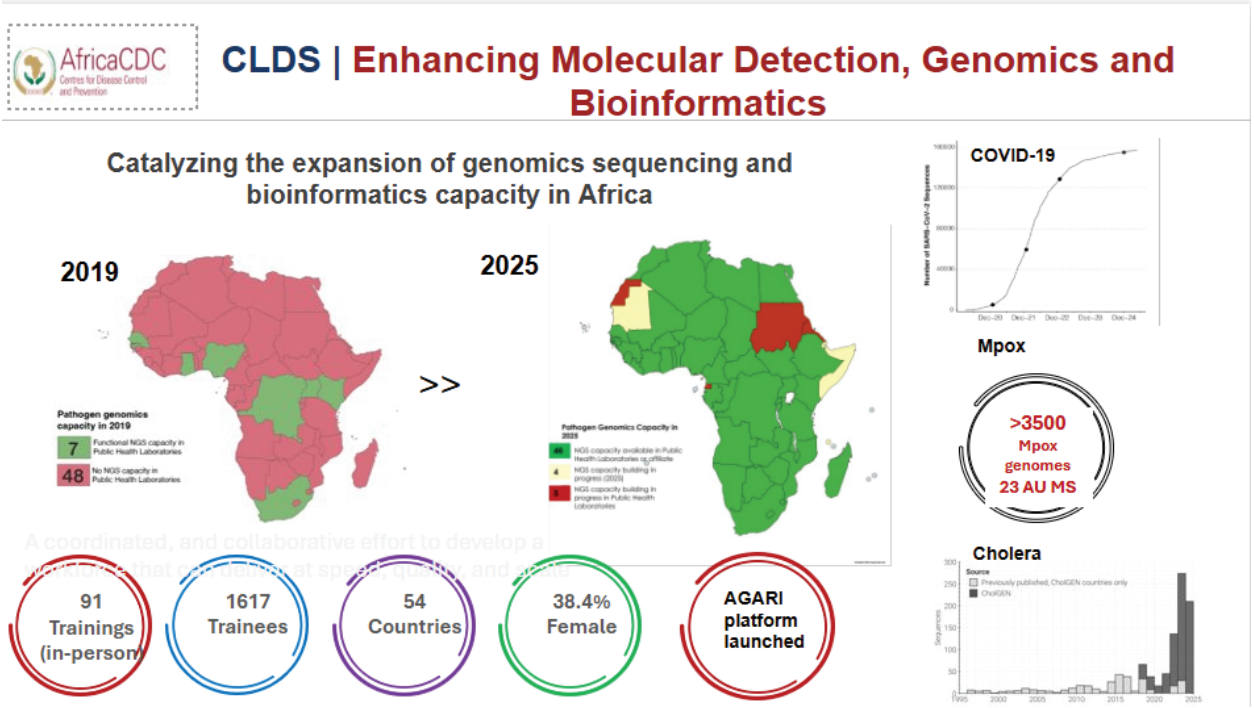


Figure 32:Rapid expansion of Molecular Detection and Genome Sequencing Capacity in AU Member States

panded to more priority diseases, such as cholera, mpox, Marburg, Ebola, vaccine-preventable diseases, and anti-microbial resistance pathogens. More than 1200 cholera genome sequences and 3500 mpox genome sequences were generated across multiple countries, helping to better understand disease transmission dynamics, including cross-border transmission.

Biosafety and biosecurity, and early warning surveillance, are core components of the International Health Regulation (IHR). Implementation of the Africa CDC biosafety and biosecurity initiative has been significantly expanded. More than 550 laboratory experts have been trained in biosafety and biosecurity. 15 Member States have developed a list of high-consequence pathogens and toxins. 8 countries are adopting the AU model legal framework into their own law. 10 institutions managing high-consequence agents have been certified, and three Centres of Excellence for biosafety and biosecurity have been established. The overall JEE score for Member States has increased significantly, with some countries seeing increases of more than 25%.

The quality of laboratory services is key to clinical care and outbreak investigation. More than 200 laboratory personnel were trained in quality management systems, laboratory leadership, and laboratory assessment. This contributed to the considerable progress the continent has made in laboratory accreditation. More than 1200 laboratories across the African continent have received ISO accreditation.

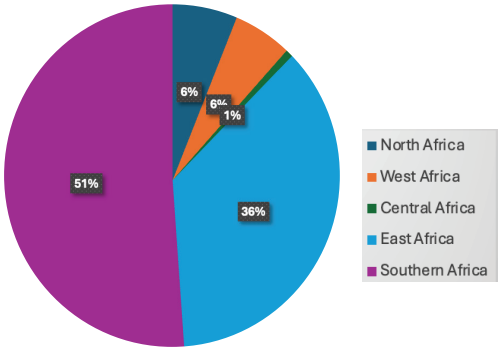


Figure 33: Proportion of laboratories that received ISO accreditation by different African Union regions (n=1264)

In 2022, Africa's laboratory and pathogen genomics capacity reflected years of underinvestment and fragmentation. Sequencing capacity existed in only 24 African Union Member States, sample referral systems were weak, and quality assurance mechanisms were uneven. In several countries, the ability to detect epidemic-prone diseases was severely constrained. For example, at the onset of the mpox outbreak in the Democratic Republic of Congo, only two laboratories were conducting routine testing, significantly delaying confirmation, contact tracing, and response escalation. In parallel, biosafety and biosecurity compliance in some laboratories fell below international standards, putting both personnel and communities at risk. These gaps underscored a fundamental vulnerability: without strong, decentralised, and trusted laboratory systems, early detection and rapid response are impossible.

Between 2023 and 2025, Africa CDC led a decisive transformation of the continent's laboratory and genomics landscape, translating Africa Health Security and Sovereignty into concrete diagnostic capability. Through coordinated investments, training, and continental coordination, laboratory systems shifted from centralized bottlenecks to decentralised networks capable of supporting timely, country-led responses.

In line with Africa CDC's mandate to establish a continental Reference Laboratory, operational readiness reached 82% in 2025. All core governance and quality documents, including the Quality Manual, Biosafety Manual, Laboratory Handbook, and managerial Standard Operating Procedures, have been finalised. Staffing is complete, with eight personnel in place: two senior laboratory staff, 4 technicians, and 2 interns. Procurement of essential equipment and supplies is complete, and three document development workshops were conducted to support system readiness.

The Reference Laboratory has also procured diagnostic test kits to enhance outbreak preparedness and response. It has begun supporting Member States, including providing technical assistance to Ethiopia during the Marburg outbreak in Jinka, December 2025. These achievements represent a major milestone in advancing Africa's continental laboratory capacity and strengthening emergency response systems.

Key achievements include:

- Mpox testing coverage increased from 38% in August 2024 to 58% by October 2024, representing a 52% improvement in just four months, and

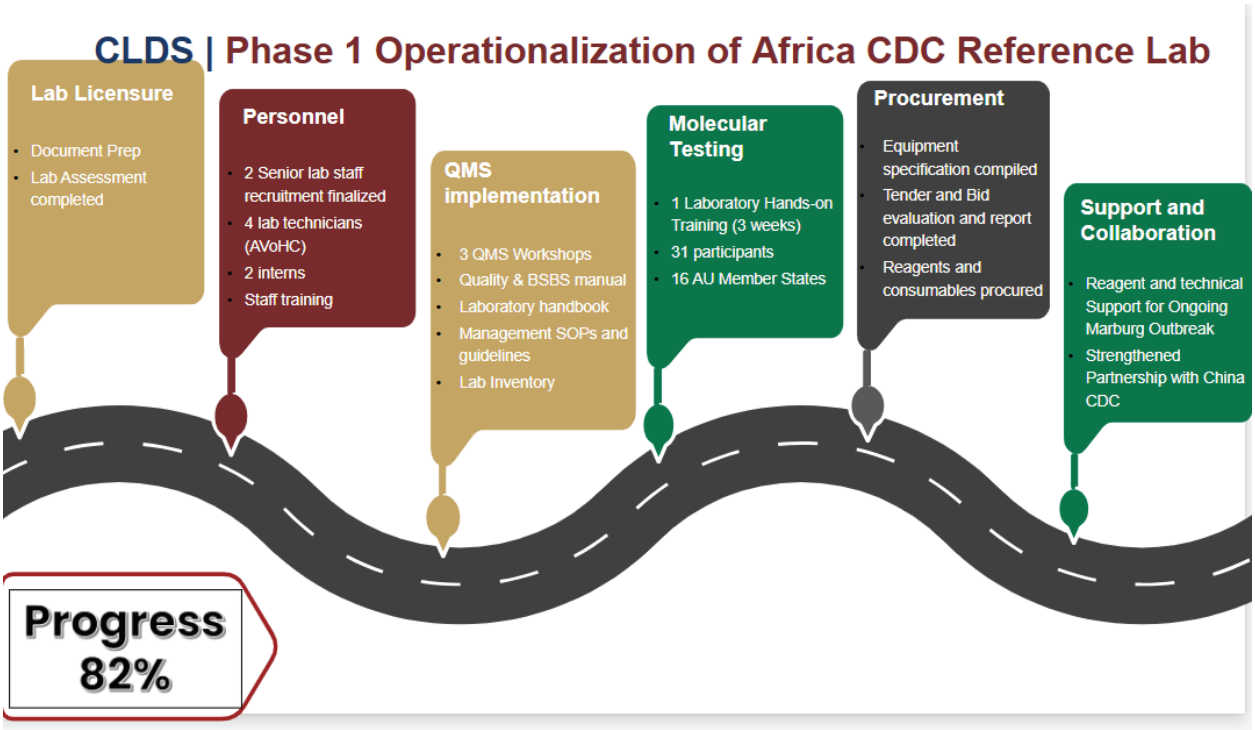


Figure 34: Flowchart of Operationalisation of the Africa CDC Reference Laboratory

reached 66% by August 2025, reflecting sustained expansion and consolidation of capacity.

- A total of 169 laboratory experts from Burundi, the Central African Republic, Congo, Angola, and Rwanda were trained in biosafety, sample collection, and molecular diagnostics, strengthening frontline capacity and institutional memory.
- More than 74,000 test kits and sequencing reagents were distributed to twenty-one countries, enabling uninterrupted diagnostic and surveillance operations during active outbreaks.
- Mpox diagnostic capacity expanded dramatically: the Democratic Republic of the Congo increased from 2 to 28 laboratories, Burundi from 1 to 56 laboratories, and Malawi from 1 to 20 laboratories. Across the continent, the median number of mpox-capable laboratories rose from 1 to 11 per country.
- Regional sequencing centres were established in Uganda and Rwanda, anchoring genomic surveillance within Africa and enabling faster detection of transmission patterns and variants of concern.

Together, these gains represent more than expanded testing capacity. They mark a structural shift from fragile, centralised diagnostics to resilient, decentralised laboratory networks embedded within national systems and linked through continental coordination. By strengthening biosafety, quality assurance, and genomic intelligence alongside diagnostic expansion, Africa CDC has helped ensure that laboratories are not only more numerous but also safer, more dependable, and fit for sustained epidemic preparedness and response. This transformation has been evaluated repeatedly during outbreaks and stands as a cornerstone of Africa's emerging health security and sovereignty.

A resilient laboratory system is built not only on human capacity but also on reliable equipment, robust infrastructure, quality assurance, and clear policy frameworks that endure beyond individual outbreaks. In 2022, many laboratories across Africa faced infrastructure gaps, fragmented procurement, limited connectivity, and inconsistent standards, constraining their ability to function as part of a continental diagnostic network. Between 2023 and 2025, Africa CDC addressed these structural weaknesses through coordinated investments that strengthened laboratory infrastructure and embedded interoperability, quality, and sustainability at scale.

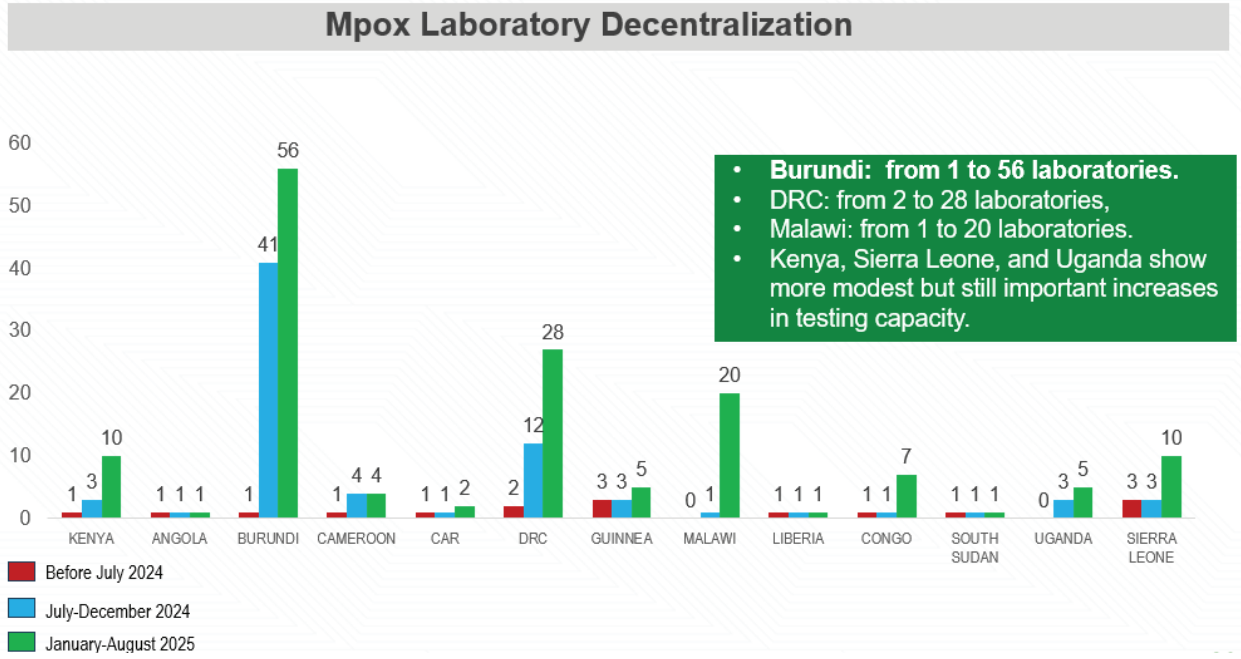


Figure 35: Mpox testing laboratories expansion across Member States from July 2024 to August 2025

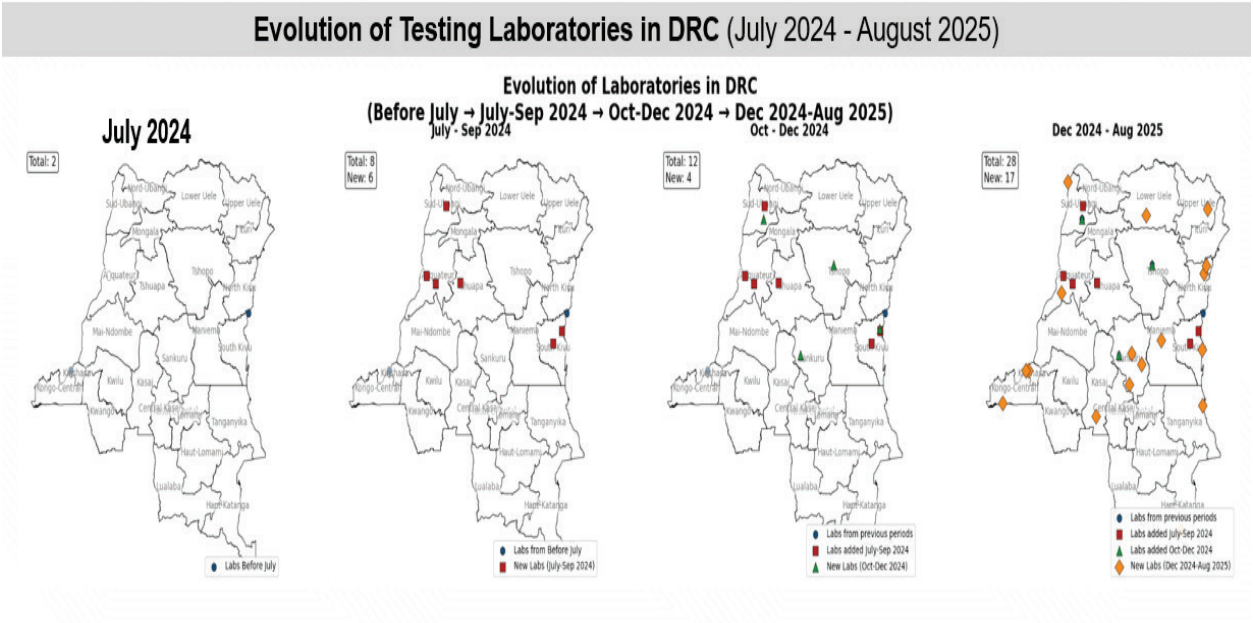


Figure 36: Mpox testing laboratories expansion in the DRC from July 2024 to August 2025.

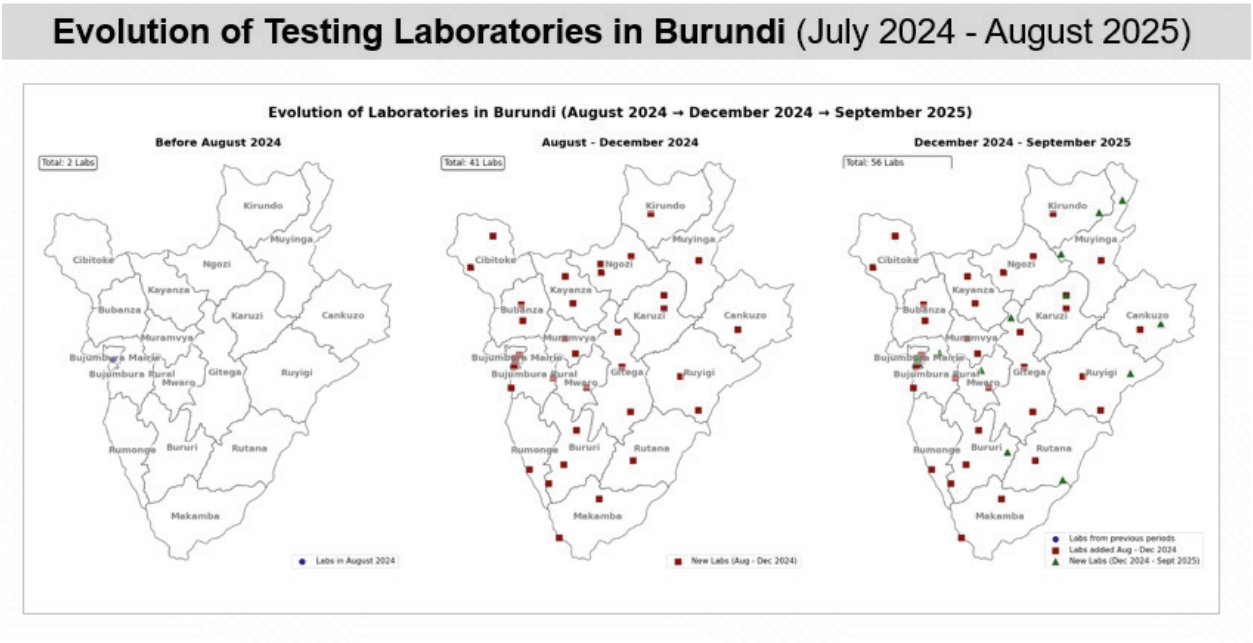


Figure 37: Mpox testing laboratories expansion in the DRC from July 2024 to August 2025

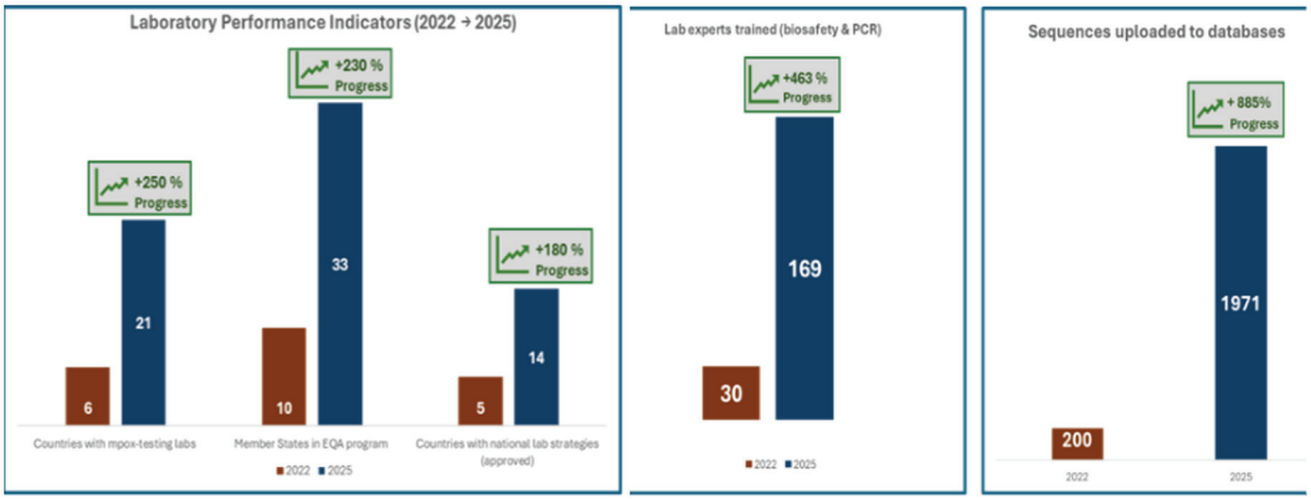


Figure 38:Laboratory Performance Indicators (2022 - 2025)

Through strategic procurement, deployment, and system mapping, Africa CDC significantly expanded access to essential diagnostic technologies across the continent.

Key achievements include:

- Procurement and distribution of 253,912 diagnostic kits valued at USD 7.59 million across 29 Member States, including 78,550 GeneXpert cartridges and 175,362 qPCR kits, ensuring continuity of testing during active outbreaks.
- Delivery of seven sequencing machines valued at approximately USD 855,000 to Burundi, the Central African Republic, Congo, Cameroon, Uganda, and Rwanda, strengthening in-country and regional genomic surveillance capacity.
- Deployment of eight qPCR machines worth approximately USD 582,280 to the Democratic Republic of the Congo and Sierra Leone, addressing critical diagnostic bottlenecks in high-burden and high-risk settings.
- Mapping of more than 5,200 laboratories continent-wide to optimise sample referral pathways, logistics planning, and rational allocation of diagnostic resources.

Quality assurance and laboratory networking advanced in parallel with infrastructure expansion, ensuring that increased testing capacity translated into reliable and actionable results.

Key milestones included:

- Enrolment of 51 laboratories from 33 countries in the World Health Organisation's global mpox External Quality Assessment programme in 2024, strengthening confidence in diagnostic performance and adherence to international standards.
- Upload of 1,971 pathogen genomic sequences to continental databases, representing the largest sequencing dataset ever generated from Africa and a major step towards data sovereignty.
- Reactivation of regional reference laboratories and their integration into the Emerging and Dangerous Pathogen Laboratory Network, enabling structured confirmation, mentorship, and surge support during outbreaks.

These technical advances were consolidated through strong normative guidance and policy leadership. Africa CDC published the Mpox Testing and Sequencing Strategy and Antigen Rapid Test Evaluation Guidance in November 2024, harmonising diagnostic protocols and reducing variability across Member States. In November 2025, the Lab Map Strategic Framework was launched to standardise geospatial mapping of laboratory systems and support evidence-based scale-up of diagnostics. Building on lessons from multiple outbreaks, Africa CDC also initiated development of the Continental Guidelines for Laboratory Capacity Decentralisation for Epidemic Preparedness and Response, currently under publication, to institutionalise decentralised diagnostics as a core preparedness principle.

Crucially, these efforts also advanced Africa's ambition for local manufacturing and reduced dependence on external suppliers. Africa CDC evaluated and endorsed Morocco's first locally produced RT-PCR kit, signalling a strategic shift towards regional production of critical diagnostics. Together, these investments demonstrate

that Africa is no longer merely expanding laboratory capacity but deliberately building a coherent, interoperable, and sovereign diagnostic ecosystem capable of sustaining preparedness and response across the continent.

The investments made between 2022 and 2025 translated into measurable, life-saving impact across Africa, demonstrating how strengthened laboratory systems directly protect populations, preserve economic stability, and reinforce continental solidarity. Faster detection, improved quality, and real-time genomic intelligence enabled countries to act earlier and more decisively, preventing outbreaks from escalating into cross-border crises.

These efforts particularly strengthened sequencing and diagnostic capacity through the procurement of sequencers, servers, laboratory equipment, and sequencing reagents, accompanied by extensive capacity-building and workforce development initiatives for laboratory personnel in more than 30 African Union Member States, including Algeria, Angola, Benin, Burkina Faso, Burundi, Cabo Verde, Cameroon, the Central African Republic, Chad, Comoros, the Republic of Congo, the Democratic Republic of the Congo, Côte d'Ivoire, Djibouti, Eswatini, Ethiopia, The Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mauritius, Morocco, Mozambique, Namibia, Niger, Nigeria, Rwanda, São Tomé and Príncipe, Senegal, Seychelles, Sierra Leone, South Africa, Tanzania, Togo, Uganda, Zambia, and Zimbabwe.

Key impacts include:

- Rapid mpox detection capacity enabled early identification and response, preventing cross-border transmission in fourteen countries and reducing the need for prolonged emergency interventions.
- Mpox testing performance improved across the continent. Testing coverage, measured as the proportion of suspected cases tested, doubled from less than 33 per cent to 66 per cent, while testing rates remained at 100one hundred cent, ensuring that all samples received by laboratories were processed. Turnaround time from sample collection to

Table 11: Laboratory Key Performance Indicators (2022 - 2025)

Indicator	2022	2025	(%) Change	Source
Member States with comprehensive laboratory strategic plans in place	16	24	+50%	Africa CDC Lab Database
Member States supported the implementation of policies and guidelines for integrated laboratory systems	7	42	+500%	Africa CDC Lab Database
Member States benefiting from annual support for laboratory infrastructure improvement	7	31	+343%	Africa CDC Lab Database
Member States advancing Quality Management Systems with Africa CDC support	16	24	+50%	Africa CDC Lab Database
Biosafety and biosecurity frameworks established, strengthened, or operationalised across Member States	0	13	New	Africa CDC Lab Database
Member States supported in geospatial mapping of lab functions, network optimisation, and specimen referral systems	2	29	+1350%	Africa CDC Lab Database
Laboratory experts trained and certified in specimen management and referral practices	94	557	+493%	Africa CDC Lab Database
Member States establishing integrated genomic surveillance for priority diseases, including AMR	0	9	New	Africa CDC Lab Database
Operationalisation status of the Africa CDC Reference Laboratory	0	82%	New	Africa CDC Lab Database
Increased access to quality diagnostics for epidemic-prone diseases across Member States	11	13	+18%	Africa CDC Lab Database

validated results fell from more than five days to just two days, accelerating isolation, contact tracing, and response decision-making.

- Genomic surveillance efficiency increased dramatically. Sequencing turnaround time was reduced from more than 30 days in 2022 to fewer than 7 days in 2025, enabling near-real-time tracking of transmission dynamics and informed adjustments to response strategies.
- Quality and safety standards expanded continent-wide. ISO accreditation coverage now reaches 1,026 laboratories, strengthening confidence in diagnostic results, protecting laboratory personnel, and anchoring preparedness within internationally recognised quality systems.

Together, these outcomes demonstrate that Africa's laboratory and genomic investments are not only technical achievements, but strategic enablers of Africa's Health Security and Sovereignty. By shortening response timelines, improving decision quality, and preventing regional spread, Africa CDC and Member States have shown that strong, decentralised, and quality-assured laboratory systems are among the most powerful tools for safeguarding the continent's health and future.

c. Surveillance and Disease Intelligence

Disease surveillance, public health intelligence collection, and analytics are vital to public health functions. In 2025, the Africa CDC tracked over 213 active public health emergencies, including 65 high-risk events, 138 moderate-risk events, and 10 low-risk events across 44 of the 55 AUMS, including infectious disease outbreaks, extreme weather events, and other significant health-related incidents. Compared with previous years, there is a steady pattern of public health events reported consistently, with more than two hundred per year over the past two years. We have also noted more disease outbreaks that spill over into the following year, some of which are protracted for up to 6 months. This may be attributable to increased vulnerability to infectious disease outbreaks, unmet health system gaps, and improvements in surveillance and disease intelligence across AU Member States. The Detection of public health events by the epidemic intelligence team has increased overtime. There is an observed increase in the percentage of public health events detected within seven days from the date of start of an event ranging from 39% in 2022 to 57.7% in 2025.

There is a noticeable regional disparity in the number of public health events across the five African Union Regions, with the Western Africa Region contributing 36% (77/213) of the total public health events on the continent, reported from 14 of 17 Member States in the region in 2025 (Fig xxx). The most reported public health events in the year were mpox, reported from 29 Member States; cholera, reported from 24 Member States; and measles, reported from 20 Member States, all of which were protracted in most AU regions.

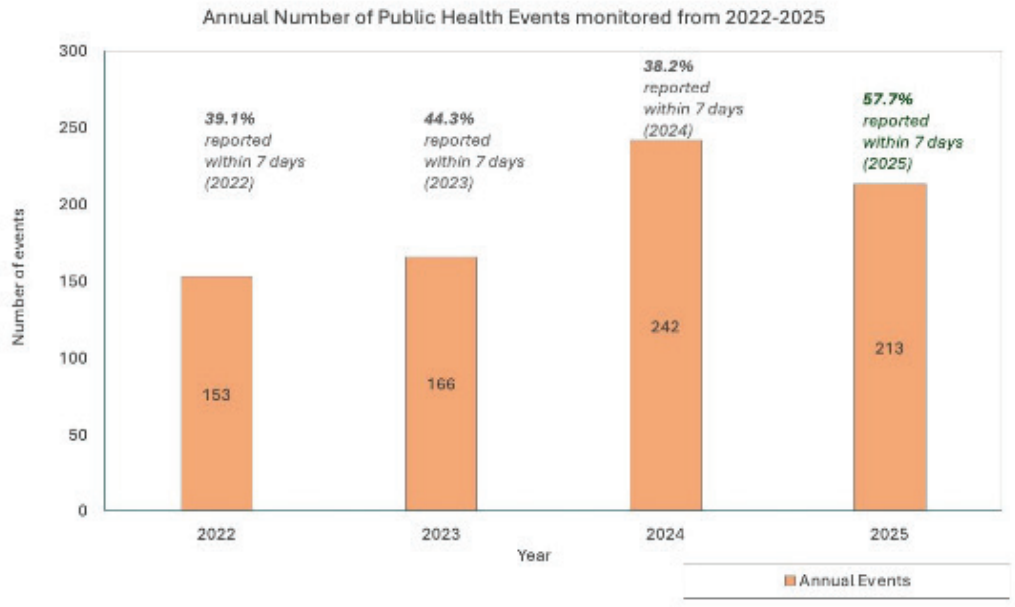


Figure 39: Annual Number of Public Health Events tracked and monitored by Africa CDC, from 2022-2025

This effort has supported early detection, rapid response, and informed decision-making for public health emergencies. Additionally, Africa CDC conducted multiple high-level briefings and consultations with Heads of State, Governments, and Health Ministers on high-impact events to secure political commitment and improve partner coordination.

To strengthen surveillance capacity further, Africa CDC developed and launched various initiatives, such as the Continental Public Health Data Centre (Central Data Repository), Climate and Health strategic framework, Wastewater and Environmental Surveillance, cross-border surveillance, and developed five strategic frameworks and guidelines, alongside workforce development and capacity-building efforts; and institutionalized data platforms, including event management system (EMS) in seven AU MS. In addition, Africa CDC strengthened continental and regional surveillance through a network of surveillance directors, enhanced cross-border surveillance, and advanced regional communities of practice on AMR, EBS, and mortality surveillance.

Event-Based Surveillance (EBS) was expanded to 38 Member States, with thirty-five adopting Africa CDC guidance and fifteen fully launching EBS implementation. To support this, Africa CDC trained 195 surveillance experts and 2,678 community health workers in four pilot countries specifically on event-based detection. Taken together with cumulative efforts since 2022, a total of 1,012 surveillance officers and 3,476 community health workers across thirty-six countries have been capacitated to detect and report unusual events.

To sum up, in 2025, Africa CDC supported over 41 countries in different capacity development efforts, including national EBS guideline rollout, adaptation and implementation (14 countries), national OH strategy development (7 countries), national HIE maturity assessments (8 countries), and mortality surveillance national action plans and data analytics (12 countries), built capacity 7-1-7 targets in central and southern Africa Regions, and strengthened national AMR surveillance systems (17 countries).

In 2022, Africa's surveillance and epidemic intelligence landscape remained highly fragmented. Only 6 African Union Member States reported real-time data to Africa CDC during public health emergencies, limiting continental situational awareness and delaying coordinated action. There was no continental mortality surveillance system, no digital alert platform linking countries in real time, and Event-Based Surveillance was confined to a small number of pilot settings. These gaps constrained Africa's ability to anticipate outbreaks, detect excess mortality, and respond early to emerging threats.

Between 2023 and 2025, Africa CDC led a profound transformation of surveillance and epidemic intelligence, laying the foundations for a continent-wide, data-driven early warning and response system. Surveillance shifted from sporadic reporting to routine, structured, and increasingly digitalised information flows that support timely decision-making at national, regional, and continental levels.

c.1. Expanded Coverage and Data Quality

Africa CDC significantly expanded surveillance coverage and strengthened data quality across the continent:

- Weekly Integrated Disease Surveillance and Response (IDSR) reports are now collected

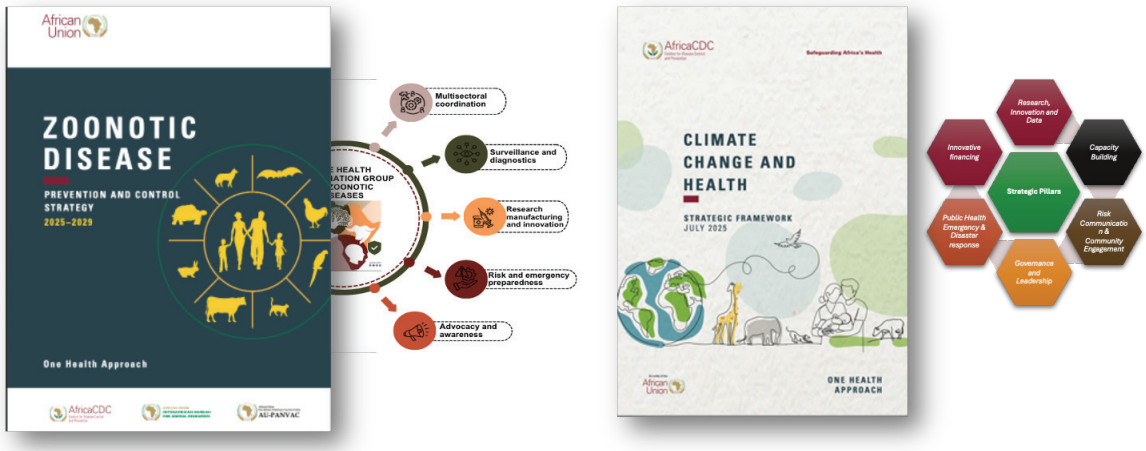


Figure 40: Strengthening Africa's Health Security via One Health

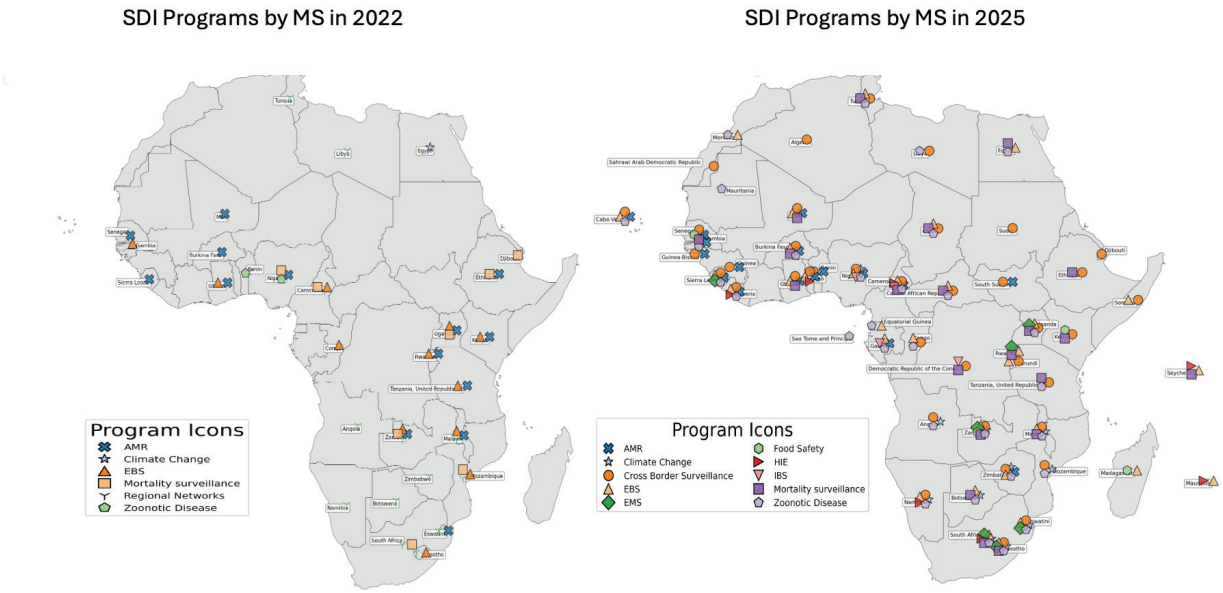


Figure 41: Distribution of SDI Program activities in 2022 vs 2025 (in 2025, SDI reached 41 countries through its capacity devellopment program)

from all African Union Member States through the Event Management System, enabling continuous tracking of public health emergencies continent-wide.

- Timeliness of reporting improved markedly, rising from 40 per cent in 2022 to approximately 68 per cent in 2025, reflecting growing national ownership and confidence in continental systems.
- In collaboration with the WHO, the Africa CDC developed Standard Operating Procedures for country categorisation during mpox outbreaks, classifying countries into four categories based on transmission status to guide escalation, resource allocation, and response intensity.

c.2. Capacity Building and Workforce Development

Investments in surveillance were matched by targeted capacity building to ensure data translated into action:

- A total of 945 Point-of-Entry officers, including both health and non-health staff, were trained across Eastern, Southern, Central, and Western Africa on cross-border alert detection and investigation.
- Africa CDC institutionalised the publication of the Africa Weekly Epidemic Intelligence Report, a regular surveillance bulletin providing a continent-wide overview of public health emergencies and emerging risks.
- Training was delivered to strengthen surveillance of antimicrobial use and consumption and antimicrobial stewardship, supporting early detection of resistance trends alongside epidemic threats.
- 22 countries were supported to develop national strategic action plans for mortality surveillance, including five countries that adapted the continental framework into national mortality surveillance guidelines and seven countries mentored on data analysis and interpretation.

c.3. Digital and Analytics Enhancements

Africa CDC also strengthened the digital backbone required for modern epidemic intelligence:

- Data managers were deployed to the DRC and regional IMST coordination hubs to improve data cleaning, analysis, and visualisation during active responses.
- A continental dashboard (https://dashboards.africacdc.org/) was launched and expanded, providing real-time visibility on cases, laboratory capacity, and vaccine deployment across Member States.
- The Central Data Repository was launched in 2025 to host harmonised datasets from all Member States under data-sharing agreements, marking a major step toward data sovereignty and trusted information exchange.

- Health Information Exchange maturity assessments were conducted for eight Member States, followed by tailored implementation roadmaps to strengthen interoperability and integration of national systems.

Together, these advances represent a fundamental shift from fragmented reporting to a coherent continental intelligence system. Africa CDC and Member States have moved closer to a model in which data flows seamlessly from communities and borders to national authorities, regions, and the continental level, enabling earlier alerts, faster coordination, and more effective action. This transformation in surveillance and analytics is a cornerstone of Africa Health Security and Sovereignty, ensuring that Africa not only responds to outbreaks but also anticipates them with confidence and clarity.

Table 12: Surveillance and Disease Intelligence Key Performance Indicators (2022–2025)

Indicator	2022	2025	(%) Change	Source
Member States Capacitated with in Public Health Intelligence and Event-Based Surveillance capacities	12	37	+208%	Africa CDC Surveillance/ EMS Database
Surveillance experts trained on EBS methodologies	208	1,012	+387%	Africa CDC Surveillance/ EMS Database
Member States with functional event management systems for epidemic intelligence	1	7	+700%	Africa CDC Surveillance/ EMS Database
Member States supported to review and improve national disease surveillance data systems	0	12	New	Africa CDC Surveillance/ EMS Database
Member States supported with ~~EMS~~ surveillance tools (plans, guidelines, SOPs) for investment readiness	8	27	+238%	Africa CDC Surveillance/ EMS Database
Member States reporting health emergency data to Africa CDC in a timely manner during disease outbreaks.	6	21	New	Africa CDC Surveillance/ EMS Database
Member States with National Action Plans aligned with Africa CDC mortality surveillance framework	0	22	New	Africa CDC Surveillance Database
Experts trained in mortality surveillance	0	347	New	Africa CDC Surveillance Database
Member States supported enhancing cross-border surveillance and PoE capacities	0	14	New	Africa CDC Surveillance Database
Surveillance experts trained in cross-border surveillance systems	0	945	New	Africa CDC Surveillance Database
Member States trained on advanced surveillance at Points of Entry	0	14	New	Africa CDC Surveillance Database
Member States with formalised multisectoral One Health coordination mechanisms addressing zoonotic diseases, antimicrobial resistance, climate change, and food safety	0	11	New	Africa CDC Surveillance Database
One Health actors trained	70	150	+114%	Africa CDC Surveillance Database

Indicator	2022	2025	(%) Change	Source
Member States with national One Health strategies for priority zoonoses	0	3	New	Africa CDC Surveillance Database
Member States with multisectoral (human-animal-environment) early warning systems	0	3	New	Africa CDC Surveillance Database
Member States with costed National Action Plans (NAPs) for AMR control	0	7	New	Africa CDC Surveillance Database
Individuals trained on AMR surveillance systems	0	300	New	Africa CDC Surveillance Database
Member States implementing national antibiotic stewardship programmes	0	15	New	Africa CDC Surveillance Database
Member States that have domesticated the IPC legal framework	1	4	300%	Africa CDC Surveillance Database
Member States supported in developing/updating food safety policies and regulations	0	2	New	Africa CDC Surveillance Database
Member States trained on health and climate change-related surveillance	0	6	New	Africa CDC Surveillance Database
HIE maturity assessments conducted in Member States	0	8	New	Africa CDC Surveillance Database
Member States with signed data-sharing agreements with Africa CDC	0	7	New	Africa CDC Surveillance Database
The Africa CDC Central Data-Repository established	0	8% (CDR prototype developed)	New	Africa CDC Surveillance Database

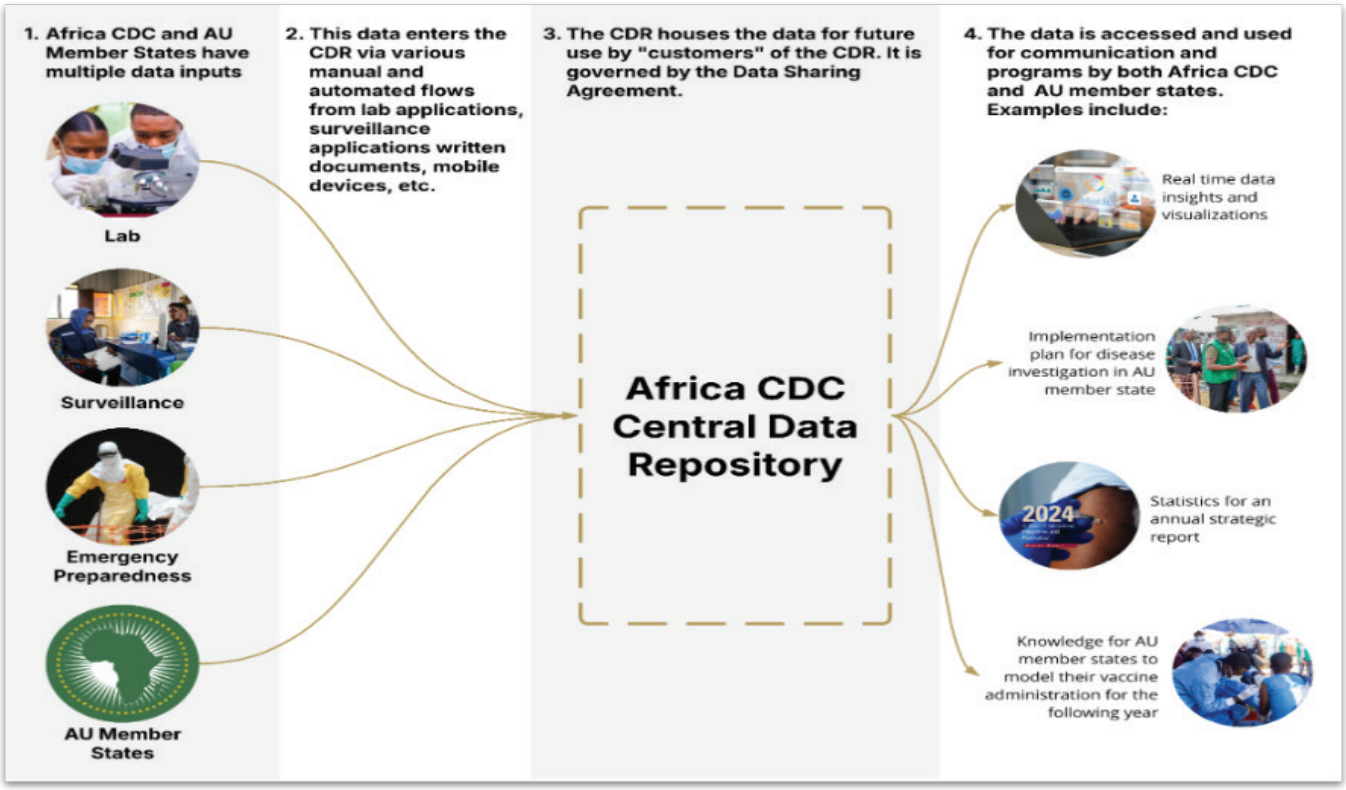


Figure 42: Africa CDC Central Data Repository System & Business Layer Diagram.

Case Study: Enhanced DHIS2 platform for outbreak data analytics

During the mpox response, Africa CDC piloted and rolled out an integrated outbreak data management system and analytics, enhancing the DHIS2 platform. Such enhanced surveillance, data integration, and digital intelligence facilitated quicker, more informed, and decisive actions across the continent. Improved data access and interoperability enabled the Africa CDC to transition from reactive reporting to proactive risk management, fundamentally transforming decision-making and resource allocation throughout Africa.

Key impacts include:

- Accelerated decision-making at the continental level, with risk assessments and epidemiological updates now issued on a weekly basis, compared to quarterly updates in 2022, thereby enabling earlier escalation and more timely guidance to Member States.
- Standardised case definitions and country categorisation frameworks during the mpox outbreak response improved comparability and transparency, allowing Africa CDC to optimise resource allocation, including the prioritisation of countries for vaccine deployment and surge support.

Integration with digital health platforms in 2025 established the foundation for advanced analytics and artificial intelligence–assisted outbreak prediction under the Health Intelligence Program, positioning Africa to anticipate risks rather than respond after escalation. Together, these impacts demonstrate how data, when standardised, trusted, and shared, becomes a strategic asset for health security and sovereignty. We plan to expand such integrated outbreak data management systems at scale across the continent. By accelerating the cycle from detection to decision, Africa CDC has strengthened the continent's capacity to act early, allocate resources equitably, and protect populations more effectively in an increasingly complex threat landscape.

d. Emergency Preparedness and Response

Emergency preparedness and response sit at the heart of Africa Health Security and Sovereignty. For many years, Africa's response architecture relied heavily on temporary coordination structures, external surge support, and donor-driven logistics that dissipated once crises subsided. By 2025, this paradigm had fundamentally changed. Africa CDC, collaborating with Member States and partners, transformed emergency readiness from a conceptual aspiration into an operational reality anchored in permanent institutions, trained personnel, and continent-wide coordination mechanisms that were repeatedly tested during complex emergencies.

Strengthening Public Health Emergency Operations Centres in Member States

A cornerstone of this transformation is the Public Health Emergency Operations Centre network. In 2025, Africa CDC supported 23 Member States to establish or strengthen PHEOCs, bringing the total number of functional centres across the continent to 33, compared to only nine in 2020. These centres now serve as the nerve centres of national response systems, enabling rapid decision-making, real-time data analysis, logistics coordination, workforce deploy-

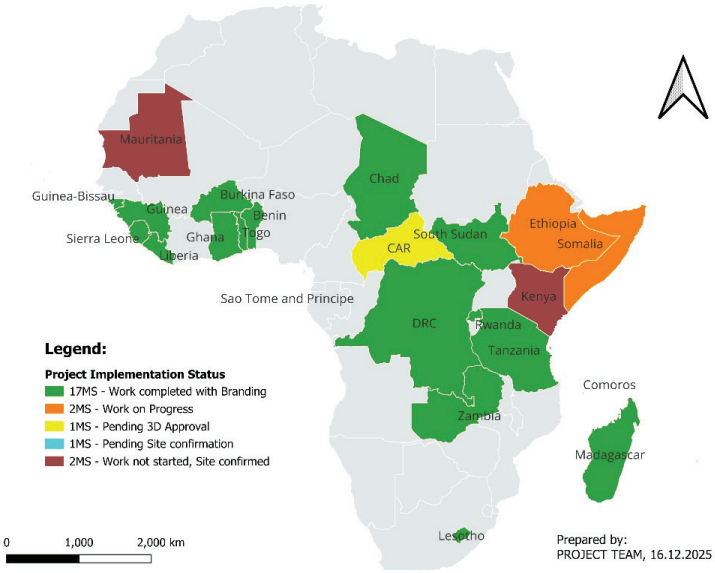


Figure 43:The 23 MS supported with PHEOC infrastructure in 2025

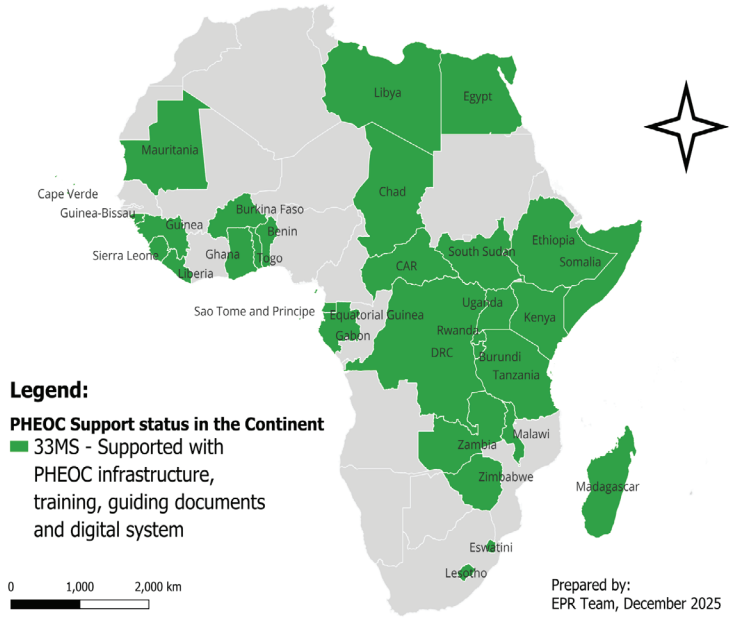


Figure 44: African Volunteers Health Corps

ment, and systematic documentation of incidents and lessons learned. Crucially, PHEOCs are fully integrated with National Public Health Institutes and Ministries of Health, ensuring that information flows seamlessly from communities and borders to national authorities, regional coordination platforms, and the continental level.

Considerable progress was achieved across regions. In Central Africa, fully equipped PHEOCs were established in the Central African Republic, the Democratic Republic of Congo, São Tomé and Príncipe, and Chad through a combination of African Development Bank financing and Africa CDC technical support. In Eastern and Southern Africa, new PHEOCs and digital equipment strengthened multi-hazard readiness, border health security, and cross-border coordination. These investments ensured that preparedness was no longer reactive or episodic but embedded within national systems with permanent capacity.

Africa's continental surge workforce, the African Volunteers Health Corps (AVoHC), provides essential operational support to both the IMST and PHEOCs. Since its establishment (2015), AVoHC has grown from 369 members from only 25 MS (45% coverage) to 1,377 from all 55 MS (100% coverage) in 2025, with representation across all AU regions and a wide range of expertise including epidemiology, clinical care, infection prevention and control (IPC), logistics, mental health and psychosocial support (MHPSS), laboratory sciences, PHEOC management, and risk communication and community engagement.

The progress was also made in terms of gender representation. Female represented on 15% in 2022 and increased to 24% in 2025, with deliberate efforts underway to strengthen gender representation and inclusion across roles and deployments.

Over the past decade, AVoHC has executed more than 575 deployments across 42 Member States, including over 119 deployments in 2025 alone. Operational highlights from 2025 include the extended deployment of 6 Rapid Response Teams across Southern Africa, as well as sustained AVoHC engagements in Central and Eastern Africa, in response to complex emergencies such as Sudan, Somalia, and other affected countries.

AVoHC maintains a 48–72-hour deployment readiness window, underpinned by a standardised, competency-based training curriculum developed with partners such as the UK Health Security Agency and the World Health Organisation. This ensures responders integrate seamlessly into national response structures from the moment of deployment. Through this process, a total of 469 AVoHC received an induction training from 2022 to 2025 and shown below.

These institutional and workforce gains were reinforced by strategic investments in logistics, coordination, and

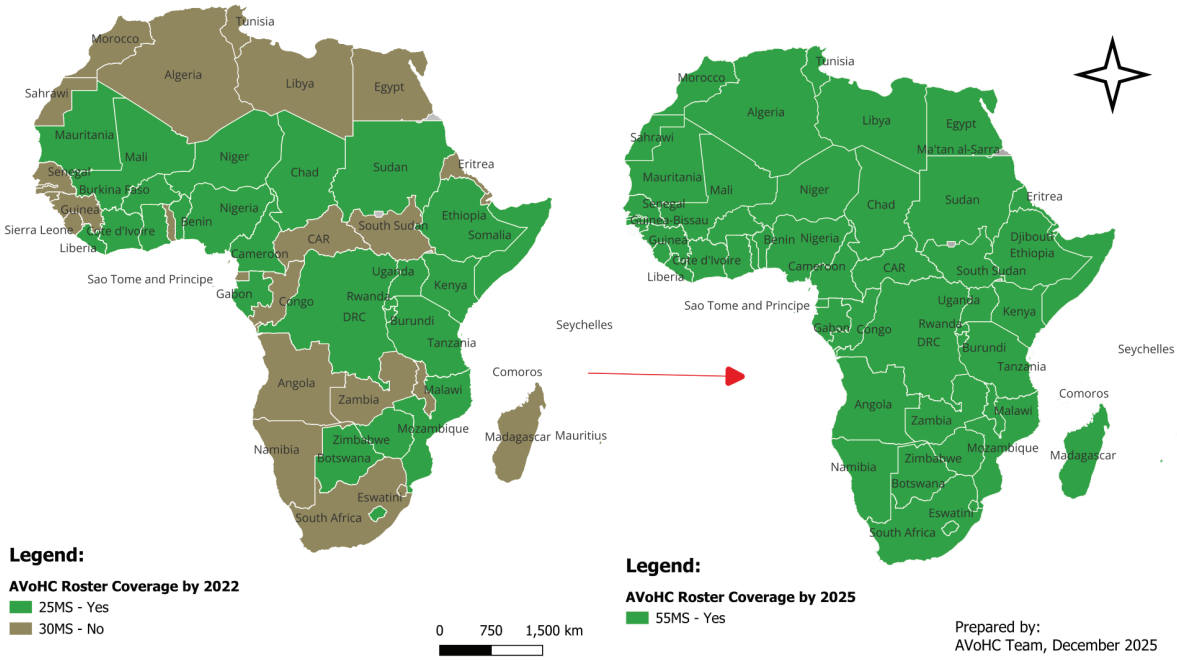


Figure 45:Distribution of AVoHC members across 55 MS in 2022 vs 2025

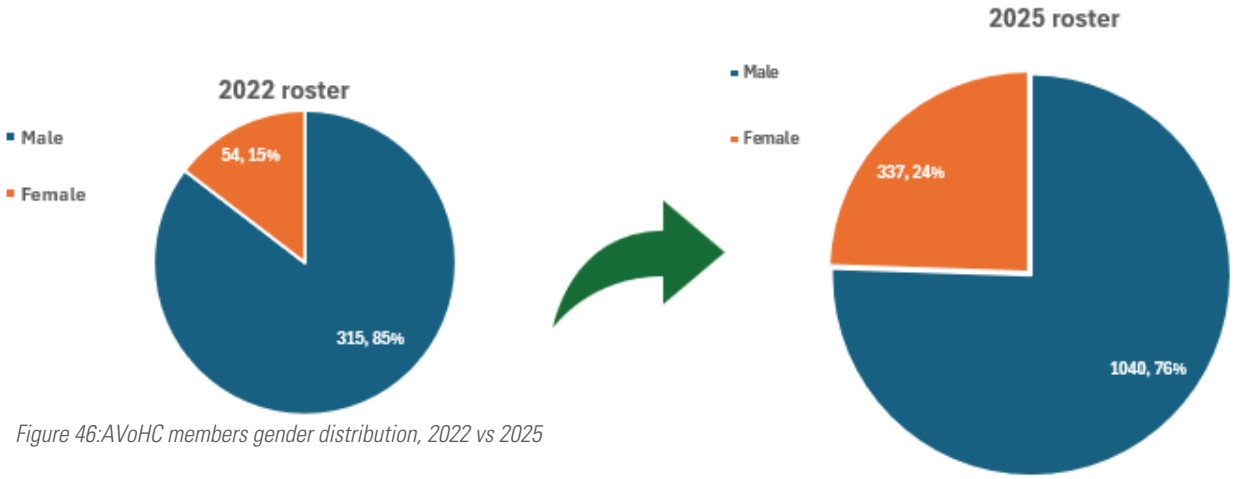


Figure 46:AVoHC members gender distribution, 2022 vs 2025

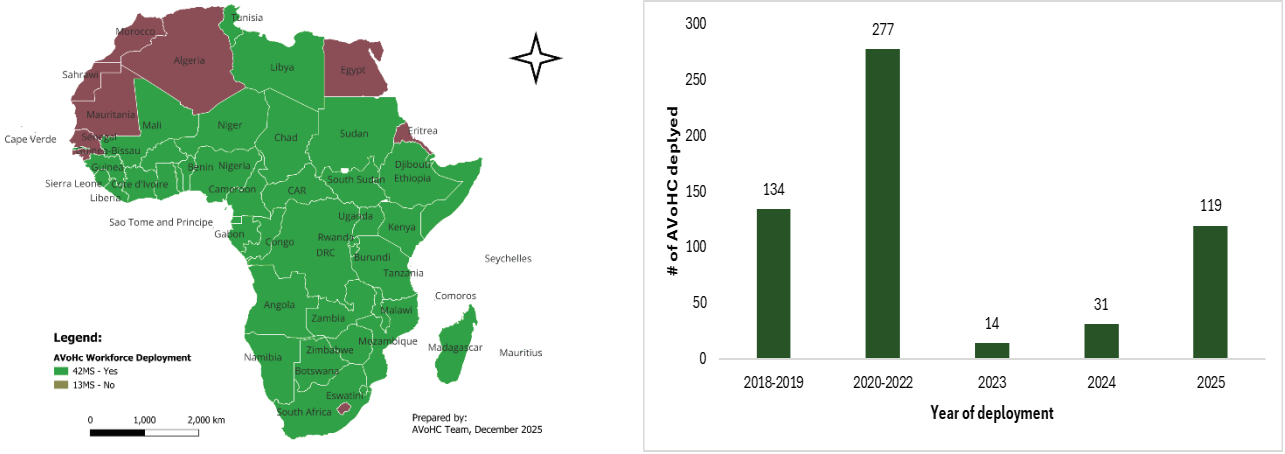


Figure 47: Deployment of AVoHC Rapid Responders to support emergency response in MS, 2018-2025

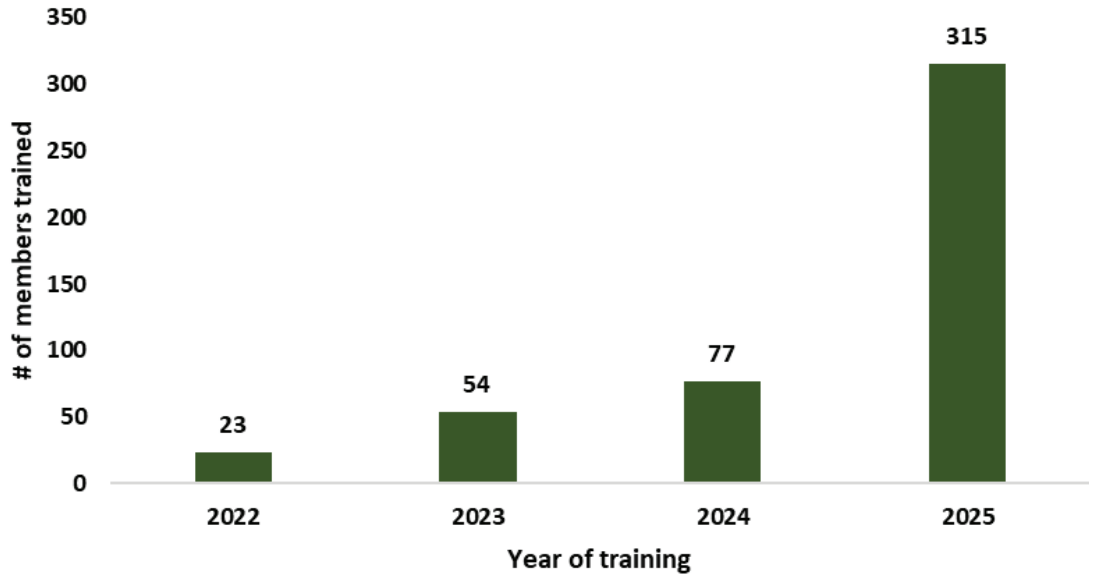


Figure 48: AVoHC induction training from 2022-2025

preparedness testing. From a baseline in 2022, when Africa CDC's emergency preparedness and response structure existed on paper, with only five functional PHEOCs, limited simulation capacity, and no continental logistics base, Africa moved rapidly to build tangible capability.

Key achievements between 2023 and 2025 include:

- Support to 33 Member States with PHEOC infrastructure, training, guiding documents and/or digital systems, backed by USD 8 million from the World Bank grant and Africa CDC's Emergency Fund. National PHEOCs were equipped with emergency operations software and video-conferencing tools, linking them to the RCC and the Africa CDC headquarters.
- Establishment of a continental logistics base in Addis Ababa and Douala in 2024, supported by a USD 2 million investment. These facilities now serve as Africa CDC's central warehouses for medical countermeasures and supported the distribution of more than 515,000 vaccine doses, 175,000 test kits, and 192,000 PPE units to 29 countries during the mpox response.
- Deployment of the joint Africa CDC–WHO Incident Management Support Team model from Kinshasa to coordinate the continental mpox response, mobilising and deploying 119 technical experts through the AVoHC mechanism and 400 community health workers across 29 countries under the principles of one team, one plan, one budget, and one monitoring framework.
- Proactive preparedness through 11 continental and regional simulation exercises conducted between 2023 and 2025, including scenarios on cholera, Marburg virus disease, and multi-hazard crises linking health and climate risks. In 2024, the first cross-border tabletop exercise brought together Kenya, Uganda, Rwanda, and the Democratic Republic of Congo, marking a new level of operational interoperability.

Together, these advances demonstrate that Africa's emergency preparedness and response capacity has moved decisively beyond ad hoc arrangements. Through permanent PHEOCs, a deployable continental workforce, pre-positioned logistics, standardised incident management, and regular stress-testing through simulations, Africa CDC and Member States have built a response architecture that is credible, resilient, and ready. This architecture has been tested repeatedly in 2025 and proven capable of delivering coordinated, country-led action at speed, anchoring Africa's collective resilience and sovereignty in the face of future health threats.

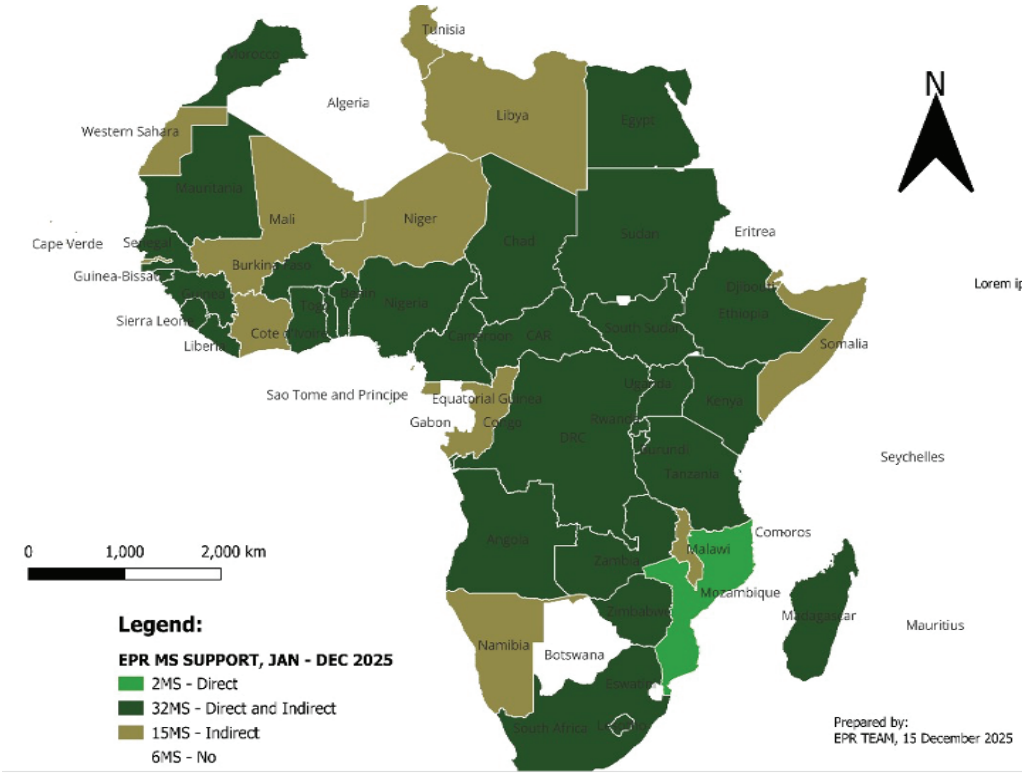


Figure 49: Africa CDC's EPR Support to MS on Health Emergency Response

Table 13: Epidemic Preparedness and Response Key Performance Indicator Results (2022 - 2025)

Indicator	2022	2025	(%) Change	Source
Member States assessed for readiness to respond in a timely manner to priority public health emergencies	0	4	New	EPR Database
Member States with functional national PHEOCs	5	33	+560 %	Malabo Report 2025
Functional Regional PHEOCs established across all five Africa CDC RCCs	0	2	New	EPR Database
National PHEOCs established and equipped with ICT infrastructure	5	32	+540%	EPR Database
Member States supported with personnel training in PHEOC management and IMS	0	8	New	EPR Database
Simulation exercises conducted or facilitated	1	11	+1000 %	EPR Database
Member States supported to conduct JEE assessments	3	8	+167%	EPR Database
Experts trained in Simulation Exercise Planning and Management	30	102	+240%	EPR Database
Risk Ranking prioritisation exercises conducted and reports disseminated to Member States	0	3	New	EPR Database
Member States supported in responding to grade 2 or 3 public health emergency events	60%	95%	+35 pp	EPR Database
Emergency warehouses and logistics hubs established to support response operations	0	1 (Douala)	New	EPR Database

Indicator	2022	2025	(%) Change	Source
AVoHC experts onboarded into the continental roster	369	1,377	+273%	EPR Database
AVoHC expert deployments (person-days per year) supported during emergency responses	15	119	+693%	EPR Database
Emergency deployments supported through AVoHC technical experts	411	575	+40%	Mpox Mid-Term Report 2025/ Annual reports (2018-2024)
CHWs mobilised to support emergency preparedness and response	0	400	New	Mid-Year Report (2025)
CHWs capacitated and deployed to support community-based surveillance, emergency preparedness, and outbreak response efforts	0	3,786	New	Africa CDC PIRS Database
Member States supported in developing public health emergency preparedness and response plans (NAPHS, multi-hazard, multi-sectoral, and contingency plans)	0	6	New	EPR Database
Africa CDC hazard atlas developed to support public health emergency preparedness planning	None	Atlas development in progress	New	EPR Database
Cross-border joint action plans implemented to support preparedness and response to public health emergencies	0	3	New	EPR Database

Operational Readiness and Financing

Africa CDC further strengthened emergency preparedness and response by implementing the Preparedness and Response Action Framework in 2024, explicitly linking technical readiness and operational benchmarks to sustainable financing mechanisms such as the Africa Epidemics Fund. This framework marked a critical shift from reactive, ad hoc funding toward predictable, performance-linked financing that rewards preparedness and early action. During the mpox response, Member States collectively contributed USD 60 million to emergency preparedness and response budgets, demonstrating growing domestic ownership and solidarity. In parallel, Africa CDC's coordinated advocacy and financing architecture helped mobilise a total of USD 1.1 billion in pledges and commitments, reinforcing the principle that Africa-led preparedness, anchored in strong institutions and clear accountability, can unlock significant and timely resources to protect lives, economies, and stability across the continent.

Integration with Other Sectors

Africa CDC further advanced a multi-hazard approach to preparedness and response by deliberately linking health risks with climate shocks and conflict dynamics through its One Health framework. This approach recognises that epidemics increasingly emerge and spread in contexts shaped by environmental stress, population displacement, and insecurity. In 2025, emergency preparedness and response began to interface more systematically with African Union Peace and Security structures, enabling closer coordination between humanitarian action and public health operations in fragile and conflict-affected settings. This integration strengthened Africa's ability to respond coherently to complex crises where health threats cannot be addressed in isolation.

Impact

These advances translated into a profound institutional transformation and measurable operational gains:

- Africa CDC now functions as a continental operations centre, capable of coordinating real-time response, logistics, workforce deployment, and partner alignment, rather than operating primarily as a policy and normative body.
- Average response time for health emergencies was reduced by approximately 50 per cent between 2022 and 2025, reflecting faster detection, financing, and operational mobilisation.

For the first time, Africa CDC successfully led a multi-partner continental response to a major outbreak

of mpox and Cholera without reliance on external management intermediaries, demonstrating Africa's capacity to coordinate large-scale emergency operations under its own leadership.

e. Science and Innovation

In 2022, Africa's research landscape for emerging and re-emerging pathogens remained fragmented and under-coordinated. Africa CDC lacked a formal continental research coordination mechanism, and collaboration among national institutes, academic institutions, and funders lacked structure and strategic alignment. African scientists were largely positioned as data contributors rather than leaders or developers of therapeutics and other medical countermeasures. In parallel, there was no comprehensive mapping of research infrastructure or an integrated understanding of research capacity across the continent. These gaps limited Africa's ability to rapidly generate evidence, influence global research agendas, and translate science into operational response.

Between 2023 and 2025, Africa CDC led a decisive shift toward African-owned, African-led research and innovation, positioning science as a core pillar of health security and sovereignty. This transformation anchored research firmly within preparedness and response systems, ensuring that evidence generation, innovation, and policy were mutually reinforcing.

Continental Research and Innovation Leadership

Africa CDC established a continental framework for research coordination and governance, enabling scale, coherence, and ethical leadership:

- The Africa CDC Research and Innovation Coordination Platform was launched in 2024, linking more than 2,500 scientists and 26 national research institutes. Continental frameworks on research governance, prioritization, and ethics were co-developed with African scientists, policymakers, and academics to guide equitable and impactful research across the continent.
- Forty-eight mpox-related studies were coordinated across Africa in partnership with WHO, CEPI, and the U.S. National Institutes of Health, addressing critical operational, clinical, and implementation gaps identified during the response.
- The Mpox Research Blueprint was developed in 2024, defining priority research areas including vaccine effectiveness, viral genomics, socio-behavioural sciences, and animal reservoir investigations, ensuring that research efforts were aligned with public health needs.
- Africa CDC co-led the implementation of the only mpox therapeutic clinical trial globally following the failure of tecovirimat to demonstrate efficacy, marking a historic step in positioning Africa as a leader in clinical research for emerging pathogens.

Strengthening pharmacovigilance and safety surveillance at Africa CDC

Pharmacovigilance and safety surveillance are central to Africa CDC's mandate, particularly during public health emergencies and outbreaks that require rapid deployment of vaccines and other medical products. During the review period, Africa CDC provided continental leadership to strengthen national and regional pharmacovigilance systems, focusing both on capacity strengthening and evidence generation to ensure timely, high-quality safety monitoring across AU Member States.

To build regional capacity, the PV Unit, in collaboration with Safety Platform for Emergency Vaccines (SPEAC), a CEPI-funded project, conducted Data and Safety Monitoring Board (DSMB) training in two cohorts, reaching 66 participants from over 30 AU Member States, strengthening their understanding of DSMB roles, responsibilities, and safety oversight in clinical trials and emergency vaccine deployments. Building on this, a two-day continental training on Adverse Events of Special Interest (AESIs) benefited 40 participants from 20 member states, enhancing their skills in identifying, reporting, and managing AESIs to ensure timely safety monitoring during vaccine rollouts and public health emergencies. Additional cohorts for DSMB and AESI training are planned for 2026 to expand the pool of capacitated experts, ensuring broader coverage across the continent.

In parallel, Africa CDC advanced efforts in pharmacovigilance evidence generation. In collaboration with WHO, CEPI, PATH, and the National Pharmacovigilance Center, the PV Unit implemented a cohort event monitoring (CEM) study to assess Mpox vaccine safety in the DRC, enrolling over 24,000 participants and providing critical real-world evidence to guide vaccine safety oversight and public health decision-making. Complementing this, a continental survey was conducted to identify barriers and facilitators affecting signal detection and management within National Regulatory Authorities and Pharmacovigilance Centres, with findings informing targeted interventions to strengthen safety monitoring systems and optimize regulatory responses during routine operations and emergencies.

Additionally, a recommendation was made to standardize pharmacovigilance tools, practices, and protocols during public health emergencies. This aims to support uniform practices and ensure timely, comparable safety data across AU Member States. With support from the Mastercard Foundation's Saving Lives and Livelihoods

Figure 50: AESIs training participants

initiative and the Infectious Diseases Institute, three generic protocols were developed to support emergency pharmacovigilance, including protocols for cohort event monitoring, sentinel site-based safety surveillance, and tracking safety outcomes among pregnant individuals during vaccine rollouts, providing adaptable frameworks for consistent, evidence-based monitoring during outbreaks.

Research on Health Systems Strengthening

Research on Health Systems Strengthening (HSS) has been instrumental in advancing Africa CDC's mission to strengthen health systems, improve health outcomes, and enhance preparedness for public health emergencies. Operating in a context of persistent disease burden, recurrent outbreaks, and declining external financing, the HSS Division focuses on policy-relevant, equity-centered, and responsive research that addresses the complex realities of African health systems.

Health systems across Africa face structural and operational challenges, including fragmented service delivery, limited domestic financing, weak implementation of interventions, and insufficient use of evidence in decision-making. Emergencies such as Ebola, Mpox, malaria resurgence, and tuberculosis highlight gaps in preparedness, continuity of services, and community trust. Many interventions fail not because of a lack of efficacy but because of weak implementation, inadequate contextual adaptation, and limited community engagement.

Development of an Operational Research framework during Emergencies and conducting operational research on multiple health priorities

Given the unique challenges of African health systems, including resource constraints, fragmented services, and recurrent outbreaks, there was a critical need for a context-specific framework to guide operational research during public health emergencies. Africa CDC developed an Operational Research Framework for Public Health Emergencies in Africa. This framework provides structured guidance for embedding research into emergency response cycles, generating real-time, policy-relevant evidence to inform coordination, service delivery, risk communication, and resource allocation. It will be made publicly available online to support uptake by Member States and partners.

Complementing this framework, operational research on malaria in Namibia, Zimbabwe, and Lesotho has identified bottlenecks in vector control delivery, essential commodity supply, and community adherence, producing recommendations to strengthen malaria programs (https://africacdc.org/news-item/africa-cdc-launches-operational-research-on-malaria-in-southern-africa/.

Ongoing operational research on Ebola in the Democratic Republic of Congo examines how health systems maintain essential services and coordinate response under prolonged outbreak conditions.

Figure 51: Field-based operational research on malaria entomology – data collection activities, 2025

Implementation Research for Health Service Improvement

Tuberculosis treatment outcomes in many African settings are undermined by high rates of patient default and loss to follow-up, highlighting the urgent need for innovative strategies to support adherence and ensure treatment completion. To improve tuberculosis patient adherence, Africa CDC conducted implementation research in Liberia and Ethiopia, exploring digital interventions including two-way SMS and phone calls. These studies address treatment adherence gaps by providing evidence on the feasibility, acceptability, and scalability of digital adherence technologies in resource-limited settings, in line with global best practices. https://africacdc.org/news-item/africa-cdc-study-explores-sms-messaging-to-strengthen-tb-treatment/

Socio-Behavioral Research and Community Engagement

Understanding behavioral drivers is critical for effective outbreak response. Africa CDC conducted socio-behavioral research on mpox across ten Member States, with data collection completed in eight countries. Findings have informed culturally appropriate risk communication and community engagement strategies, increasing compliance with preventive measures and enhancing trust in health services.

Health System Reform and Sustainability

In response to declining donor funding, the Africa CDC conducted a rapid multicountry assessment on health system reforms, examining financing, governance, and service delivery innovations. Data collection in Zimbabwe and Burundi has highlighted strategies to enhance system resilience, strengthen primary health care, and advance Universal Health Coverage, providing evidence to guide sustainable domestic financing and governance models.

Through these integrated efforts, Africa CDC demonstrates leadership in translating evidence into actionable interventions, addressing systemic health challenges, and supporting Member States in routine and emergency contexts.

Strengthening Scientific Publishing Capacity of African Health Researchers

Africa lags behind the global average in publication output. Only 2-3% of global health-related publications are authored by African researchers, despite Africa bearing 25% of the global burden of disease. This is due to limited capacity among African researchers, limited research and publication funding, and the inherent bias of journal publishers against African researchers and manuscripts, among other factors. Africa also lags in documenting the best practices and lessons from program implementation. Africa CDC is addressing this gap by implementing a well-tailored scientific writing training and mentorship program for early-career health professionals and researchers from National Public Health Institutes and Ministries of Health. In 2025, Africa CDC provided scientific writing training and mentorship to more than 80 participants from 25 AU member states, resulting in the development of manuscripts from health programmes they were implementing in their respective countries. Africa CDC published a record number of 158 high-quality, policy-relevant scientific articles in international peer-reviewed journals (*Figure 52)*

Africa CDC-owned Journal of Public Health in Africa (JPHIA) provides a platform to bring the African health

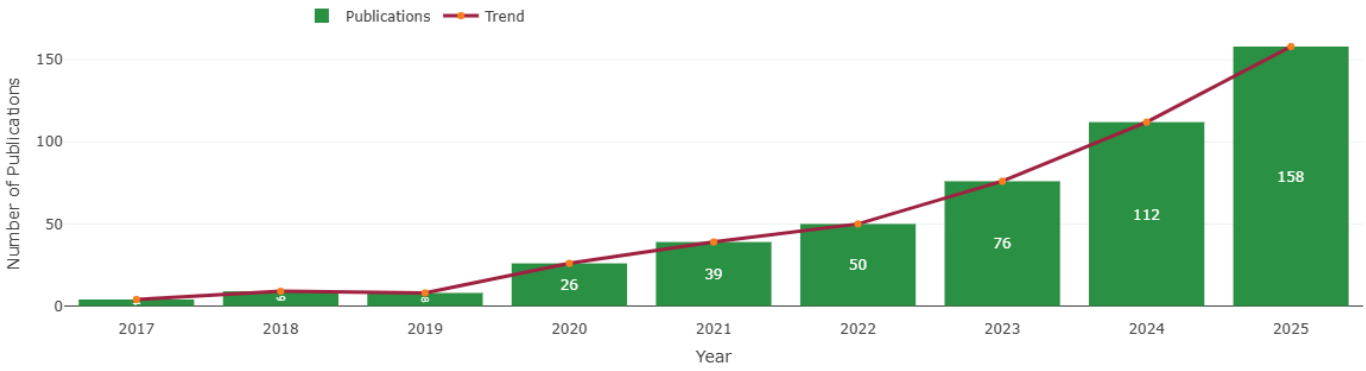


Figure 52: Trend of scientific publications by Africa CDC

discourse, lessons, and practices to the forefront. In 2025, the JPHIA published a record 167 articles submitted from 47 African countries (*Figure 53).*

Knowledge Management system facilitating knowledge exchange and informed decision-making

Africa CDC is mandated to strengthen the capacity of public health institutions across Africa through a continent-wide network focused on preparedness, surveillance, laboratory systems, emergency response, and research. Central to this mission is a robust knowledge management infrastructure that ensures timely access to information, fosters collaboration, and enhances evidence-based decision-making. A strong knowledge management system enables: the generation, collection, and dissemination of critical public health information; collaboration among stakeholders to share lessons learned and best practices; data-driven decision-making to improve epidemic preparedness and response; and timely communication with the public and partners during health emergencies.

As per the Africa CDC strategic plan (2023-2028), knowledge management activities have been implemented to strengthen the translation of research into policy and practice and to foster knowledge and information exchange across member states. This includes, but is not limited to, proactively identifying where new guidance is needed to support member states in policy development (both for emergency and non-emergency contexts), analyzing evidence to develop guidance materials for member states, promoting frameworks that guide member states' public health policy development, regularly assessing gaps within existing policy frameworks, regularly publishing African scientific findings, and capacitating researchers in member states to publish in Africa CDC's Journal of Public Health in Africa and other scientific journals. It also includes proactively engaging member states on relevant public health policy guidance and recommendations and providing technical assistance to support member states in translating policies into practice, including the adoption of innovations and the facilitation of health knowledge generation, sharing, and translation in member states.

Africa CDC has established the African Knowledge Management Platform (https://khub.africacdc.org/)—a centralized platform that curates and shares knowledge products from both Africa CDC and Member States. These include outbreak response reports, best practices, and innovative solutions to strengthen health systems and disease control efforts. In 2025, Africa CDC strengthened the knowledge management systems by developing guiding documents such as the knowledge management strategy, framework, and implementation roadmap, launching the continental knowledge management portal, and scaling up this initiative by expanding the hub's reach to five Member States—Namibia, Gabon, Tunisia, Uganda, and Nigeria. Rolling out to more member states will continue in 2026.

Innovation and Technology Development

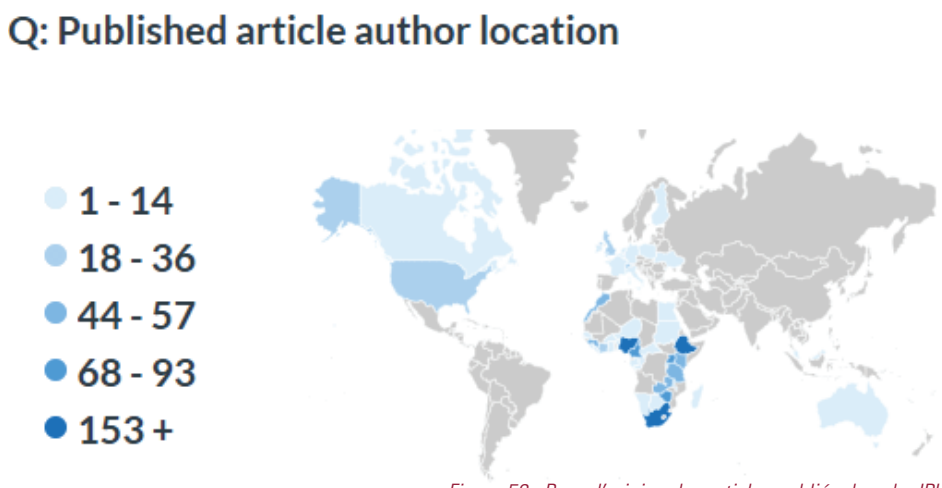


Figure 53 : Pays d'origine des articles publiés dans le JPHIA

Africa CDC also advanced innovation as a strategic enabler of preparedness and response, bridging research with digital transformation and product development:

- The Africa CDC Innovation Hub was launched in 2024 to incubate digital and biotechnology solutions for disease surveillance, outbreak response, and health system resilience.
- Pilot artificial intelligence–based early-warning tools integrating climate and outbreak data were supported in Kenya and Rwanda, strengthening predictive analytics for epidemic preparedness.
- Partnerships with the Science, Technology and Bioinformatics Fund enabled the establishment of National Intelligence Data Centres, linking research with digital analytics for maternal and child health and epidemic monitoring.
- In collaboration with Drive Africa at the University of Cape Town and the DRIVE Centre at Emory University, Africa CDC supported the development of two antiviral candidates targeting chikungunya and filoviruses, including Ebola Sudan, Ebola Zaire, and Marburg viruses.
- Africa CDC launched the first AI-enabled study for the detection of mpox in Kinshasa, Democratic Republic of Congo, demonstrating the feasibility of deploying advanced digital diagnostics in high-burden, complex settings.

4th International Conference on Public Health in Africa (CPHIA)

The 4th International Conference on Public Health in Africa (CPHIA 2025), held in Durban, South Africa, marked a defining moment in Africa's health diplomacy and institutional leadership. Convened under the theme "Moving Towards Self-Reliance to Achieve Universal Health Coverage and Health Security in Africa," the conference brought together over 1,400 in-person delegates, 16,530 virtual participants, and leaders from more than 20 countries, including ministers of health, scientists, civil society, and youth.

CPHIA 2025 firmly positioned Africa CDC as the lead voice on the continent's health agenda, with the Director-General declaring, ***"Africa is no longer a recipient. We are co-architects of global health."*** The event was strategically aligned with the continent's push for health financing autonomy, local manufacturing, and integrated digital and genomic systems.

With over **48 in-person side events, three plenaries, and 8 high-level sessions**, the conference facilitated policy alignment on priority areas, including:

- Domestic health financing and investment cases
- PHC digitalisation and resilient infrastructure
- Local manufacturing of vaccines and diagnostics
- One Health, climate resilience, and AMR
- Continental accountability frameworks and data sovereignty

Importantly, **the Durban Promise,** the outcome declaration of CPHIA 2025, set forward an African-led commitment to strengthen public health institutions, workforce development, and regional collaboration. The launch of the **Africa CDC Strategy for Youth En-**

The CPHIA 2025 in Durban, South Africa.

gagement and Participation in Global Health (YES! Health) 2025-2028, in collaboration with GIZ African Union, brought renewed focus on intergenerational investment and innovation, and reinforced the commitment to building a future where young people lead Africa's public health transformation.

CPHIA is now widely recognised as Africa's flagship convening on public health policy, science, and investment. Its outcomes feed directly into the African Union's AHSS Agenda and the global health reform discourse, ahead of South Africa's G20 Health Ministers' Summit.

Together, these achievements mark a fundamental transformation. Africa is no longer a passive site for externally driven research but an active architect of its scientific future. By institutionalising research coordination, elevating African scientific leadership, and linking innovation directly to preparedness and response, Africa CDC has laid the foundations for a sovereign research ecosystem capable of generating solutions for Africa and contributing meaningfully to global health security.

Table 14: Science and Innovation Key Performance Indicator Results (2022 - 2025)

Indicator	2022	2025	Change (%)	Source
Active continental research projects coordinated by Africa CDC	0	48	New	Mid-Term Mpox Report 2025)
Scientists engaged in Africa CDC-led continental network	200	2,500	+1,150 %	Africa CDC PIRS Database
Research blueprints published (Africa CDC)	0	3	New	Africa CDC PIRS Database
Continental research ecosystem formally established and operational	No	Yes	New	Africa CDC PIRS Database
Scientific publications from Africa CDC	50	158	+216%	Publications Tracker
African-led scientific articles published in the Journal of Public Health in Africa (JPHIA)	0	167	New	JPHIA dashboard

Africa CDC leadership and young people at the launch of YES!Health Strategy at CPHIA 2025, Durban, South Africa.

Indicator	2022	2025	Change (%)	Source
Policy briefs and technical guidance developed and disseminated based on African-generated research	0	2	New	Africa CDC PIRS Database
Continental mapping of health research institutions completed.	0	36	New	Africa CDC PIRS Database
Institutions supported with research capacity needs assessments	0	70	New	Africa CDC PIRS Database
Member States adopting knowledge management and sharing systems	0	5	New	Africa CDC Knowledge Hub Portal

Partnerships for Scientific Excellence

Strategic partnerships are central to Africa CDC's ambition to position Africa not only as a site of research but as a global leader in scientific discovery, innovation, and translation. Between 2023 and 2025, Africa CDC deliberately reshaped its partnerships to move beyond transactional collaboration toward co-creation, shared governance, and African scientific leadership, ensuring that global cooperation strengthens continental capacity and health security and sovereignty.

Key achievements include:

- Africa CDC co-convened the Africa Research Summit in 2024 with the WHO Regional Office for Africa and the Coalition for Epidemic Preparedness Innovations, bringing together governments, funders, and scientists to define joint priorities for pandemic research aligned with Africa's needs and realities.
- Through coordinated advocacy and strengthened scientific credibility, Africa CDC secured USD 40 million in co-funding for applied research from the U.S. National Institutes of Health, the European Union's Horizon Europe program, and the Wellcome Trust, reinforcing Africa-led research on priority epidemic threats.
- A formal collaboration was established with the

Africa Health Research Institutes Consortium to strengthen ethical review processes, harmonise data standards, and promote trust, transparency, and equity in multicountry research.

- Africa CDC co-convened an African Scientific Conference on Natural Therapeutics with the Government of Uganda, bringing together one hundred African scientists from multiple Member States. This conference led to the development and launch of two natural therapeutic molecules against mpox discovered and advanced by African scientists, demonstrating Africa's capacity to translate indigenous knowledge and local innovation into concrete health solutions.
- Strategic collaborations were established with leading research institutions in South Africa, including the National Institute for Communicable Diseases, the Council for Scientific and Industrial Research, and the Nuclear Medicine Research Institute, as well as with the Kenya Institute of Primate Research. These partnerships support African scientists across the full research continuum, from discovery science to in vitro and in vivo studies, helping bridge the gap between innovation and translational impact.

Together, these partnerships illustrate a new model of scientific collaboration in which Africa sets the agenda, leads discovery, and translates science into solutions for its own populations and for the global community. By anchoring partnerships in equity, shared governance, and long-term capacity building, Africa CDC is contributing to a sovereign and sustainable African research ecosystem that strengthens preparedness, response, and resilience across the continent.

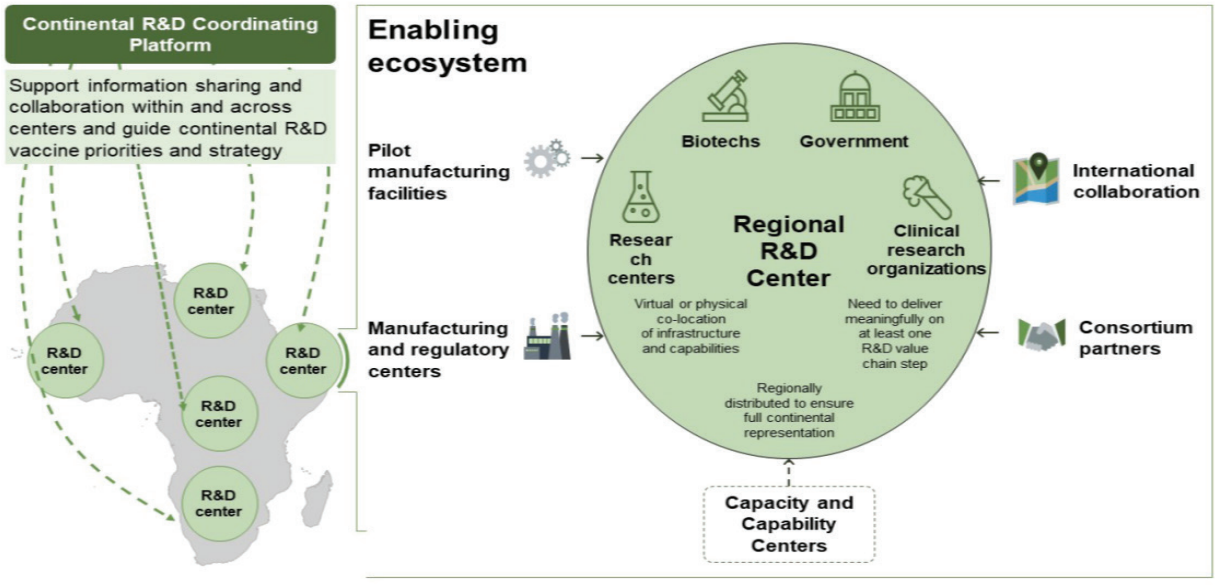
Africa CDC strengthened continental research governance, knowledge management, and applied research, supporting 35 Member States in mapping and defining national health research priorities and identifying health research institutions involved in drug discovery, pre-clinical research, and clinical trials. Mapping outputs identified forty-eight drug discovery sites, 370 basic science and pre-clinical research sites, 209 clinical trial sites, and two hundred vaccine research sites. Outbreak research governance was strengthened through an ethics workshop held in Kigali in September 2025, which produced guidelines for a 10–15-day joint ethics review procedure.

Key results in 2025

Africa CDC has emerged as the continent's scientific coordinator and trusted knowledge broker, anchoring research, innovation, and evidence generation within Africa's broader agenda for health security and sovereignty. Under its leadership, Africa's research priorities are no longer peripheral but increasingly shape global discussions and investments on pandemics, climate and health, and biomanufacturing. This shift has translated into faster action: the time from research concept to implementation has been reduced from an average of 12 months in 2022 to approximately four months in 2025, enabling evidence to inform responses in near real time.

As a result, international research institutions from Europe, the United States, and Latin America are increasingly seeking structured partnerships with the Science Directorate of Africa CDC, recognising it as the continent's scientific clearing house for research and de-

Figure 54: Africa CDC Science and Innovation Ecosystem (2025)



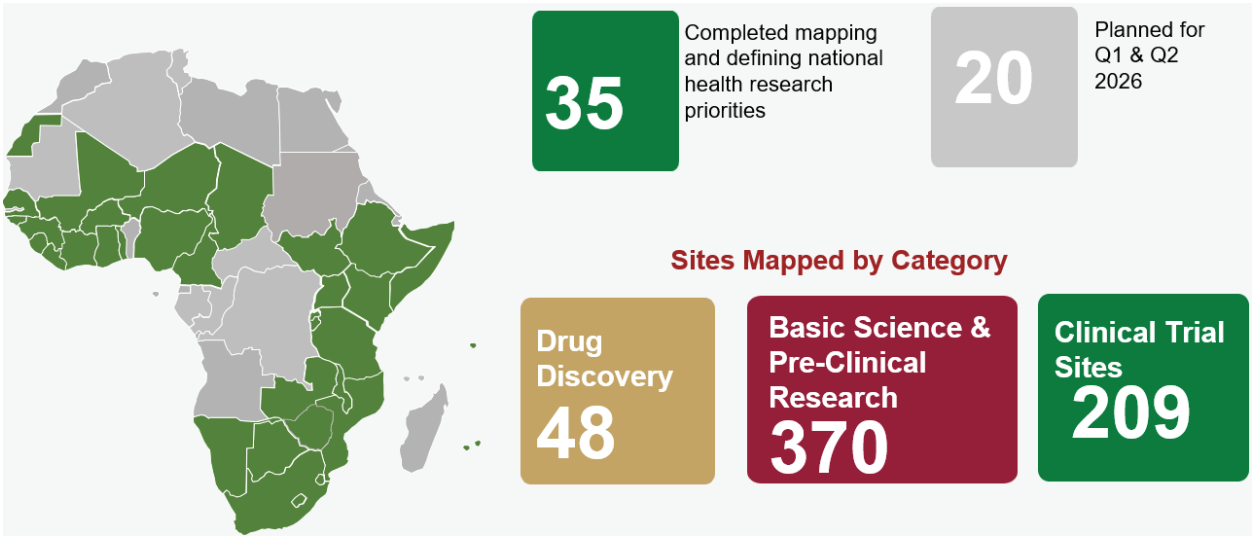


Figure 55: Africa CDC Science and Innovation Mapping of Research Infrastructure in Africa (2025)

velopment. This role strengthens coordination, reduces duplication, and ensures that research conducted on the continent directly supports outbreak response and accelerates progress towards Africa's local manufacturing agenda. Together, these gains demonstrate that Africa CDC is not only coordinating science but also actively redefining how knowledge is generated, governed, and translated to protect Africa's health and future.

Emergency Financing (AfEF and Mpox Funds)

In 2025, the Africa Epidemics Fund (AfEF) shifted emergency response financing from a vulnerability to a continental asset. Under Africa Health Security and Sovereignty, AfEF is not merely a funding line; it is Africa's outbreak insurance mechanism: fast, African-governed, and designed to stop epidemics before they become crises. Historically, delayed financing meant delayed action, and delayed action meant escalation. AfEF reversed that logic by cutting the average time to mobilise emergency financing from 21 days to 7 days, enabling earlier containment through rapid diagnostics, the immediate deployment of AVoHC and IMST capacity, community protection and RCCE, and the timely replenishment of emergency stockpiles.

The Africa Epidemics Fund (AfEF) and associated mpox emergency financing translated continental commitments into visible operations on the ground. A total of USD 38,691,743 was secured, of which USD 14,031,265 was disbursed or committed to emergency operations, leaving a current AfEF balance and rapid-response window of USD 24,660,478 to sustain readiness and enable immediate activation when outbreaks emerge or escalate. These resources supported cholera preparedness and response through the procurement of rapid diagnostic tests in twelve countries, financed emergency operations during mpox and Marburg responses, and strengthened cross-pillar execution by aligning funding decisions with operational readiness and logistics capacity. In mpox high-burden settings, including Sierra Leone, Ghana, Guinea, Liberia and others, AfEF helped sustain response operations where caseloads and pressure on health systems were highest. In Namibia, AfEF-enabled action within 48 hours of the outbreak declaration supported early technical assistance, strengthened surveillance and case management, and accelerated laboratory confirmation, contributing to containment at source with no more than two confirmed cases.

AfEF also financed critical country missions and response acceleration packages in priority settings affected by mpox and cholera (including Angola, Burundi, Congo, Democratic Republic of Congo, Kenya, Malawi, and others). These missions supported high-level coordination, intra-action reviews, vaccination supervision and active case search, supportive supervision for surveillance and IPC, and intensified RCCE and community-based activities to reduce fragmentation and strengthen country ownership of response execution. These actions directly reinforced the path towards de-escalation and the transition from emergency control to sustained elimination efforts.

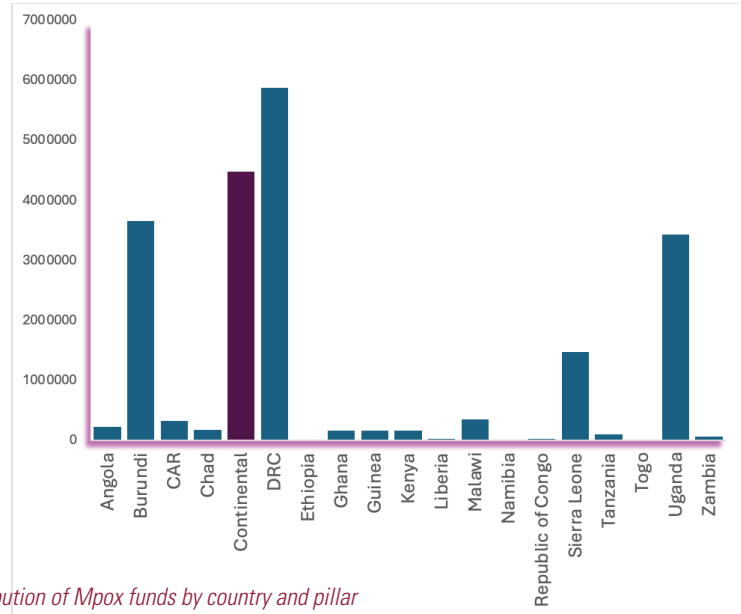


Figure 56:Distribution of Mpox funds by country and pillar

AfEF strengthened the backbone systems that translate political decisions into operational action. In 2025, AfEF-supported investments enabled a 40 per cent expansion of storage and distribution capacity at the AU logistics hub in Douala, Cameroon, reinforcing Africa's ability to move vaccines, PPE, and laboratory supplies quickly across borders. This is what security looks like in practice: predictable financing linked to prepositioned supplies, coordinated surge teams, and a standing incident management architecture. AfEF therefore increases continental confidence not by promise but by proven speed, reach, and repeatable delivery.

AfEF as the financing engine of ERRS

Looking ahead, AfEF will be positioned as the catalytic financing engine for the Emergency Response Readiness System (ERRS), Africa CDC's legacy model from the mpox response, designed to strengthen the first 48 hours to four weeks of any outbreak response. ERRS will institutionalise a continentally owned "ready-to-act" mechanism built on pre-approved plans, surge rosters, logistics pathways, and rapid decision-making at HQ, RCC, and country levels. AfEF will make ERRS operational by ensuring that, as soon as an outbreak is declared or escalates, financing is released immediately to activate deployments, diagnostics, and materials, without waiting for ad hoc pledges or delayed procurement.

In this model, AfEF provides fast-disbursing, trigger-based financing, while ERRS provides the operational architecture that converts resources into action. Together, they will ensure that outbreaks are contained at source, response fragmentation is minimised, and Member States experience preparedness as real protection, not an abstract promise.

AfEF's future will also be strengthened through deliberate linkages with longer-term financing instruments, including Pandemic Fund–supported investments and the African Development Fund. The strategic direction is to create a coherent financing ladder: AfEF to finance and execute the first-response surge; Pandemic Fund and AfDB instruments to finance sustained system strengthening, including PHEOCs, laboratories, surveillance, the workforce, and local manufacturing, so that every emergency response simultaneously builds lasting resilience. This integrated approach will reinforce Africa's health security, accelerate sovereignty, and demonstrate that investing early in preparedness is the most cost-effective way to protect Africa and the world.

Country Impact

Pandemic prevention, preparedness, and response delivery translated into clear and tangible benefits for African Union Member States. By moving from fragmented, crisis-driven support to integrated continental systems, Africa CDC enabled countries to respond faster, coordinate better, and sustain essential health services even under prolonged pressure.

Key benefits for Member States included:

- Faster detection and reporting of public health threats, reducing surveillance blind spots and enabling earlier, more decisive intervention.
- Reduced response fragmentation, as countries operated within a shared continental incident management framework that aligned national efforts with regional and continental coordination.
- Predictable access to surge expertise through Africa CDC mechanisms, allowing countries to rapidly address critical skills gaps without lengthy bilateral negotiations or ad hoc arrangements.
- Expanded laboratory reach, particularly for diagnostics and genomic sequencing, strengthening outbreak detection, monitoring, and response at subnational and national levels.

- Stronger national ownership, with preparedness and response capacities embedded within national institutions rather than dependent on external or temporary platforms.

For countries facing repeated or concurrent outbreaks, PPPR support proved especially transformative. By stabilizing response operations and reinforcing institutional continuity, Africa CDC helped reduce operational strain, protect essential health services, and ensure that emergency response did not come at the expense of long-term system resilience.

Translating Continental Strategy into National Impact

Between 2023 and 2025, Africa CDC shifted from episodic emergency support to embedded, country-owned delivery, demonstrating how continental systems translate into measurable national outcomes. The following case studies illustrate how laboratories, vaccines, genomics, and therapeutics were mobilized under a unified architecture to strengthen preparedness and response.

Case Study in Burundi: Decentralizing Laboratory Capacity during the Mpox Response

Challenge

At the onset of the mpox outbreak, Burundi faced limited diagnostic capacity concentrated in the capital, leading to delays in confirmation, contact tracing, and response escalation particularly in border and rural areas. Through the IMST laboratory pillar, Africa CDC supported rapid decentralization of mpox diagnostics, deploying testing capacity to sub-national laboratories and strengthening sample referral networks. This included:

- Moving from one to fifty-six laboratories able to detect mpox
- Deployment of GeneXpert platforms and cartridges
- Training of laboratory personnel in mpox diagnostics and biosafety
- Integration of decentralised laboratories into national and continental reporting systems

Impact

- Diagnostic turnaround times were significantly reduced.
- Mpox testing expanded beyond the capital to all fifty-six districts of the country.
- Earlier detection enabled faster isolation, contact tracing, and community engagement.

Strategic Significance

Burundi demonstrated that laboratory decentralisation is not a luxury but a prerequisite for epidemic control, validating Africa CDC's strategy of embedding diagnostics within routine national systems rather than relying on centralised emergency testing.

Case Study in Uganda: Generating Evidence on Mpox Vaccine Effectiveness in Real-World Settings.

Challenge

As mpox vaccines were deployed under emergency conditions, there was limited funding, real-world evidence on effectiveness, optimal targeting, and operational feasibility in African settings. Africa CDC supported Uganda to mobilise 361,480 doses of vaccines and integrate vaccine effectiveness research into the mpox response by:

- Deploying 193,958 doses of vaccine to control the outbreak
- Embedding research protocols within routine vaccination activities
- Strengthening surveillance to link vaccination status with clinical outcomes
- Supporting collaboration between national authorities, Africa CDC, and academic partners

Impact

- Uganda generated locally relevant evidence on mpox vaccine effectiveness.
- Findings informed adaptive vaccination strategies and prioritisation of high-risk groups.
- Evidence contributed to continental learning and policy discussions on mpox vaccination.

Strategic Significance

Uganda illustrates how response and research can be integrated, enabling Africa to generate its own evidence base and reduce dependence on external data for policy decisions.

Case Study in Rwanda: Rapid and Innovative Response to Marburg Virus Disease

Challenge

The detection of Marburg virus disease (MVD) required an immediate, high-precision response to prevent escalation, given the pathogen's high case fatality rate and

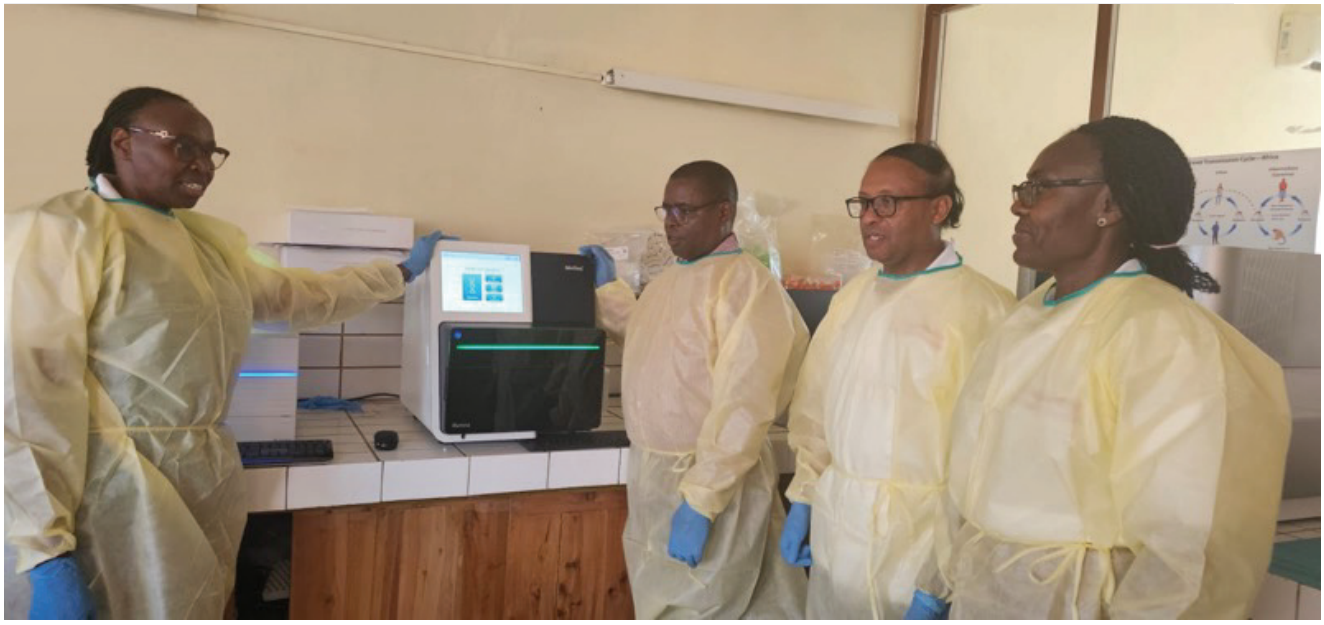


Figure 57: Training for Laboratory Decentralisation in Bujumbura, Burundi

epidemic potential.
Africa CDC supported Rwanda through:

- Rapid IMST activation and coordination
- Deployment of innovative research approaches, including use of candidate vaccines and remdesivir under monitored protocols
- Strengthening of laboratory diagnostics, IPC, and clinical management
- Real-time data sharing and genomic analysis

Impact

- Rwanda achieved rapid containment of MVD cases with the lowest case fatality observed.
- No uncontrolled transmission occurred.
- The response demonstrated safe, ethical, and effective use of innovative countermeasures in African settings.

Strategic Significance

Rwanda's response showcased Africa's ability to deploy advanced biomedical tools rapidly and responsibly, reinforcing confidence in Africa-led outbreak management.

Case Study in Sierra Leone: Integrated Community-Centred Response Driving Rapid Decline in Mpox Transmission.

Challenge

Sierra Leone faced sustained community transmission of mpox, driven by delayed case detection, stigma, limited community trust, and challenges in reaching high-risk and mobile populations. Traditional facility-based surveillance alone proved insufficient to interrupt transmission chains.

Under national leadership and IMST coordination, Sierra Leone implemented a fully integrated response model that combined community-based surveillance, targeted vaccination, and innovative Risk Communication and Community Engagement (RCCE). Central to this approach was Operation "Find Them All," which focused on proactive case finding and early interruption of transmission at the community level.

Key elements included:

- Deployment of community health workers and volunteers to strengthen event-based and community surveillance
- Rapid linkage of suspected cases to testing, isolation, and care
- Targeted mpox vaccination of contacts, frontline workers, and high-risk groups
- Innovative RCCE strategies co-designed with

communities to address stigma, misinformation, and care-seeking behaviour.

Real-time coordination through the IMST framework, ensuring alignment across surveillance, laboratories, vaccination, and RCCE pillars.

Impact

- Significant and sustained decline in reported mpox cases following implementation of Operation "Find Them All" which was later implemented in Liberia.
- Improved early detection and reporting from communities previously underrepresented in surveillance data.
- Increased vaccine uptake driven by trust-based RCCE approaches.
- Strengthened community ownership of outbreak response efforts.

Strategic Significance

Sierra Leone contained mpox faster by integrating community surveillance, vaccination, and RCCE. It offers a scalable PPPR model where trust and prompt action stop outbreaks at source.

Case Study in Democratic Republic of the Congo (DRC): Genomic Surveillance and Preventive Vaccination in the Ebola Response (Bulape)

Challenge

The Ebola outbreak in Bulape required swift differentiation between flare-ups and new transmission chains, alongside rapid protection of at-risk populations.

Africa CDC supported the DRC through:

- Deployment of genomic surveillance through INRB to characterize the outbreak and guide response decisions
- Support for preventive mass vaccination strategies
- Integration of laboratory, epidemiology, and vaccination data through IMS coordination

Impact

- Transmission chains were rapidly identified and interrupted.
- Preventive vaccination protected frontline workers and contacts.
- The outbreak was contained efficiently with minimal spread.

Strategic Significance

The DRC case underscores the power of genomics-informed response, where science directly shapes operational decisions and accelerates containment.

Case Study in Namibia: Early Leadership and Rapid Containment of Mpox at Source

Challenge

When mpox was first detected, Namibia faced the risk of rapid spread through population mobility and cross-border interactions. Although only a small number of suspected cases were identified, the potential for escalation required immediate action to prevent wider transmission and avoid the need for prolonged emergency measures.

Under strong national leadership and with early, targeted technical support from the Incident Management Support Team (IMST), Namibia implemented swift containment measures focused on early detection, case management, and surveillance. Key actions included:

- Rapid activation of national surveillance systems and alert mechanisms
- Prompt deployment of IMST technical assistance to support case investigation and response coordination.
- Establishment of effective case management protocols aligned with continental guidance.
- Accelerated laboratory testing and confirmation, enabling timely decision-making.
- Strengthened coordination between public health authorities, laboratories, and frontline health workers.

Impact

- Mpox transmission was contained at source, with only two confirmed cases reported.
- No secondary transmission was documented, avoiding escalation into a larger outbreak.
- Early laboratory confirmation and surveillance enabled rapid isolation and monitoring of contacts.
- The country avoided the need for large-scale emergency deployment or prolonged response operations.

Strategic Significance

Namibia's experience demonstrates the power of early leadership, preparedness, and rapid technical support in outbreak control. By acting decisively at the first signs of risk and leveraging IMST expertise, Namibia prevented mpox from gaining a foothold. This case underscores a core principle of Africa CDC's PPPR model: when countries lead, systems are ready, and support is deployed early, outbreaks can be stopped before they become emergencies.

Figure 60: Operation Find Them All in Freetown, Sierra Leone

Across Burundi, Uganda, Rwanda, Namibia, Sierra Leone, and the DRC, a consistent set of lessons emerges, highlighting the transformation underway in Africa's epidemic preparedness and response. Decentralised systems, particularly when anchored in community-based surveillance, as demonstrated in Sierra Leone, proved more effective than centralised emergency models by enabling earlier detection, faster action at the subnational level, and stronger community ownership. Namibia further showed how early leadership and rapid IMST support can contain outbreaks at source before they escalate.

Embedding research within response operations accelerated learning and allowed countries to adapt strategies in real time, strengthening both effectiveness and sustainability. The safe and ethical deployment of advanced tools, including vaccines, therapeutics, and genomic surveillance, demonstrated that innovation can be operationalised rapidly when governance and coordination are strong. These experiences confirm that Africa CDC's added value lies in integration: aligning community intelligence, laboratories, vaccination, genomics, financing, and coordination within a single continental framework. Together, these cases provide concrete evidence that Africa Health Security and Sovereignty is not aspirational; it is achievable, scalable, and already delivering results across the continent.

Strengthening Primary Health Care in Africa

In 2025, Africa CDC significantly advanced the continent's Primary Health Care (PHC) transformation agenda as a cornerstone of Africa's Health Security and Sovereignty (AHSS). Through strong political leadership, technical coordination, and effective budget execution, the Centre for Primary Health Care delivered results at scale, strengthened continental governance mechanisms, and positioned PHC as the primary platform for resilient, equitable, and epidemic-ready health systems across Africa.

At the continental level, Africa CDC consolidated its leadership in community health systems strengthening, building on a validated landscape survey covering 51 AU Member States. As of 2025, over 1.04 million CHWs are deployed across 48 Member States, with females representing 51% of the workforce. Africa CDC spearheaded a continental acceleration framework toward 2 million CHWs by 2030, supported by an emerging investment case, standardized polyvalent curriculum, and sustained high-level political engagement through AU-led platforms at WHA and UNGA.

Programmatically, Africa CDC strengthened SRMNCAH, immunization, infectious diseases, NCDs, injuries, and mental health through policy support, workforce development, and continental frameworks.

Key achievements included;

- **Sexual, Reproductive, Maternal, Newborn, Child and Adolescent Health (SRMNCAH):** Supported the finalization of national SRH strategies in two Member States (Lesotho, Cameroon), strengthening policy coherence and alignment with continental priorities for equitable and resilient PHC delivery.
- **Immunisation:** Advanced the Continental Immunization Strategy to over 90% completion, reinforcing coordinated action on vaccine

Figure 61: First Ebola patient discharged in Bulape.

coverage, equity, and system strengthening across Member States.

- **Infectious Diseases:** Expanded hepatitis and triple-elimination (HIV, viral hepatitis, and syphilis) capacity in more than 15 Member States, strengthening prevention, diagnosis, and integrated service delivery at national and subnational levels.
- **Noncommunicable Diseases (NCDs) and Injuries:** Operationalized a regional peer-review mechanism for NCDs and injuries, promoting shared learning, accountability, and evidence-based policy action across countries.
- **Mental Health:** Scaled continental leadership and workforce capacity, with mental health leadership initiatives exceeding targets (129% of planned experts trained), reflecting growing demand and strengthened institutional commitment to mental health as a core PHC and health security priority.

Figure 62: Health ministry strengthens response to Mpox

What's Next? Strategic Priorities to Deepen Impact under Pillar 2 (PPPR)

Africa's future in health security will be defined by whether outbreaks are prevented, contained at source, or allowed to escalate into regional and global crises. Under the Africa Health Security and Sovereignty vision, PPPR is not a cost to be managed; it is an investment that protects lives, safeguards economies, and strengthens Africa's position as a global Centre of excellence in outbreak preparedness and response. The world's health security is inseparable from Africa's. When Africa detects earlier and responds faster, the entire world becomes safer.

The results already point to what is possible. Between 2024

and 2025, the number of public health events declined from 242 to 213. This is not a coincidence. It reflects the early dividends of stronger surveillance, faster laboratory confirmation, integrated incident management, and more predictable financing. The direction is clear: the trend can be accelerated and scaled until outbreaks become fewer, smaller, and routinely controlled before they disrupt communities and national systems. When outbreaks are contained early, domestic resources can shift from crisis response to the investments that matter most for people's primary health care and universal health coverage.

Building on lessons and gains achieved between 2023 and 2025, Africa CDC will drive the following strategic priorities under Pillar 2, anchored under a single continental umbrella: the Emergency Response Readiness System (ERRS).

Emergency Response Readiness System (ERRS) as the Umbrella Framework

Africa CDC will institutionalize the Emergency Response Readiness System as a sustainable, agile, and continentally owned framework that can be activated immediately upon declaration of an outbreak or escalation of transmission. ERRS will serve as the legacy model of Africa CDC's mpox response, designed to strengthen the first 48 hours to four weeks of any response through pre-approved, well-coordinated technical and financial mechanisms. Under ERRS, Africa CDC will focus on the following operational priorities:

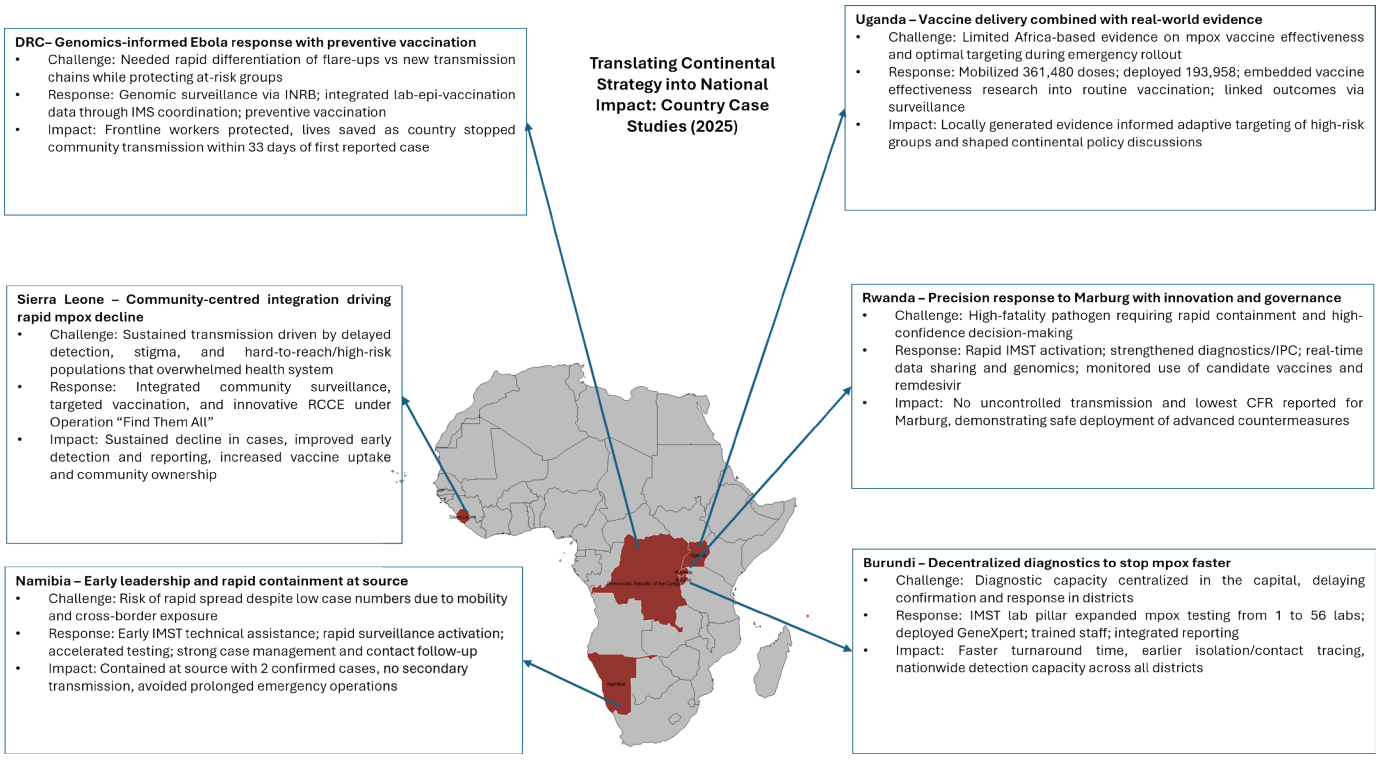
- **Rapid deployment within 48 hours**
  Ensure rapid mobilization of personnel, financing, and essential materials within the first 48 hours of an outbreak declaration, reducing delays that allow outbreaks to grow into crises.
- **Rapid financing through the Africa Epidemics Fund**

  Operationalize a fast-disbursing financing window under the Africa Epidemics Fund to unlock immediate resources for diagnostics, surge deployments, logistics, and community engagement, ensuring that response action starts when it matters most rather than after escalation.
- **A core operational backbone at all levels**

  Establish and maintain a standing operational backbone linking headquarters, Regional Collaborating Centres, and countries, enabling immediate coordination, tasking, and accountability through an IMST-enabled approach.
- **Real-time data and digital readiness**

  Strengthen real-time data collection, report-

Figure 63: Case study of early response intervention to drive early containment



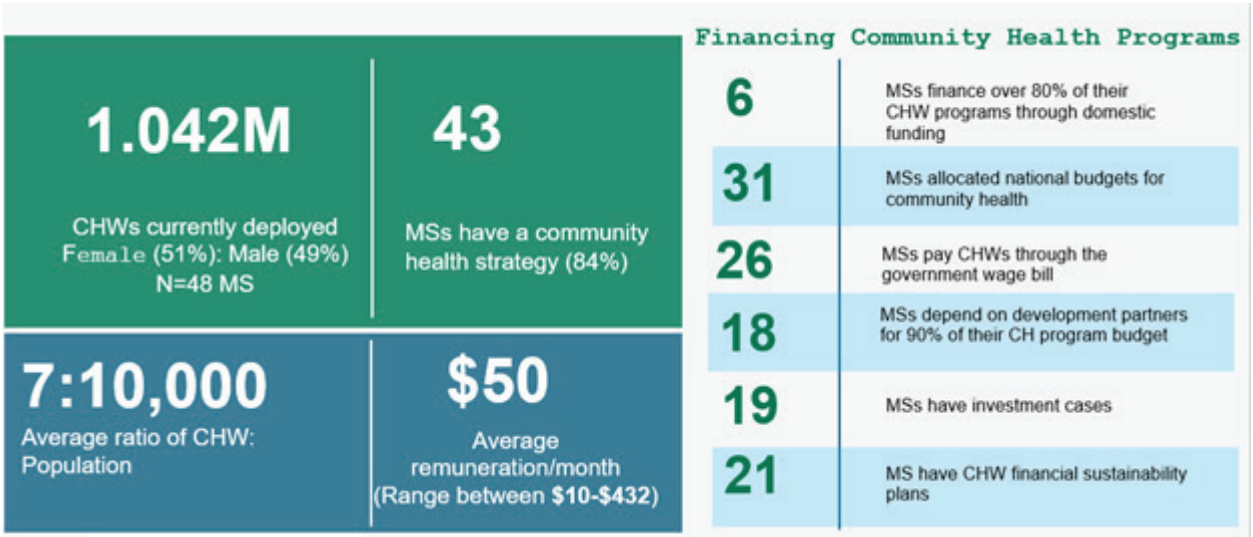


Figure 64: Key summary findings of the continental landscape survey on CHWs

ing, and operational dashboards through digital platforms such as DHIS2, ensuring that early decision-making is guided by live intelligence rather than retrospective reporting.

- **Strategic and operational reserves**

  Create and manage strategic and operational reserves of critical supplies, protocols, and guidelines to enable rapid activation without waiting for emergency procurement or fragmented partner pipelines.

- **Alignment of national and continental plans**

  Align national response plans with continental strategies while reinforcing country-led execution, ensuring coherence across borders and consistent application of best practice within a shared continental framework.

Within this ERRS umbrella, Africa CDC will deepen impact through the following complementary strategic shifts:

- **From preparedness to resilience**

  Africa CDC will support countries to permanently embed PPPR capabilities within national systems, so readiness is institutionalized and sustained, rather than dependent on ad hoc funding, temporary deployments, or crisis-driven improvisation.

- **Predictive analytics and epidemic intelligence**

  Africa CDC will strengthen integrated data systems, modelling, and early warning to anticipate outbreaks before they escalate, enabling earlier preventive action and targeted interventions at community, national, regional, and continental levels.

- **Sustainable surge capacity**

  Africa CDC will expand and professionalize continental and regional response rosters, ensuring predictable, skilled, and rapidly deployable teams aligned with ERRS activation triggers and country-defined needs.

- **Linking preparedness to financing**

  Preparedness benchmarks will be tied to predictable financing mechanisms, including the Africa Epidemics Fund and relevant Pandemic Fund instruments, rewarding readiness and early action while reducing response delays.

- **Integration across AHSS pillars**

  PPPR will be systematically aligned with digital transformation, financing reform, workforce development, and local manufacturing to close end-to-end gaps from detection to delivery, strengthening sovereignty and resilience across the continent.

Preparedness and response are only as strong as the financing, systems, and governance that sustain them. Through ERRS and this integrated approach, Africa CDC will continue to anchor a model in which countries lead, regions coordinate, and global partners support.

The objective is ambitious and achievable:

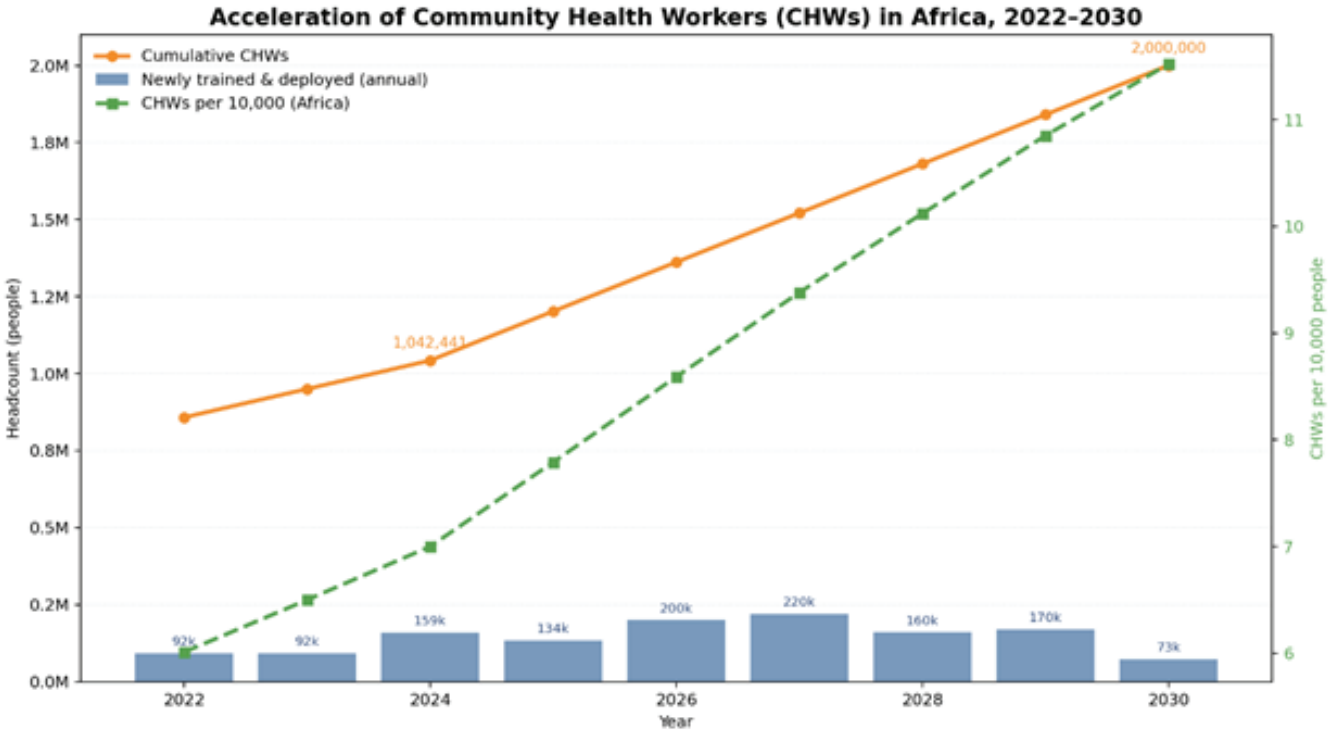


Figure 65: Projection towards achieving the 2 Million CHW in Africa by 2030

a continent where outbreaks are detected early, controlled rapidly, and prevented from becoming crises freeing domestic resources to invest in stronger primary health care, universal health coverage, and a healthier, more resilient Africa that strengthens global health security. Preparedness and response are only as strong as the financing systems that sustain them. Pillar 3 examines how Africa CDC advanced sustainable health financing and domestic resource mobilisation, reducing dependence and strengthening Member State ownership of health security.

4.3 Pillar 3: Sustainable Health Financing & Domestic Resource Mobilisation

4.3.1. Why This Pillar Matters: The Financing Constraint is Structural

Africa's health security is undermined less by absolute scarcity than by fragmentation, misalignment, and weak visibility over how priorities are financed and executed. As fiscal space tightens and external assistance becomes more volatile, Pandemic Prevention, Preparedness and Response (PPPR) cannot rely on parallel funding channels and ad-hoc emergency appeals. It depends on whether health security priorities are integrated into national plans, budgets, and accountability systems, and whether spending is executed with discipline and transparency.

In 2025, the urgency of this agenda became undeniable. The year was marked by a sharp financing shock an abrupt decline in external assistance that disrupted essential services and exposed structural vulnerabilities in aid-dependent models. In response, Africa CDC accelerated the AHSS financing agenda and strengthened the continental architecture to help Member States shift from dependency toward sovereignty, predictability, and results.

This pillar documents how Africa CDC working with Member States, Regional Economic Communities, global health initiatives, development banks, and partners supported Member States to strengthen (i) alignment of financing with national priorities under the Lusaka Agenda, (ii) transparency and comparability of health security expenditures, and (iii) rapid and predictable financing for cross-border and multi-country threats.

In 2025, Africa CDC produced the continental publication *Africa's Health Financing in the New Era* to support Member States in transitioning to sustainable and sovereign financing models in the face of declining external resources.

Africa carries a disproportionately high share of global

Figure 66: Accelerated Continental Immunisation Strategy

disease burden while accounting for a minimal share of global health expenditure. The constraint is not only low spending; it is that financing is fragmented across schemes, partners, and reporting lines, weakening national ownership and diminishing value for money.

There are four structural pressures defining the financing transition:

- Declining development assistance for health (DAH) after the COVID-19 surge, with major reductions in 2025.
- Rising out-of-pocket payments, shifting the burden to households, and deepening financial hardship.
- High and rising debt, constraining budgets, and increasing fiscal risk.
- System inefficiency, with large leakages from payroll, procurement, fragmentation, and weak public financial management.

4.3.2. Key Results in 2025

Africa CDC just released the most complete document to date on health financing in Africa called "Financial implication of Africa Health Security and Sovereignty".

This document presents the most comprehensive analysis to date of health financing in Africa in the post-ODA-cut era. Its conclusion is unequivocal: ***Africa's path out of aid dependency will not be found by chasing more money, but by stopping the massive inefficiencies and waste in the money it already has.*** *This is not primarily a funding crisis; it is an efficiency crisis.*

The evidence is compelling. Pooled procurement alone can reduce the cost of health commodities by 30–33%. Integrated service delivery can generate US$1.3–1.6 billion in annual savings. Human-resources reforms can unlock up to US$6.8 billion per year. When combined with decisive reforms in planning, digitization, procurement, and public financial management, Africa can generate efficiency gains of approximately US$14 per capita—equivalent to US$16 billion in 2026 and US$37 billion by 2050.

These gains are transformational. Within five years, they are sufficient to replace roughly 50% of current donor financing and reduce external dependence to below 20% of total health expenditure. Africa is therefore no longer positioning itself as a passive recipient of aid, but as a proactive architect of its own health security.

At the heart of this transformation is Africa Health Se-

curity and Sovereignty (AHSS), a unifying vision that reframes health not as a social sector expense, but as a foundation of continental sovereignty, economic resilience, and geopolitical credibility. It affirms a simple truth: Africa's health security is inseparable from its economic future and global standing.

In 2025, these pressures converged into a clear policy imperative: health financing reform is now a health security requirement. The pillar therefore focuses on how Africa CDC supports Member States to secure financing that is predictable, transparent, and aligned to recover fiscal space through efficiency and governance gains.

A defining operational shift in 2025 was the decision to move beyond episodic technical assistance and recruit embedded expertise to the point where financing decisions are made: the national budget process.

Africa CDC recruited 20 Public Financial Management (PFM) experts to be deployed to priority countries into Ministries of Health and Ministries of Finance to strengthen allocative and technical efficiency, improve execution discipline, and integrate PPPR and UHC priorities into Medium-Term Expenditure Frameworks (MTEFs).

These PFM specialists were designed as catalytic capacity, not function as generic advisors but as embedded counterparts supporting countries to:

- link health security priorities to budget structures and ceilings,
- strengthen cash and commitment controls relevant to health execution,
- reduce unspent balances and delayed procurement,
- consolidate fragmented reporting requirements, and
- improve credibility in dialogue with finance authorities and partners.

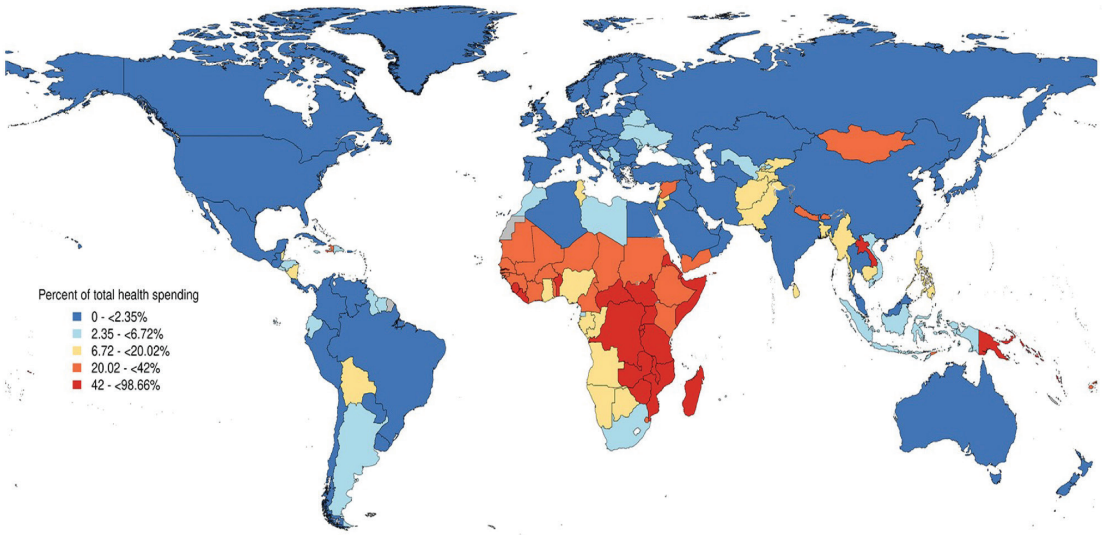
The Scale of the Challenge: Low Per-Capita Spending, High Household Burden

Across Africa, total health expenditure remains low around US$85 per capita, and fewer than half of countries meet the benchmark required to deliver an essential package of services. Even where totals are rising, rapid population growth dampens per-capita gains.

At the same time, the financing mix is often regressive: households in many countries pay 40–60% of total health spending out-of-pocket, exposing millions to catastrophic expenditure and impoverishment. In 2025, the Director General's message explicitly framed this as both a social crisis and a sovereignty crisis when aid declines, households become the payer of last resort, and the poorest pay the price.

The Binding Constraint: Inefficiency and Fragmentation

ODA as of % of total health spending (WHO 2021)



Africa's heavy reliance on external aid highlights the urgent need to strengthen domestic fiscal capacity and financial resilience.

Figure 67: Africa's Health Financing in a New Era Concept Paper, April 2025

The most actionable source of near-term fiscal space is efficiency. Across systems, a substantial share of spending is lost to misallocation, duplication, leakage, and weak management. Analysis conducted by Africa CDC shows that wages and procurement dominate at more than 75% the domestic budgets, leaving limited discretionary space for prevention, preparedness, and primary health care.

Fragmentation amplifies inefficiency. Countries are forced to operate dozens of schemes, hundreds of implementing partners, and parallel plans, budgets, and reporting processes. This raises transaction costs, weakens accountability, and prevents strategic purchasing. It prevents national oversight and leadership.

The 2025 agenda therefore prioritized reform pathways that are *operational*, not theoretical: align spending to one national plan and budget; strengthen execution discipline; improve procurement efficiency; and build routine expenditure tracking to make financing visible and comparable.

The Political Engine: Lusaka Agenda as the Financing Alignment Framework

The Lusaka Agenda provides the political mandate to shift from donor-driven financing toward nationally steered systems, aligned support from global health institutions, anchored in One Plan, One Budget, One M&E.

In 2025, Africa CDC institutionalised this agenda by hosting and operationalising a continental coordination function, the Lusaka Agenda Continental Secretariat, tasked with aligning partner flows to national priorities and monitoring progress through a continental scorecard and dashboard.

The core logic of the pillar include:

- **Alignment**: External resources should reinforce national plans and budgets, not operate in parallel.
- **Visibility**: Spending and results must be traceable, comparable, and usable in policy dialogue.
- **Accountability**: Progress must be monitored using common indicators and peer comparison.
- **Sovereignty**: Countries lead; partners support within a coherent framework.

In 2025, the Lusaka Secretariat developed an accountability framework with performance indicators and a digital continental dashboard, validated in December 2025 and positioned for rollout thereafter.

Building the Evidence Base: Health Security Investment Cases in 2025.

To shift the financing dialogue from short-term project negotiations to nationally owned priorities, Africa CDC supported Member States in developing Health Security Investment Case documents that quantify the costs of core capacities (surveillance, laboratories, workforce, PHEOCs, logistics), identify financing gaps, and outline feasible domestic and blended financing pathways.

In 2025, ten countries completed their national health investment cases, with several others in advanced drafting stages. This marked a strategic shift: rather than relying on donor-developed proposals, countries are increasingly using multi-year investment cases to engage Ministries of Finance, parliaments, and partners on priorities aligned with the AHSS and the Lusaka Agenda.

At the continental level, two major investment cases have been developed to strengthen Africa's health financing architecture:

- i) Africa CDC's continental investment case, which presents a robust, evidence-based narrative positioning health financing as a strategic pillar of sovereignty and resilience.
- ii) A continental Community Health Workers (CHWs) investment case, currently under validation, with formal adoption by Member States expected in 2026.

Health Expenditure Tracking: From Ad-Hoc Support to Routine Accountability

A major pillar objective is to strengthen transparency and comparability of health security expenditures. Africa CDC starts to support a continental shift toward routine health expenditure tracking, including convening the first continental tracking session in Côte d'Ivoire in December 2025 and moving toward an annual cycle of tracking, analysis, and policy dialogue.

This approach is intentionally practical: expenditure tracking is paired with technical assistance to interpret findings and produce policy briefs that finance ministries can use turning data into budget decisions.

To consolidate monitoring functions under one platform, Africa CDC proposes a continental Health Financing Observatory with a scorecard that integrates:

- Health expenditure tracking results,
- Lusaka financing alignment indicators, and
- Implementation monitoring.

The strategic value of the Observatory is that it transforms financing transparency into an annual accountability function: it supports peer comparison, structured dialogue, and systematic follow-up across Member States.

In 2025, the foundation for this approach was advanced through the Lusaka Secretariat's accountability framework and digital dashboard, validated in December 2025, establishing a platform for real-time visibility and peer accountability on financing reforms.

Innovative and Blended Financing: From Concepts to Structured Mechanisms

The pillar's innovation agenda focuses on instruments that expand fiscal space while strengthening country ownership: solidarity levies, targeted health taxes, diaspora bonds, debt-for-health swaps, earmarking of extractive revenues, and efficiency-linked savings.

In 2025, Africa CDC supported Member States to explore these channels alongside pooled procurement savings and other reforms, recognising that instruments vary in feasibility and maturity across contexts.

At the continental level, the Africa Health Financing Strategy (established earlier in the period) structured the agenda around domestic financing, innovative

Figure 68: Lusaka Agenda Monitoring and Accountability framework Validation Workshop with AU Member States

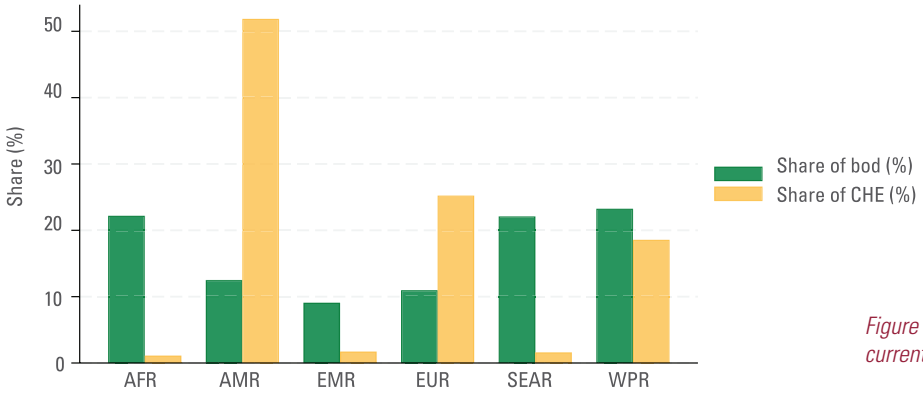


Figure 69: Burden of disease vs current health expenditure by region

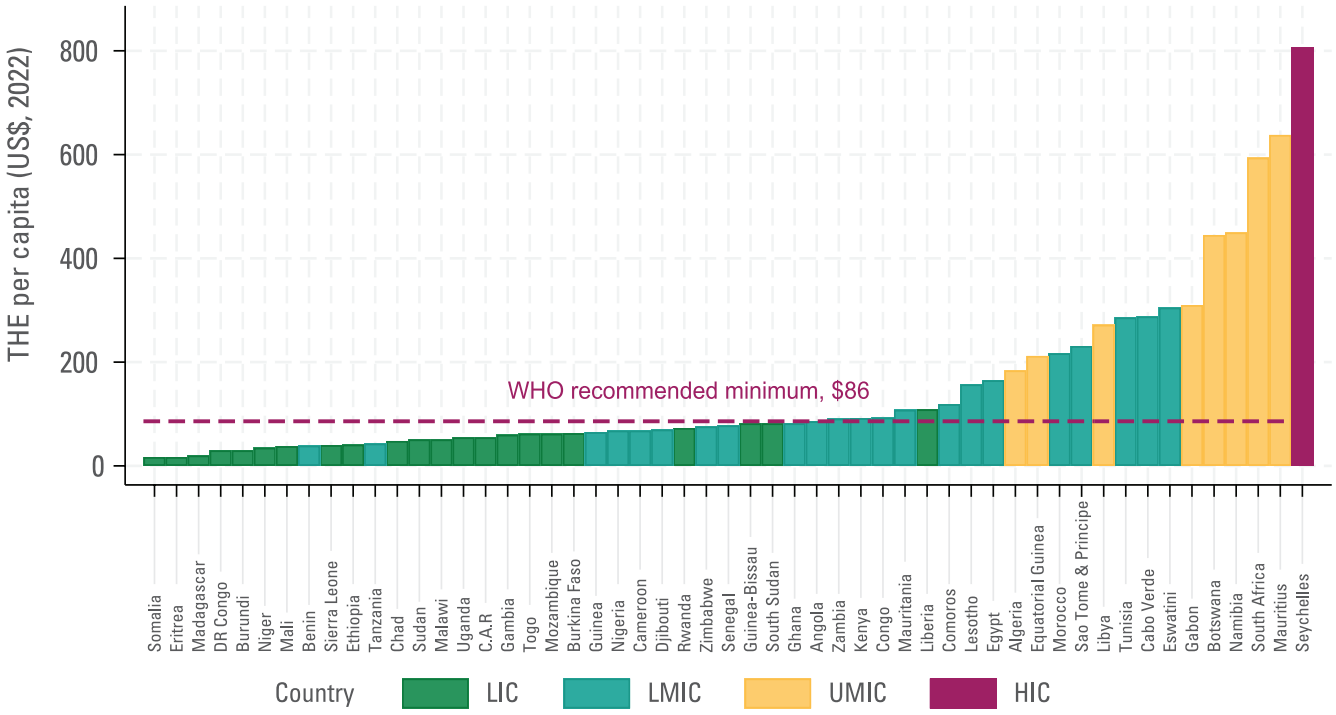


Figure 70: "Total Health Expenditure per Capita by Country (Africa, 2022)

mechanisms, and governance/accountability, while standardising expectations on co-financing in major initiatives (e.g., minimum co-investment ratios).

Resource Mobilisation in 2025: Africa CDC as a Financing Platform

Africa CDC's 2025 financing work combined two dimensions:

- **Institutional financing** to deliver the continental mandate; and
- **Policy influences** to shape how global resources flow, align, and are governed.

As of 2025, Africa CDC mobilised **US$463 million** through engagements with bilateral partners, multilateral funds, and philanthropy supporting both Africa CDC institutional strengthening and Member State activities in surveillance, laboratories, digital health, PHC, and emergency response. Also in 2025, Africa CDC successfully operationalised the Africa Epidemics Fund (AfEF), as illustrated in section 2 of the framework for its operationalisation.

More importantly and beyond volume, Africa CDC leveraged negotiations to influence replenishment agendas, pushing for greater flexibility to fund systems, stronger country ownership, and clearer linkages between PPPR and UHC investments, aligned to the Lusaka Agenda principles. Africa CDC advocated, supported and mobilised more than US$50 billion for African Member States through major mechanisms (e.g., US Government through AFGHS, European Union, Gavi, Global Fund, Pandemic Fund and others); and more than US$10 billion in financing to support African manufacturing of health products.

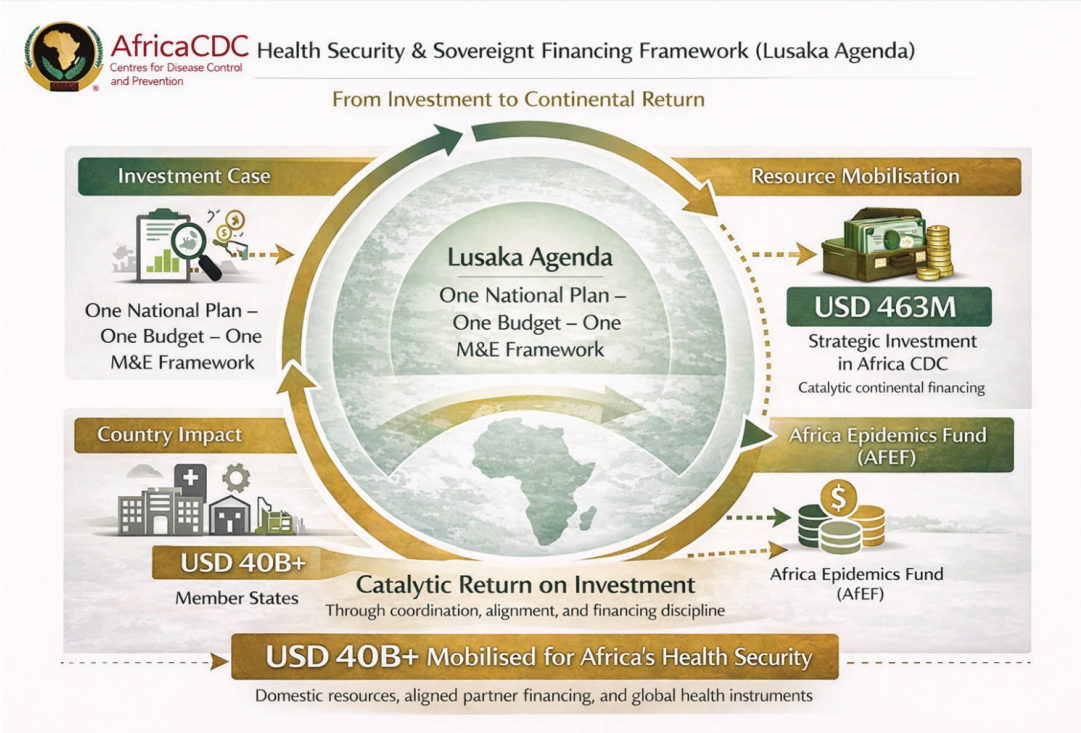


Figure 71: The Lusaka Agenda financing cycle linking national plans, investment cases, resource mobilisation, and measurable country impact

Modelling the Impact: Closing the Financing Gap Through Efficiency

The total budget for the continent to provide basic essential care is estimated at $132billion in 2025, and it rises to $325billion in 2050.

- Projected THE is estimated at $112billion and increases to $259billion in 2050.
- The financing gap is $20billion in 2025 and rises to $66billion in 2050.

This analysis underscores the need for African countries to focus a lot of attention on health financing-related reforms to maximise the value of the available budget.

Figure xxx also shows the projected net budget loss from inefficiencies, based on the 23% inefficiency estimate.

In 2025, projected THE net of inefficiency is estimated at $86billion versus total projected THE of $112billion and it is estimated at $199 billion versus total projected THE of $259billion in 2050.

The gap between projected THE and projected THE net of inefficiencies can be regarded as the ceiling for efficiency gains that can be realized by implementing the different reforms suggested by Africa CDC as illustrated in figure 66 showing the efficiency gains that can be achieved by implementing different reforms as follows:

- **Pooled procurement**: While pooled procurement is a pillar in itself under local manufacturing and supply security as supported by various partners including the World Bank, AfDB, AfreximBank, Gavi and GFATM, it is also a financing reform because it directly creates savings that can be reallocated to preparedness and primary health care. Savings of $3.9billion in 2025 to $9.7billion in 2050. This assumes that all countries are using pooled procurement for 100% of their government medicines and medical supplies budgets.
- **Other procurement**: Savings of $702million in 2025 to $1.7billion in 2050
- **Human Resources for Health salaries**: Savings of $6.8billion in 2025 to $16.8billion by cutting ghost workers through digitization.
- **Human Resources for Health capacity building:** $139million in 2025 to 169million in 2050
- **Service delivery integration**: Savings of $1.3 billion in 2025 to $1.6billion in 2050.

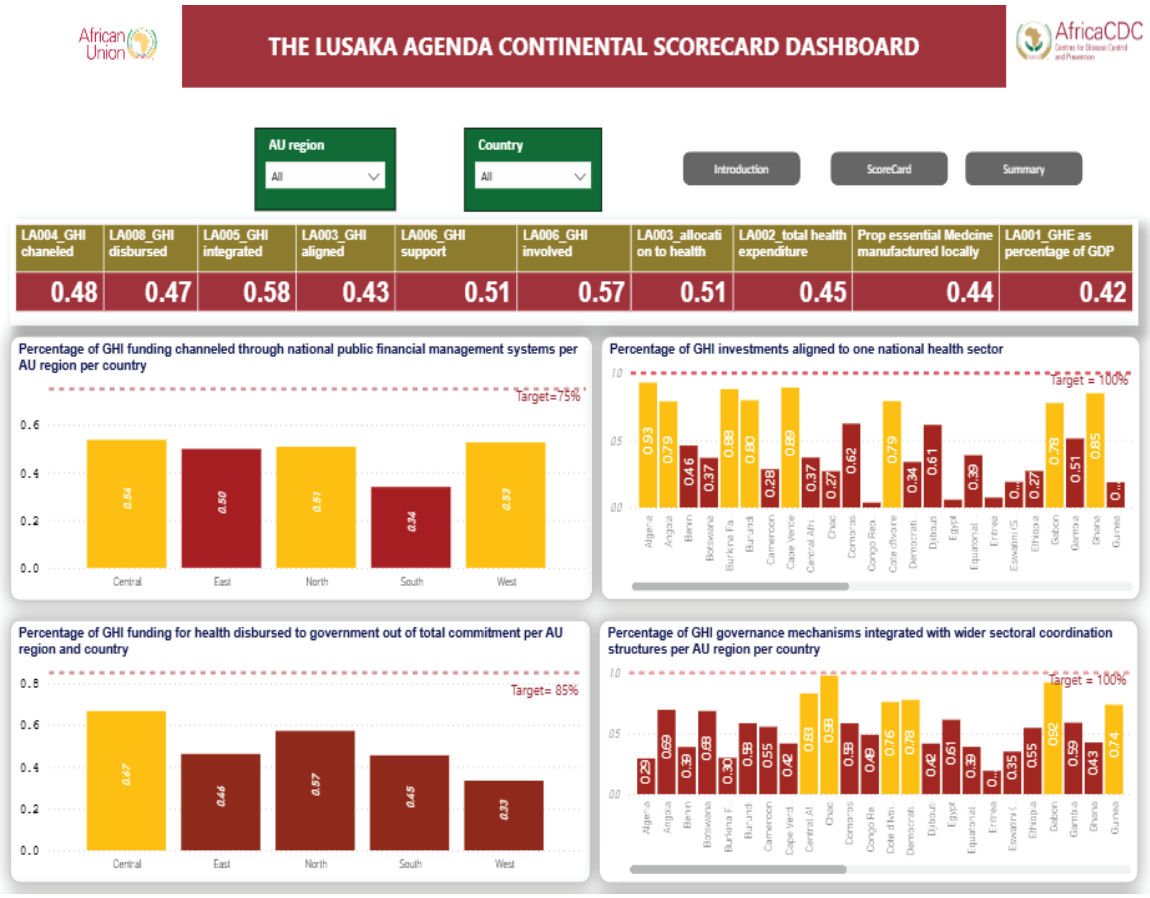


Figure 72: Lusaka accountability framework and dashboard indicators

- **Converting OOP spending to prepayments**: Savings of $3.3billion to $6.9billion
- **Total efficiency gains**: savings of $ 16billion in 2025 to $36.9billion in 2050

Critical Meetings and Milestones in 2025: Regional and Global Engagement

In 2025, the financing agenda advanced through targeted political and technical convening at continental and global levels especially around the Lusaka Agenda and the "health financing shock" context.

Selected high impact convenings (2025):

- **AU Assembly High-Level Meeting on Domestic Financing (February 2025)**: strengthened political signalling on domestic financing as a sovereignty priority.
- **Global advocacy and diplomacy**: Africa CDC engaged at the G20 Foreign Ministers Meeting (South Africa, February 2025), reinforcing the link between health security, fiscal space, and macroeconomic constraints.
- **Ministerial consultation on Health Financing (17 May 2025):** positioned health financing as a cross-ministerial agenda spanning health and finance authorities.
- **High-level meeting on health financing at the margins of the 78th World Health Assembly (WHA) (May 2025):** elevated the agenda in global forums and reinforced alignment principles.
- **Lusaka Agenda accountability framework and digital dashboard (validated November 2025):** established a single continental mechanism for monitoring alignment and progress, positioned for rollout thereafter.

Country & Political Impact.

The value proposition of the health financing pillar is practical and measurable:

- **More coherence:** financing aligns better to nationally defined priorities under One Plan and One Budget.
- **More predictability**: countries move away from volatile, fragmented project flows and toward structured budget pathways.

Figure 73:The Lusaka agenda Monitoring and Accountability Validation workshop photos

- **Better execution**: embedded PFM support improves budget execution and reduces delays.
- **Lower transaction costs**: consolidation of reporting and alignment mechanisms reduces duplication.
- **Better evidence**: investment cases and expenditure tracking strengthen the credibility of budget dialogue.
- **Faster response financing**: AfEF reduces time-to-funding for emergencies, preventing escalation.

What's Next

The 2025 recruitment of 20 PFM experts and the establishment of the Lusaka Secretariat made these shifts operational, not aspirational embedding reforms into the routines of budget preparation, negotiation, and execution.

The Africa CDC Director General's 2025/2026 message frames health financing reform as the foundation for sovereignty: Africa must define priorities, lead solutions, and finance resilience from within. The central argument is not that Africa lacks resources, but that it loses too much to fragmentation and inefficiency, and that recovered value can replace a significant share of donor dependence. He is emphasizing that:

- External financing decline is a structural shift, not a temporary dip.
- Households are paying too much; financial protection is a health security issue.
- Inefficiency (20–40% leakage) is recoverable fiscal space.
- Reform must institutionalise One Plan, One Budget, One Report, and strengthen PFM in health.
- With improved planning, purchasing, and governance, Africa can fund core health security functions and reduce dependency.

"Leadership without sustainable financing is fragile. Africa is not poor; it is mis-organised and fragmented. If we recover even part of what is wasted, we can finance health security on our own terms."

In 2026, the financing agenda focuses on consolidating health security financing as a core accountability function:

- **Deepen Lusaka Agenda alignment** so external support reinforces national plans, budgets, and M&E frameworks.
- **Strengthen the continental platform for financing dialogue**, supporting Member States' engagement with partners, regional bodies, and global health financing mechanisms.
- **Institutionalise transparency tools**, including the Health Financing Observatory and scorecard, building on the Lusaka dashboard validated in late 2025.
- **Link financing decisions to value and priorities** through integration with Health Technology Assessment (HTA) and Essential Public Health Functions (EPHF), ensuring budgets flow to high-impact public health investments.

- **Sustain and scale the embedded PFM model**, moving from early gains to institutional capacity and routine performance improvement across more Member States.

The strategic aim is to anchor health security financing in national systems and continental governance reducing fragmentation, increasing resilience, and strengthening sovereignty over time. Pillar 4 examines how Africa CDC advanced digital transformation and data sovereignty to support real-time decision-making, interoperability, and continental intelligence.

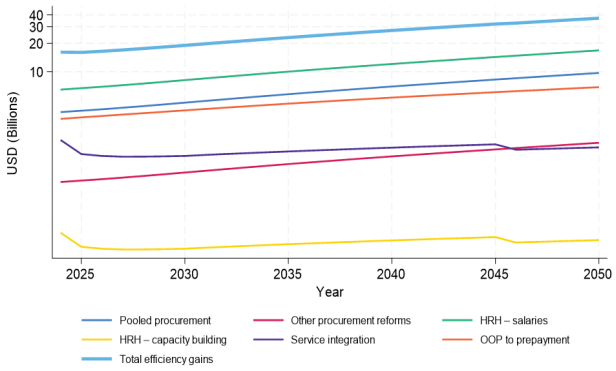


Figure 74: Summarises the Resource Gap Analysis for The African Continent From 2025 To 2050

4.4 Pillar 4: Digital Transformation & Data Sovereignty

4.4.1. Why This Pillar Matters

In 2025, speed is governance. Health security decisions are only as effective as the data that inform them and the systems that move information across borders in real time. Fragmented data, delayed reporting, and externally controlled platforms undermine preparedness, slow response, and weaken sovereignty.

AHSS Pillar 4 addresses this constraint directly by advancing digital transformation anchored in African ownership of data. The objective is not digitisation for its own sake, but a continental intelligence ecosystem that enables early warning, coordinated action, transparent accountability, and trusted data sharing under rules defined by Africa.

Africa CDC strengthened epidemic intelligence and digital health systems through expansion of Event-Based Surveillance to 38 Member States, supported by training of national and community-level surveillance personnel. The Central Data Repository (CDR) was advanced as a continental platform for aggregating and analysing surveillance and operational health data, supported by the increase in data-sharing agreements with 7 Member States. Health Information Exchange and maturity assessments and digital maturity pilots were initiated to support national interoperability roadmaps.

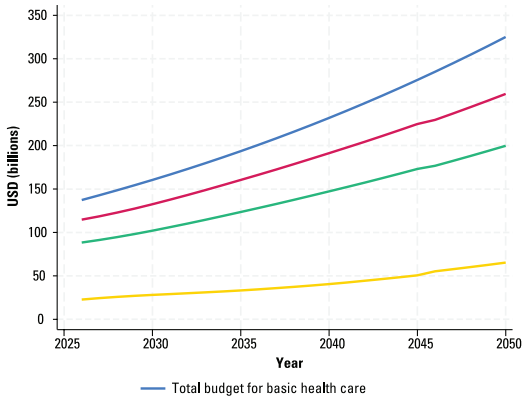


Figure 75: Health Financing Needs, Resources, and Gaps (Africa), 2025-2050

4.4.2 Key Results in 2025

Data is a strategic public health asset. In 2025, Africa CDC made tangible progress toward the AHSS Agenda by advancing digital transformation and strengthening data governance, laying the foundation for trusted, interoperable, and sovereign health information systems that enable faster, more coordinated decision-making.

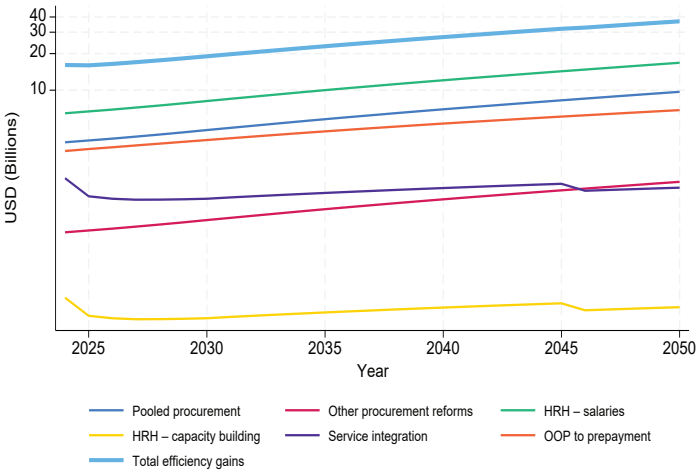


Figure 76: Efficiency Gains by Source (Billions USD), 2025-2050

Cohesive Digital Health Architecture for Africa

In parallel, Africa CDC advanced the development of several strategic frameworks to guide continental digital transformation. Through a co-creation process involving over 40 Member States and technical experts, the Digital Health Governance Framework (DHGF) and a Model Digital Transformation Strategy (DTS) were developed to support national alignment with Africa's digital health priorities. These tools are designed to reinforce governance foundations for interoperability, digital architecture, and data sovereignty. Simultaneously, progress was made on the Africa Health Data Governance Framework, aimed at establishing common continental standards for ethical data use, security, and sovereign data governance.

In 2025, Africa CDC adapted and validated the Digital Maturity Assessment (DMA) Tool to support Member States in evaluating their digital health readiness. Phase I assessments were completed in Botswana and Zimbabwe, with initial scoping initiated in Nigeria, Senegal, Ethiopia, Côte d'Ivoire, and Uganda. A standardized digital maturity toolkit was developed to support Member State engagement and capacity building. Findings from the DMA have been integrated into Africa CDC's Digital Health Observatory Framework, and individual country reports have been shared, identifying gaps, challenges, and key priority areas for improvement.

Securing Africa's Health Intelligence: Data Centre Readiness

The operational readiness of the Africa CDC Data Centre has advanced significantly. A contract for ISO 27001 certification was awarded to a qualified provider, marking a key milestone toward compliance with international standards for information security management. To enhance system reliability and institutional compliance, all essential maintenance licenses have been secured. These developments contribute to Africa CDC's pursuit of Tier III certification, reinforcing the Data Centre's capacity to securely host both institutional and Member State data in accordance with global benchmarks for availability, resilience, and data sovereignty.

Digitization of Primary Health Care Centres

Africa CDC made modest but strategic gains toward the target of digitizing 100,000 Primary Health Care (PHC) facilities, supporting Member States in strengthening frontline health systems through digital transformation. To guide this process, a PHC Digitalization Expert Committee was established, convening leading experts and Member State representatives to drive continental alignment.

A draft PHC Digitalization Framework was co-developed with Member States and technical partners, articulating a shared vision, digital architecture, and guiding principles for scaling PHC digital transformation across Africa. The Committee issued a formal Communiqué urging AU Heads of State to prioritize PHC digitalization as a strategic pillar of the Africa Health Security and Sovereignty (AHSS) Agenda.

To catalyse implementation, Africa CDC secured USD 10 million through STBF to initiate pilot programmes in three Member States. This was complemented by an additional USD 20 million mobilized to scale PHC digital platforms in six countries, with another USD 10 million grant in advanced negotiation with the Mohamed Bin Zayed Foundation, aimed at expanding pilots to three more Member States.

Operationalization of the Africa CDC Knowledge Hub (KHub)

In 2025, Africa CDC advanced a continental shift from fragmented digital platforms to integrated, interoperable, and strategically governed knowledge systems. A major milestone was the launch of the Africa CDC Knowledge Hub (KHub), a continental portal designed to centralize and scale health intelligence, knowledge sharing, and collaboration. The rollout was supported by knowledge management (KM) assessments and consultations in five Member States (Uganda, Namibia, Gabon, Tunisia, Nigeria), and the validation of both a continental KM strategy and implementation roadmap.

The Journal of Public Health in Africa (JPHIA)

The Journal of Public Health in Africa (JPHIA) published 167 articles in 2025, reduced its editorial turnaround time from 72 to 48 days, and reached contributors from 47 Member States. The journal maintained its indexing in PubMed and Web of Science, was included in the Directory of Open Access Journals (DOAJ) and remains accredited by South Africa's Department of Higher Education and Training (DoHET)—solidifying its status as a leading platform for African public health scholarship. A new continental guideline for Knowledge-to-Policy Translation was also developed, reinforcing the use of African-generated evidence in decision-making.

In addition, Africa CDC supported 36 Communities of Practice, provided access to over 3,000 scientific journals through Elsevier and Science Direct, and offered scientific writing mentorship to more than 80 early-career professionals, strengthening research capacity and knowledge dissemination across the continent.

Integrated surveillance, intelligence, and early warning ecosystem

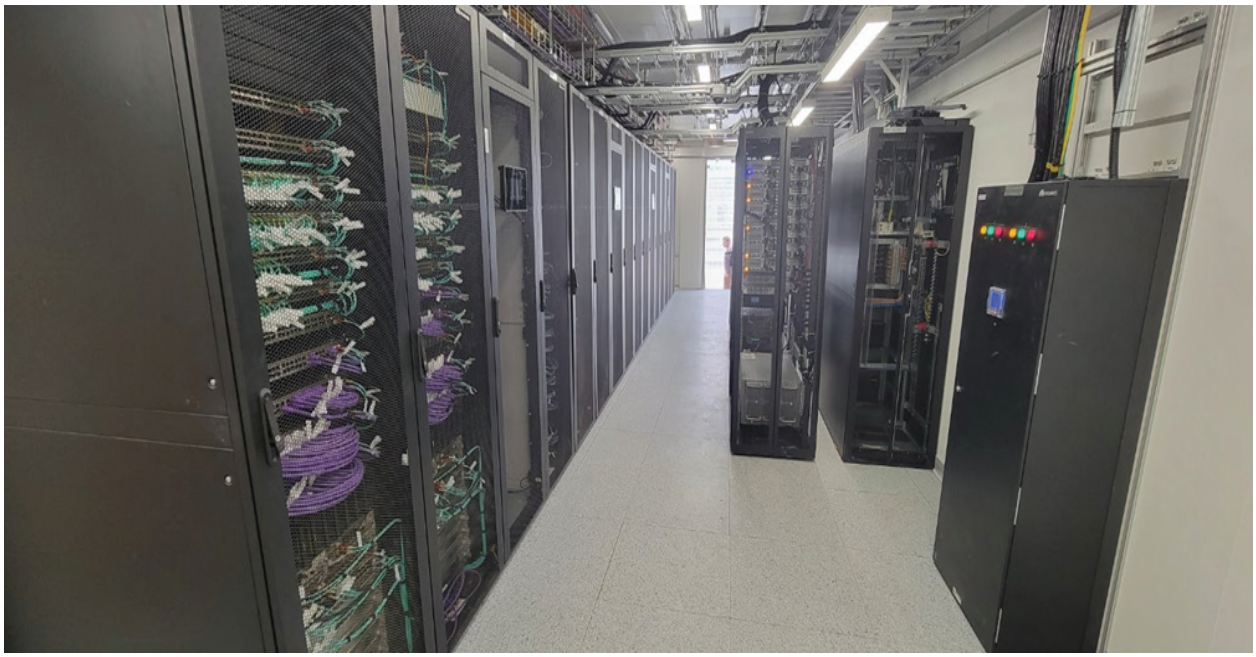
Africa CDC strengthened epidemic intelligence and digital health systems through expansion of Event-Based Surveillance to 38 Member States, supported by training of national and community-level surveillance personnel. The Central Data Repository (CDR) was advanced as a continental platform for aggregating and analysing surveillance and operational health data, supported by expanded data-sharing agreements with Member States.

Continental health intelligence

- Africa CDC strengthened continental event-based surveillance and integrated multiple data streams epidemiological, laboratory, genomic, and operational into shared situational awareness products.
- Real-time dashboards supported leadership decisions during multi-country events, reducing information asymmetry between countries, regions, and partners.

Interoperability and standards

- Africa CDC promoted common data standards and interoperability principles to reduce duplication and enable cross-border analysis.



`Figure 77: Africa CDC Data Centre Operational Readiness

- Technical guidance supported Member States in aligning national digital health systems with continental frameworks was deployed in 13 Member states.

Data sovereignty and governance

- Africa CDC advanced governance principles that affirm Member State ownership of health data, with Africa CDC acting as custodian for continental aggregation and analysis not as a data owner.
- Clear protocols guided how data are shared, used, and protected during emergencies, reinforcing trust among countries.

Operational digitalisation

- Digital tools supported emergency coordination, logistics tracking, laboratory networks, and performance monitoring.
- Improved internal systems strengthened visibility over operations, finances, and results, enabling faster executive action and clearer accountability.

4.4.3 Country Impact

For Member States, digital transformation delivered tangible benefits:

- **Faster alerts and decision-making,** reducing delays in outbreak detection and escalation.
- **Improved cross-border coordination**, as countries operated from a shared evidence base.
- **Reduced reporting burden**, through harmonised indicators and platforms.
- **Greater confidence in data sharing**, supported by agreed governance and safeguards.

These gains strengthened national capacity while enabling continental coherence, an essential balance for sovereignty.

Figure 79: Trend of African made publications and by Geographical coverage

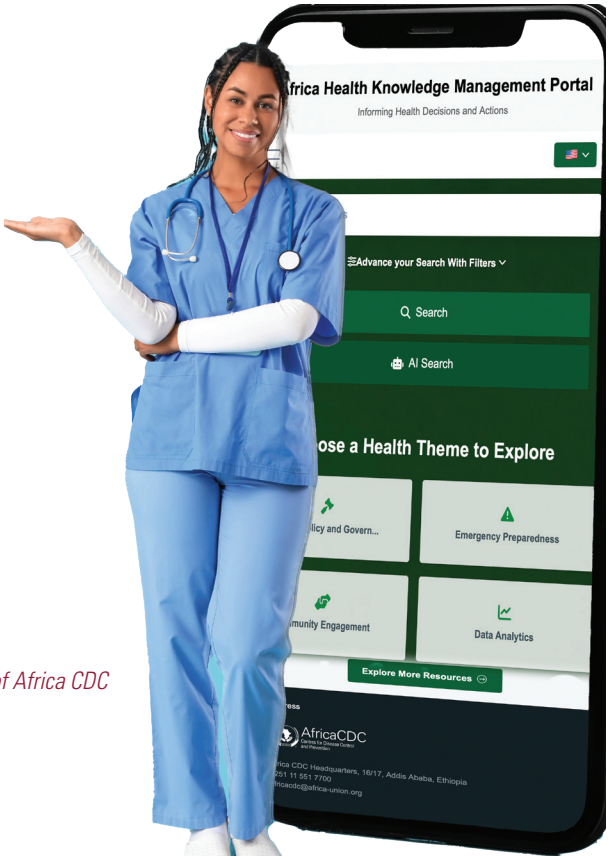
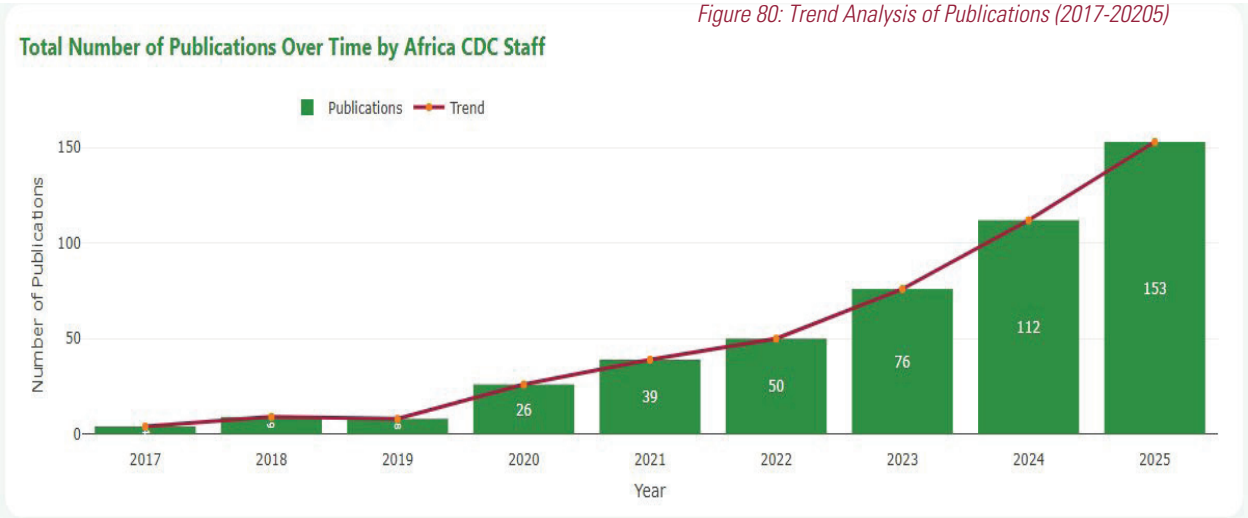


Figure 78: Dashboard of Africa CDC Knowledge Hub Portal

Figure 80: Trend Analysis of Publications (2017-20205)



4.4.4. What's Next

To consolidate Pillar 4, Africa CDC will prioritise:

- **From platforms to ecosystems**

  Integrating surveillance, laboratories, emergency operations, financing, and supply-chain data into a unified continental intelligence ecosystem.

- **Institutionalising data governance**

  Finalising and operationalising data-sharing agreements that protect sovereignty while enabling timely collective action.

- **Strengthening country digital capacity**

  Supporting Member States to modernise national systems so that continental interoperability does not depend on ad hoc workarounds.

- **Cybersecurity and resilience**

  Protecting sensitive health data and operational systems against cyber threats.

- **Using data for political accountability**

  Elevating dashboards and scorecards to support Head-of-State and Ministerial oversight of health security performance.

Digital intelligence accelerates decisions, but access to physical countermeasures determines outcomes. Pillar 5 examines how Africa CDC advanced local manufacturing and pooled procurement to secure supply, stabilise markets, and convert preparedness into protection

4.5 Pillar 5: Local Manufacturing & Pooled Procurement

The fifth pillar of the AHSS Agenda is focused on transforming Africa's role in the global health economy. Currently, over 90% of the vaccines and medicines used on the continent are imported, leaving African nations vulnerable to supply chain disruptions, export restrictions, and the broader political economy of scarcity. The COVID-19 pandemic exposed this vulnerability in stark terms, with Africa pushed to the back of the global vaccine queue while many Member States struggled to access even basic protective equipment. The lesson was clear: health security cannot be achieved without manufacturing sovereignty.

In response, the African Union set an ambitious target to produce at least 60% of vaccines used on the continent by 2040, while expanding local production of diagnostics, therapeutics, and other essential medical products.

During 2024–2025, the Partnership for African Vaccine Manufacturing (PAVM) was upgraded to the Platform for Harmonised African Health Manufacturing (PHAHM), with Africa CDC serving as the technical lead. In parallel, the African Pooled Procurement Mechanism (APPM) was 75% designed and operationalized, with a full launch anticipated in early 2026.

By late 2025, the APPM had already aggregated $3.2 billion in projected demand across 25 countries and signed its first framework agreements. The mechanism is expected to reduce procurement costs by 8–12%, while improving delivery timelines and supplier reliability.

Africa CDC collaborated with Member States, Regional Economic Communities, development banks, man-

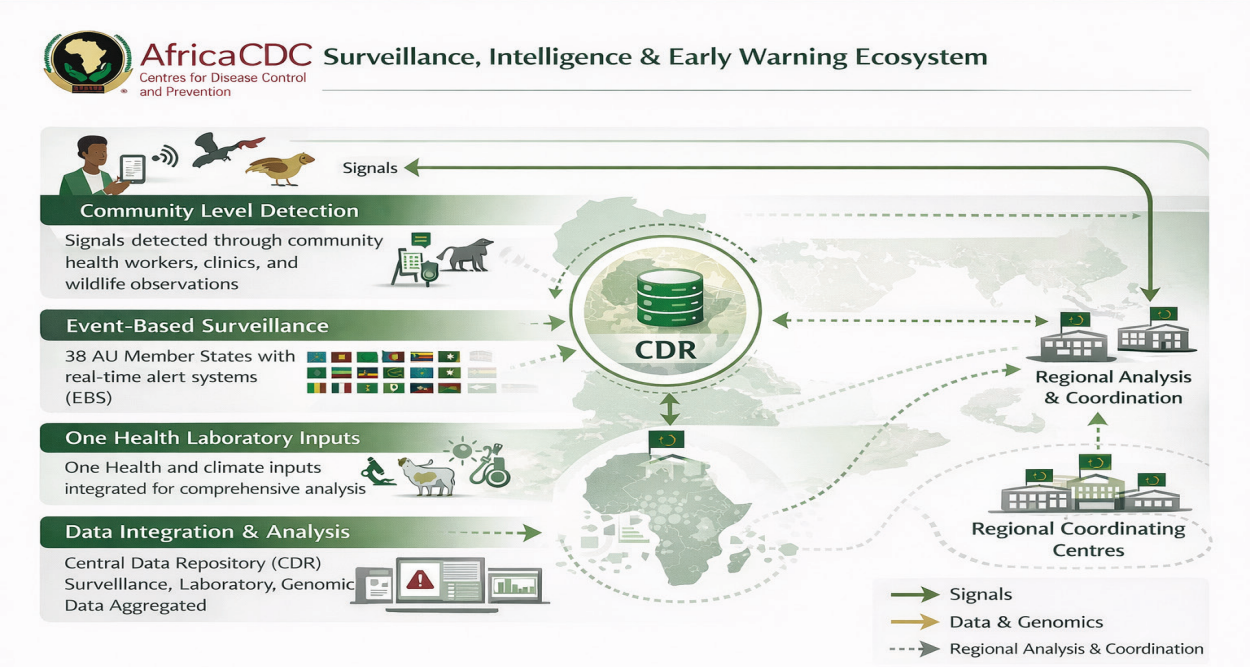


Figure 81:Africa CDC's integrated surveillance, intelligence, and early warning ecosystem linking community signals to continental decision-making

ufacturers, research institutions, and global partners to operationalize this vision. The results go far beyond incremental gains they represent a structural shift: the emergence of a health–industrial compact that integrates public health security with industrialisation, innovation, trade, technology transfer, and youth employment.

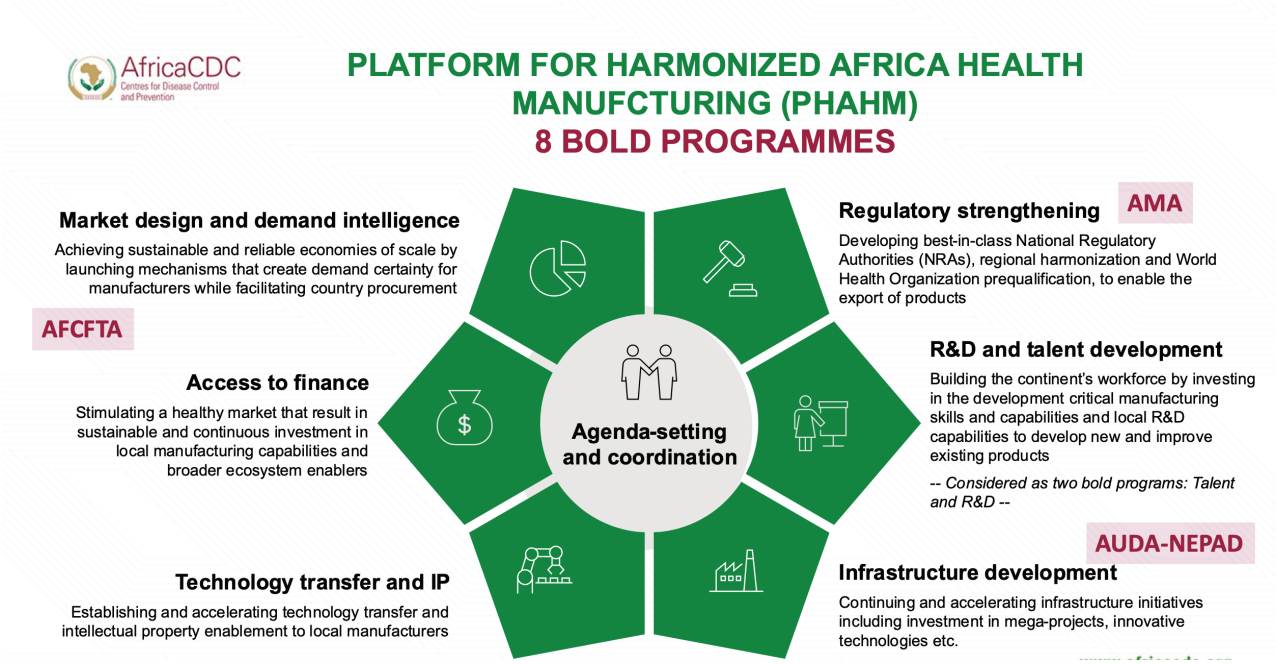
To date, Africa CDC has identified twenty-five vaccine manufacturing initiatives across the continent. Projections suggest that by 2030, three African manufacturers could supply up to eight WHO-prequalified vaccines. Alongside these projects, local capacity is expanding in other strategic areas, bed-net production in Angola and Nigeria, and antiretroviral (ARV) manufacturing in Kenya, Uganda, and South Africa.

Together, these initiatives form the foundation of a diversified and resilient manufacturing ecosystem capable of meeting a growing share of Africa's health needs.

A major milestone in 2025 was the operationalization and early rollout of the APPM. Historically, African nations procured health commodities independently, often at higher prices, in smaller volumes, and with weak negotiating power.

The APPM addresses these challenges head-on, offering a coordinated, demand-aggregated platform that enhances bargaining strength, improves procurement efficiency, and builds a more resilient health supply chain across the continent. Its initial focus on maternal and child health medicines has already demonstrated its potential. In the first pilot phase, participating countries reported price reductions of between 12 and 18 percent on selected products, alongside improvements in quality assurance and delivery reliability. These gains are not only fiscal; they mean that more women and children receive essential medicines, that supply chains become more stable and that ministries of finance gain confidence that pooled procurement can deliver better value than bilateral purchasing.

Beyond cost savings, the APPM is a powerful market-shaping tool. For years, global buyers have been reluctant to contract African manufacturers, citing uncertain demand, perceived risk, and concerns about sustainability. The APPM changes this equation by offering predictable, aggregated orders that de-risk investment and create a credible, rules-based continental market. In 2025, Africa CDC used its convening authority and the APPM platform to advocate with global health partners for increased procurement from African manufacturers. As a result, major buyers committed to purchase products from the three leading ARV manufacturers based in Kenya, Uganda, and South Africa, to increase procurement from vaccine manufacturers in Africa, and to expand sourcing of locally produced bed-nets from plants in Angola and Nigeria. These commitments are early but concrete evidence that procurement reform, coupled with political leadership, can unlock industrial investment, and move African manufacturers up the global value chain.



However, building factories is not enough. Sustainable manufacturing sovereignty depends on a robust science, innovation, and regulatory ecosystem. To this end, Africa CDC accelerated the development of a continent-wide research and development (R&D) platform in 2025. A comprehensive mapping of basic, pre-clinical and clinical research infrastructure was completed in thirty-six Member States, providing the empirical basis for a Hub-and-Spoke model in which a network of Centres of Excellence will anchor vaccine, diagnostic and therapeutic R&D, supported by satellite laboratories and clinical trial sites. The mapping exercise revealed both strengths and gaps: some countries have advanced clinical trial capacity and BSL-2/3 laboratories, while many others host underutilised platforms and lack coordinated translational science infrastructure. Africa CDC is already using these findings to guide new investments, partnerships, and technology transfer so that fragmented assets are transformed into a coherent continental R&D system that serves manufacturing objectives rather than operating in isolation.

Africa CDC's leadership in the Mpox Research and Development Blueprint demonstrates how this ecosystem can operate in practice. The blueprint Africa's first continent-wide R&D platform for a major outbreak defined priority scientific questions, standardised study protocols and harmonised laboratory methods across multiple countries. Under this framework, Africa CDC coordinated a multi-country socio-behavioural study in ten Member States, conducting more than 23,000 interviews to understand risk factors, transmission dynamics, health-seeking behaviours, and community perceptions.

These data are now guiding vaccination strategies, risk communication, and clinical guidelines. At the same time, two therapeutic candidates for priority pathogens advanced through in vitro testing in South Africa and in vivo studies in Kenya, with preparations underway for multicounty clinical trials across East, West and Southern Africa. Synthetic libraries and pseudo-viruses targeting twenty-two priority pathogens were also developed, strengthening Africa's pre-clinical capabilities and enabling faster evaluation of future vaccine and drug candidates.

Human capital is another essential pillar of manufacturing sovereignty. In 2025, Africa CDC consolidated the Regional Capability and Capacity Networks (RCCNs) to build a new generation of African biomanufacturing experts. Through these networks, the first cohorts of biomanufacturing fellows were placed in facilities in Egypt, Senegal, and South Africa. These fellows received advanced training in vaccine production processes, quality management, Good Manufacturing Practice (GMP) compliance and regulatory science. Over time, the RCCN model is expected to generate hundreds, and eventually thousands, of highly skilled African professionals capable of operating, managing, and regulating complex manufacturing plants. This investment in skills is strategic: without competent engineers, technicians, quality managers and regulatory specialists, bricks and mortar cannot translate into sustainable and competitive manufacturing capacity.

Strengthening supply chains and logistics is the final operational link between manufacturing plants and communities. Recognising that production alone is in-

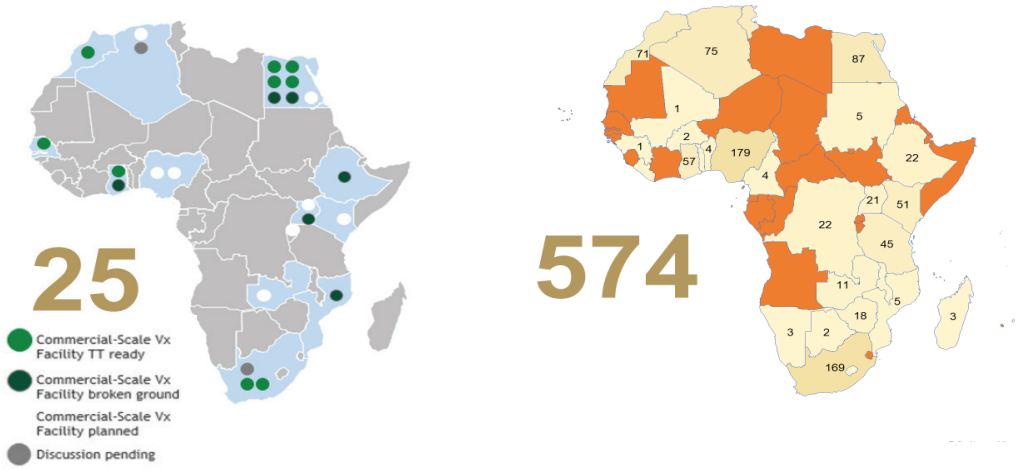


Figure 82: Local Vaccine Manufacturing Initiatives

sufficient, Africa CDC invested in upgrading the AU Continental MCM warehouse hosted in Douala, Cameroon, with support from the African Development Bank. In 2025, this hub's storage capacity was increased by 40 percent, and its cold-chain infrastructure was modernised. The Douala hub functions as a central node for surge response and is being progressively integrated with APPM operations. This integration will allow African-produced medicines and vaccines to be procured in bulk, pre-positioned strategically, and distributed rapidly and equitably across Member States. Already, in Southern Africa, reinforced cold-chain and logistics systems in Malawi, Zambia and Lesotho have improved readiness to receive and deploy products secured through pooled procurement.

Regionalisation has been a defining feature of Pillar 5's implementation. In Southern Africa, the 4th Regional Ministerial Steering Committee (ReSCO) endorsed Africa CDC's Green Book vision and AHSS manufacturing targets, anchoring procurement, and manufacturing reforms in regional political processes. Investments in cold-chain and logistics valued at around USD 1 million have strengthened the region's capacity to receive and distribute locally produced vaccines and therapeutics. In Eastern Africa, RCC support to Mauritius, Eritrea, Somalia, and Sudan focused on regulatory readiness, supply chain strengthening and emergency systems, ensuring that these countries can participate meaningfully in pooled procurement schemes and absorb new products swiftly during emergencies.

In Central Africa, enhancements to PHEOCs, regional sample transport systems and laboratory infrastructure in the Central African Republic, Chad, São Tomé and Príncipe, and the Democratic Republic of the Congo created the enabling conditions for uptake of locally manufactured commodities and participation in continental tenders. These efforts were reinforced by the Central Africa Partners Forum, which began aligning partner investments with regional manufacturing and procurement priorities. In Northern Africa, progress on RISLNET and strengthened regional governance frameworks laid the foundation for harmonised quality assurance, regulatory convergence and post-market surveillance key prerequisites for scaling manufacturing and cross-border trade in health products.

Taken together, these developments underscore a fundamental point: manufacturing sovereignty is not only about building factories; it is about building systems. These systems include regulatory agencies capable of timely and rigorous product approval. In this regard Africa CDC in collaboration with AMA and AMRH/AUDA_NEPAD have established a regulatory reliance among the 8 national regulatory authorities that have achieved the WHO Maturity Level 3. The system also includes R&D platforms that generate African innovations, human capital pipelines that supply skilled workers, pooled procurement mechanisms that shape markets, cold-chain networks and logistics hubs that move products efficiently, digital supply chains that provide real-time visibility, and regional governance structures that coordinate action.

Every investment made in 2025 from the 12–18 percent price reductions achieved through the APPM, to the 36 countries mapped for R&D, the 23,000 interviews in mpox research, the 22 pathogens covered by synthetic libraries, the 40 percent expansion of the Douala stock-

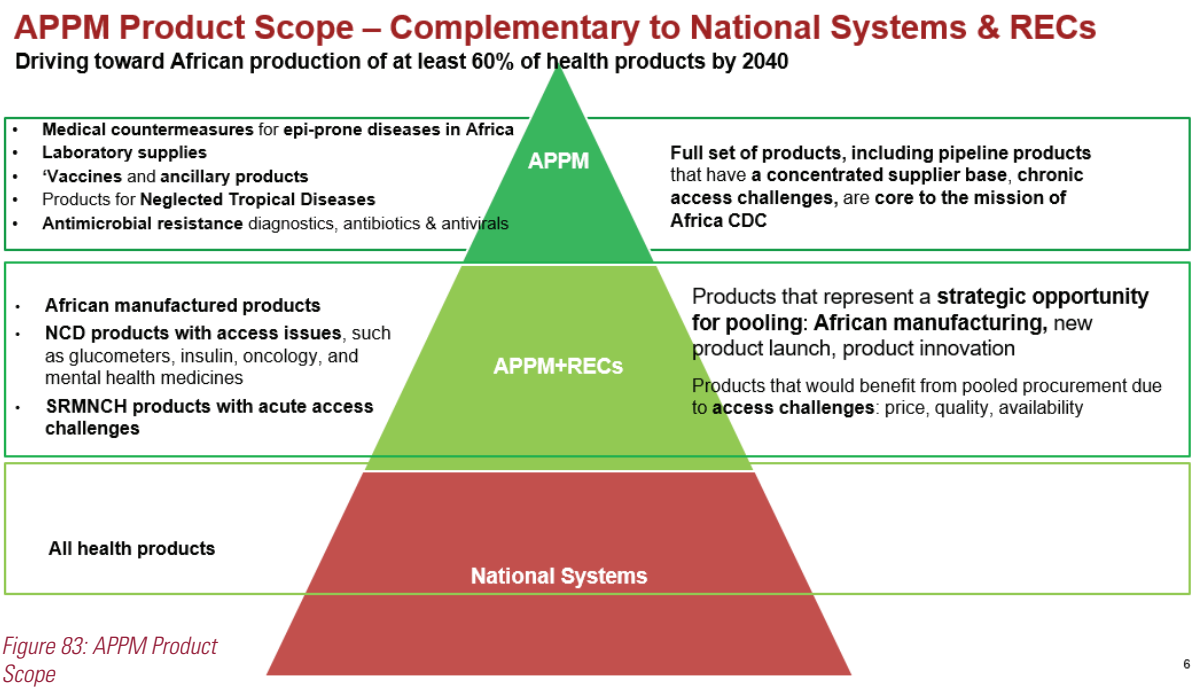


Figure 83: APPM Product Scope

pile, and the deployment of biomanufacturing fellows adds another brick to this architecture. A sustainable manufacturing ecosystem should be underpinned by an appropriate financing mechanism. In 2025, Africa CDC has worked with Gavi, the vaccine alliance to operationalize the African Vaccine Manufacturing Accelerator, a 1.2 billion USD innovative financing mechanism to support African vaccine manufacturers for the next 10 years. In addition, Africa CDC co-developed a financing product to operationalize the 2 billion USD financing available from Afrieximbank.

Looking ahead, the path is clear but demanding. The APPM must expand its product scope to include a broader range of vaccines, oncology medicines, NCD-related commodities, and critical diagnostics. The African Medicines Agency (AMA) must be fully operationalised and empowered to function as a continental regulator that supports and accelerates African manufacturing. Regional manufacturing hubs will need to be scaled and tightly linked to AfCFTA trade arrangements so that medical products can move swiftly and tariff-efficiently across borders. RCCNs must train a far larger cadre of African manufacturing professionals across engineering, quality, regulatory and management domains. Securing sustainable financing from domestic budgets, development finance institutions, blended finance instruments, and innovative facilities will be essential to consolidate these gains and move from pilot investments to transformative scale.

Moreover, as more African manufacturers begin commercial production, risks are becoming more pronounced. African firms are entering markets dominated by global suppliers that benefit from decades of scale, subsidised finance, mature regulatory systems, and integrated supply chains. Creating a structural competitiveness gap that African firms cannot close through commercial effort alone Without targeted market-entry and market-shaping interventions, African production risks being priced out of its own market before scale is achieved. To correct this imbalance, Africa needs to deploy time-bound, rules-based market formation tools, including price-preference margins, volume guarantees, advance purchase commitments, predictable offtake through APPM, and regulatory reliance pathways. These measures are not protectionism; they are the same instruments used by all successful manufacturing economies to reach scale. Market shaping is therefore the bridge from political commitment to commercial viability and from viability to sovereignty.

The vision of Pillar 5 is bold but necessary. Africa must build, produce, and procure the medical products it needs to protect its populations. The continent can no longer rely on unpredictable global markets or external goodwill to secure lifesaving commodities. Instead, it will nurture its own scientific talent, strengthen its own regulatory systems, shape its own markets, and take its rightful place in global manufacturing ecosystems. Through local manufacturing and pooled procurement, Africa is laying the foundations not only for health security, but also for economic sovereignty, technological leadership, and shared prosperity for generations to come.

4.5.1 Why This Pillar Matters

Health security fails when countermeasures are unavailable, unaffordable, or arrive too late. Recent crises exposed Africa's structural vulnerability: dependence on external suppliers, fragmented purchasing power, and limited influence over allocation decisions. These weaknesses are not logistical inconveniences; they are strategic risks that undermine sovereignty, preparedness, and public trust.

Moreover, with the health products market projected to reach **USD 350 billion by 2040** and with the potential to generate up to **sixteen million jobs**, African manufacturing is also about economic security and growth.

AHSS Pillar 5 responds by repositioning local manufacturing and pooled procurement as core security instruments. The objective is not autarky, but strategic autonomy the ability to secure timely access to quality-assured products through predictable demand, regional production, and coordinated purchasing.

4.5.2 Key Results in 2025

In 2025, Africa CDC moved the continent from declarations to operational market-shaping.

Africa's manufacturing base is expanding.

- 574 health product manufacturers registered with their NRAs mapped across Africa.
- More than twenty-seven vaccine manufacturing initiatives advancing, with at least 8 products expected to reach WHO PQ or market by 2030.
- A growing pipeline of bed nets, diagnostics, and therapeutics manufactured on the continent.
- More than twenty technology transfer projects are underway.

Pooled procurement becomes executable.

- Africa CDC operationalised the African Pooled Procurement Mechanism (APPM) as a continental purchasing platform aligned with national priorities.
- Pooled procurement of **10 SRMNCH products across ten pilot countries**, with the next procurement cycle scheduled for early 2026; and procurement pipelines were established, to enable countries to aggregate demand, reduce price dispersion, and shorten delivery timelines.
- Procurement governance frameworks clarified roles between Africa CDC, Member States, and partners preserving sovereignty while capturing scale.

Regulatory capabilities and efficiencies

- **Nine National Regulatory Authorities** achieving WHO Maturity Level 3, strengthened National Quality Control Laboratories (including South Africa, Rwanda, and Senegal), and **AMA operationalisation underway** with its first Director-General appointed.
- **Regional Capacity and Capability Networks (RCCNs)** established to contribute to the building of a future workforce of **9,000–14,000 skilled professionals** in biomanufacturing.

Unprecedented financing

More than USD 10 billion mobilised for African health product manufacturing, including.

- **Gavi's African Vaccine Manufacturing Accelerator (AVMA), USD 1.2 billion**
- **Afreximbank's USD 2 billion pledge** to finance African health product manufacturing.
- **A joint European Union (Team Europe Initiative) and Gates Foundation partnership**, mobilising **USD 1 billion** to support health product manufacturing across the continent.
- The African Development Bank (AfDB) launched a USD 6 billion initiative to transform Africa's health sector, with a specific focus on developing local pharmaceutical manufacturing capacity and infrastructure.

These mechanisms shifted manufacturing from aspirational policy to bankable pipelines, reducing investor uncertainty and supporting sustainable scale-up.

Manufacturing coordination advances

- Africa CDC strengthened coordination across the continental manufacturing ecosystem, linking producers, regulators, financiers, and purchasers. Africa CDC also convened member states to garner political commitment for African health products manufacturing.
- Quality assurance, regulatory reliance, and workforce development were addressed as system constraints, not afterthoughts.
- Manufacturing priorities were aligned with preparedness needs, including vaccines, diagnostics, and essential medical supplies.

Sustained political momentum and partner engagement.

Baseline (2022)

Africa CDC's support to local manufacturing was at an early stage through the Partnership for African Vaccine Manufacturing (PAVM). The continent produced < 1 % of its vaccine needs, less than 10% of all its health product neds, and had no coordinated platform for regulatory alignment, technology transfer, financing, and manufacturing workforce development.

Achievements (2023 – 2025)

Creation of the Platform for Harmonized African Health Manufacturing (PHAHM)

- In 2024, the AU Assembly upgraded PAVM to PHAHM, with Africa CDC as its technical lead.
- PHAHM provides a continent-wide framework for coordination of vaccine, diagnostic, and therapeutic manufacturing. PHAHM brings together AU institutions (AMA, AUDA-NEPAD, AfCFTA, RECs), African DFIs (Afreximbank, AfDB), global health procurers (Gavi, Global Fund, Unitaid, UNICEF), multilateral and bilateral partners (EU, US, UAE, Japan, World Bank), African manufacturer associations (AVMI, FAPMA, etc.), and leading research and training institutions (IPD, CSIR, ABI) to build a coherent continental health products manufacturing ecosystem.
- More than 27 manufacturing initiatives mapped across Africa[1], including in Algeria, Egypt, Ethiopia, Ghana, Kenya, Morocco, Mozambique, Nigeria, Rwanda, Senegal, South Africa, Uganda, and Zambia

Technology Transfer (TT) and Capacity Building

- In addition to workshops conducted on the continent by WIPO, IGAD and others, Africa CDC conducted two continental TT workshops in partnership with CEPI, WHO, and EU to address gaps in business planning and biomanufacturing skills.
- At least ten African manufacturers received technical training on ave we revised the report as requested by KOICA? I am assuming that they are referring to the Q2/Q3 report.
- , cold-chain design, and clinical trial regulation.
- RCCNs (Regional Capability and Capacity Networks) established in four regions of Africa with four secretariats i.e. Institute Pasteur de Dakar, Senegal (western African RCCN), African Biomanufacturing Institute, Rwanda (eastern African RCCN), Institute Pasteur de Maroc, Morocco and Unified Procurement Authority, Egypt (northern African RCCN) as well as Council for Scientific and Industrial Research, South Africa (southern African RCCN) for workforce development and fellowship programs.

Continental Leadership and Policy

- Africa CDC co-led the G20 High Level Independent Panel that launched the report "Closing the Deal: Financing Security Against Pandemic Threats[2]" which included the recommendations to accelerate geographically diversified access to medical countermeasures (MCMs): enable development bank at-risk financing for MCM advance purchases; and, operationalize financing for tests, treatments, and PPE.

Regulatory and Market Integration

- The operationalisation of the African Medicines Agency (AMA) in October 2025, preceded by the appointment of the first Director General in June 2025, represents a major continental milestone, providing the institutional anchor for regulatory harmonisation, convergence, and reliance across AU Member States.
- Global Fund aligned procurement strategies with the upcoming African Pooled Procurement Mechanism (APPM) to anchor demand.

4.5.2 Situation Analysis as of 2025

The continent currently hosts **574 health product manufacturing companies** registered by National Regulatory Authorities (NRAs) in their countries of production. This compares with approximately **5,000 manufacturers in China** and **10,000 in India** -- economies of comparable population scale. Given the size and growth trajectory of Africa's health product market, there remains a significant need to expand the number and scale of manufacturers to achieve the continent's objective of producing 60% of its needed health products on the continent.

1 For comparison of similar economic populations: China has 41-43 vaccine manufacturers (https://journals.lww.com/mgmj/fulltext/2020/07010/human_vaccines_industry_in_china,_2019__part_i.8.aspx#:~:text=China%20has%2041%20vaccine%20manufacturing%20companies%2C%20including,companies%20and%20multinational%20companies%20that%20manufacture%20vaccines.) and India has at least 88 vaccine manufacturers https://isid.org.in/wp-content/uploads/2023/01/WP258.pdf

2 2025, Closing the Deal: Financing Our Security Against Pandemic Threats, Report of the G20 High-Level Independent Panelhttps://nam.edu/pandemic-financing/

The sections below provide a synopsis of the current manufacturing landscape by product category.

Vaccine Manufacturing

Africa currently has more than twenty-seven vaccine manufacturing initiatives underway, designed to address both routine immunisation needs and outbreak response. At least 8 vaccine products are expected to reach WHO prequalification (PQ) or market by 2030. This compares with 41-43 vaccine manufacturers in China and at least eighty-eight in India, economies of comparable population scale.

Africa CDC and AU Member States are working to ensure that vaccines produced on the continent are integrated into national immunisation programmes and supported by predictable, financed, and consolidated demand. This is essential to ensure the commercial viability and long-term sustainability of manufacturing investments and to achieve the continental target of increased local production.

Therapeutics Manufacturing

Therapeutics manufacturing represents the largest segment of Africa's health product manufacturing base. Key characteristics include:

- A predominance of small- to medium-sized generic manufacturers producing essential medicines, including antibiotics, antimalarials, antiretrovirals (ARVs), analgesics, and antihypertensives.
- Limited but growing capacity for insulin, injectables, sterile products, and more complex formulations.
- An emerging pipeline for biosimilars and biologics, including monoclonal antibodies, next-generation HIV and TB medicines, and early interest in RNA platforms and advanced therapeutics.
- Heavy reliance on imported Active Pharmaceutical Ingredients (APIs), with more than 95% of APIs imported.
- Approximately 25 manufacturers of HIV products across Africa.
- More than 90 manufacturers of malaria products across more than thirty countries, with Ghana, Ethiopia, Kenya, Nigeria, and Uganda serving as the larger hubs.
- Manufacturing activity remains focused on formulation and packaging rather than upstream production or product development.

Local manufacturing of sterile intravenous (IV) fluids has emerged as a basic and critical capacity across the continent, particularly considering recurrent cholera outbreaks and the high cost and logistical challenges associated with importing these products.

Diagnostics Manufacturing

Diagnostics manufacturing in Africa is less mature than therapeutics, but strategically critical and rapidly evolving. Current activity is concentrated in:

- Rapid diagnostic tests (RDTs) and lateral flow assays.
- Basic laboratory reagents and consumables.

Local production of molecular diagnostics, including PCR platforms, remains limited, with most platforms imported. However, assembly, packaging, and partial reagent production capacities are expanding. Critical products including malaria and mpox rapid diagnostic tests (RDTs), HIV and TB diagnostics, COVID-19 tests, and basic laboratory consumables such as swabs, reagents, and plastics are currently produced or assembled in countries including Kenya, Morocco, South Africa, Egypt, Nigeria, Tunisia, Senegal, Rwanda, and Uganda, with varying levels of local value addition ranging from assembly and packaging to partial reagent and component production.

Bed Net Manufacturing – case analysis.

Africa currently imports more than 95% of insecticide-treated bed nets required for malaria control. These products are often manufactured in countries with little or no malaria burden and are produced exclusively for African markets, highlighting the paradox whereby Africa represents a large, predictable, and commercially viable market, yet captures limited value.

At present, there are two WHO-prequalified bed net manufacturers in Afric**a**, located in Tanzania and Uganda. Additional manufacturing capacity is under development in Angola and Nigeria, with other initiatives under consideration.

In 2024, approximately 167 million bed nets representing around 90% of global procurement were purchased for African countries. The African Leaders Malaria Alliance (ALMA) estimates Africa's annual requirement at approximately two hundred million bed nets. At an average cost of **USD 2–4 per net**, this represents a market valued at **USD 400–600 million annually** a scale that could support at least five competitive African manufacturers.

However, demand is currently met by eleven non-African manufacturers, creating intense competitive pressure. Without deliberate market-shaping interventions such as pooled procurement, predictable demand, preferential purchasing, and transitional pricing sup-

Table 15: Local Manufacturing and Technology Transfer Key Performance Indicators (2022 -2025)

Indicator	2022	2025	(%) Change	Source
Continental manufacturing initiatives mapped	8	>27	+237%	Africa CDC Annual Report 2024
Manufacturers capacitated in GMP and clinical standards to meet regulatory expectations	0	>10	New	Malabo Report 2025
Tech Transfer agreements	2	>20	+900%	Various public reports and Africa CDC records
Countries benefiting from the Africa CDC Manufacturing Fellowship programs	0	10	New	Various public reports and Africa CDC records
Financing mobilized to scale local production and technology transfer capacity	USD 1.5 billion	>USD 10 billion	+567%	Various public reports

port emerging African manufacturers will struggle to compete on price while building scale and efficiency. In the absence of such measures, there is a real risk that Africa's nascent bed net manufacturing base will fail not due to lack of demand, but because of premature exposure to full global competition.

Africa CDC facilitated the establishment of a bed net manufacturing partnership in Angola, bringing together the Government of Angola, Alcaal as the local manufacturer, ALMA for technical and strategic support, and BASF as the technology transfer partner.

Cross-cutting constraints

Across product segments, Africa's manufacturing base remains dependent on manufacturing and marketing licences from originator companies, with limited continental R&D capacity and very few first-production products manufactured on the continent. Even when clinical trials are conducted in Africa, new products are rarely manufactured first in Africa. This deprives African manufacturers of first-to-market advantages, constrains competitiveness, and reinforces external dependence.

Manufacturers consistently identify the following constraints:

- Fragmented and unpredictable demand.
- Limited pooled procurement mechanisms.
- Intense competition from established global manufacturers.
- Regulatory and quality compliance barriers.
- Limited access to working capital and scale-up finance.

Fragmented markets and uncertain offtake continue to deter investment, while aggressive price competition from international suppliers further constrains competitiveness. In parallel, limited uptake of African-manufactured therapeutics and diagnostics by global procurement organisations remains a major barrier to scale.

Political Commitment

AU Member States have demonstrated growing political commitment through national policy actions, investment decisions, and support for the "Buy African" agenda. Sustaining this momentum will require translating political intent into procurement decisions, market-shaping instruments, and financing mechanisms that allow African manufacturers to reach scale and compete sustainably.

4.5.3. Technology Transfer

As Africa continues to build its domestic manufacturing capabilities, technology transfer remains a critical enabler of the continent's health products manufacturing ecosystem. Technology transfer supports the rapid establishment of locally anchored production capacity, accelerates learning curves, and enables African manufacturers to enter complex product markets that otherwise might take decades to develop organically. It is therefore not a temporary substitute for local innovation, but a strategic bridge toward sustainable manufacturing, skills accumulation, and technological sovereignty.

There are more than 20 vaccine and health product technology transfer initiatives currently underway across the continent. These initiatives are aligned with continental priorities, public health needs, and outbreak risk profiles, and span vaccines, therapeutics, diagnostics, and vector control products. They are being implemented through a combination of bilateral partnerships, multilateral platforms, and South–South cooperation, with increasing emphasis on end-to-end capability

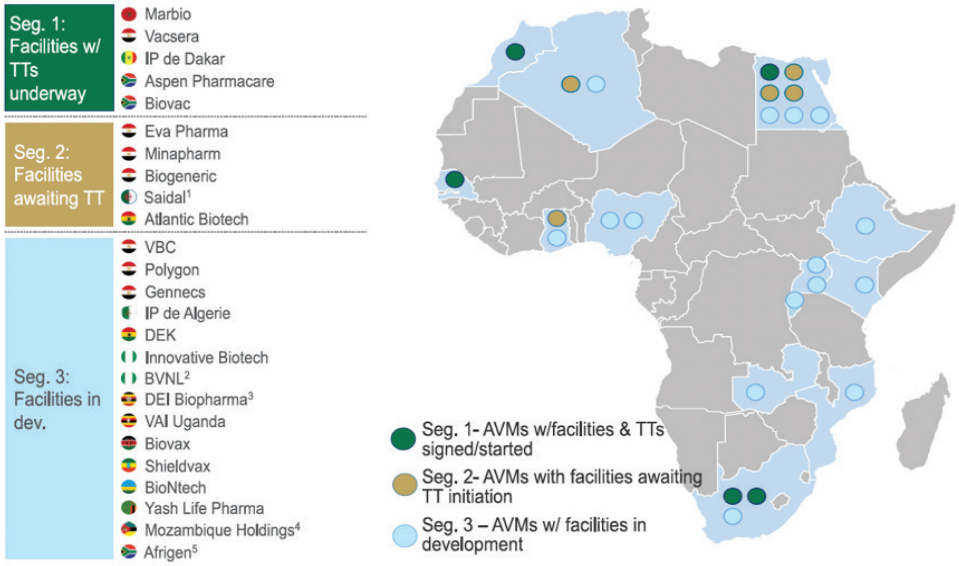


Figure 84:Therapeutics Manufacturing

transfer, including process know-how, quality systems, workforce training, and regulatory readiness.

Selected Technology Transfer Initiatives Underway

Vaccines:

- Oral Cholera Vaccine (OCV), Ghana, South Africa and Zambia
- Meningitis Vaccine, South Africa.
- Yellow Fever Vaccine, Senegal
- Hexavalent Vaccines, South Africa (acellular and whole cell pertussis)
- Pneumococcal Vaccines, Egypt, Morocco, and South Africa,
- Rotavirus Vaccine, South Africa
- Inactivated Polio Virus Vaccine, Egypt, and South Africa
- Measles-Rubella Vaccine, Senegal
- Td, TT and Snake venom, Ghana

Non-Vaccines Health Products

- Long-Lasting Insecticide Treated Bed Nets, Angola and Nigeria
- Insulin in Egypt and South Africa
- Lenacapavir in Egypt

These initiatives demonstrate the breadth and maturity of Africa's technology transfer portfolio, covering both routine immunisation and outbreak response products, as well as essential therapeutics and vector control commodities. Several initiatives are already progressing toward regulatory submission, WHO prequalification, and market entry, while others are focused on upstream process development and workforce training.

MRNA Hubs

In addition, Africa is advancing next-generation platform technologies through the establishment of mRNA technology transfer hubs, which represent a strategic investment in long-term manufacturing resilience and innovation capacity. Led by the WHO mRNA Technology Transfer Programme in collaboration with Africa CDC, AU Member States, and global partners, these hubs are designed to enable platform-based manufacturing capabilities that can be rapidly adapted for multiple vaccines and therapeutics.

The mRNA hubs focus not only on product-specific transfer, but on end-to-end capability development, including process development, quality systems, analytical methods, regulatory readiness, and workforce training. While initial efforts centred on COVID-19 vaccine candidates, the platform is being positioned to support future applications, including vaccines for tuberculosis, malaria, HIV, and emerging pathogens, as well as potential therapeutic uses.

Importantly, the mRNA hubs are intended to function as shared continental assets, supporting regional manufacturers and research institutions rather than duplicating capacity country by country. Their success will depend on sustained investment, integration with national manufacturing strategies, regulatory convergence under the African Medicines Agency (AMA), and the availability of predictable demand and financing

pathways to transition from technology acquisition to commercial viability.

Together with traditional technology transfer initiatives, the mRNA hubs strengthen Africa's ability to absorb, adapt, and eventually originate advanced health technologies, reinforcing the continent's long-term goal of health security, innovation, and manufacturing sovereignty.

Going forward, Africa CDC, AU Member States and partners are working to ensure that technology transfer initiatives are:

- Integrated into national and continental market frameworks, including APPM, to secure predictable demand.
- Supported by regulatory convergence and reliance pathways under the African Medicines Agency (AMA).
- Accompanied by financing instruments aligned with industrial scale-up timelines; and
- Designed to move beyond fill-and-finish toward full manufacturing value chains, including formulation, quality control, and, where feasible, upstream inputs.

Technology transfer, when strategically deployed and paired with market access, regulatory support, and financing, is a powerful tool to accelerate Africa's transition from import dependence to competitive manufacturing. It will remain a central pillar of Africa's manufacturing strategy, supporting immediate public health needs while laying the foundation for long-term innovation, resilience, and health sovereignty.

4.5.4 Access to Manufacturing Input Materials

Reliable access to quality-assured manufacturing input materials, including active pharmaceutical ingredients (APIs), excipients, reagents, packaging materials, filters, vials, and other critical components, is a foundation for advancing vaccine and pharmaceutical manufacturing in Africa. Without secure, affordable, and predictable access to these inputs, African manufacturers are unable to operate at scale, control costs, or meet regulatory and quality requirements.

Over the past two years, Africa CDC has conducted a systematic diagnosis of supply-chain_bottlenecks affecting manufacturers across the continent and has worked with AU Member States, manufacturers, and partners to develop targeted, actionable solutions to enhance resilience and competitiveness.

Key Challenges Identified

The assessment identified several structural constraints, including:

- **Limited bargaining power** of individual manufacturers when negotiating long-term

Fig 85: Photos. Africa CDC and ALMA visiting Alcaal in Luanda Angola, supporting the technology transfer from BASF

supply agreements with global input suppliers.

- **Complex, costly, and unreliable logistics**, including high freight costs and extended lead times.
- **Exposure to foreign-exchange volatility and macroeconomic instability**, increasing input costs and financial risk.
- **Fragmented trade regulations and procedural inconsistencies**, resulting in delays and uncertainty at borders.
- **Limited market intelligence**, including challenges in forecasting demand, identifying reliable suppliers, and ensuring quality assurance of inputs.

These constraints collectively increase production costs, disrupt manufacturing schedules, and weaken the business case for sustained investment in African manufacturing.

Strategic Response

- In response, Africa CDC working with manufacturers, AU Member States, RECs, and partners is identifying solution pathway around mutually reinforcing pillars:
- **Localisation of Input Materials**: Promote the domestic and regional production of critical inputs, including APIs, reagents, consumables, and packaging materials, to reduce external dependency and exposure to global supply shocks. This includes identifying priority inputs for localisation and supporting targeted industrial investments.
- **Regional Access and Supply Consortia**: Explore pooled procurement mechanisms, shared warehousing, and regional logistics platforms to aggregate demand, improve negotiating power, reduce unit costs, and ensure more equitable access to inputs across countries and manufacturers.
- **Trade and Regulatory Harmonisation**: Work with AfCFTA, customs authorities, and RECs to simplify and align cross-border trade regulations, reduce non-tariff barriers, and facilitate faster and more predictable movement of manufacturing inputs across borders.
- **Long-Term Supplier Agreements:** Consider the facilitation of long-term, framework supply agreements with qualified global and regional input suppliers, anchored in aggregated demand and supported by appropriate financing and risk-mitigation instruments. These agreements are essential to secure price stability, reduce exposure to foreign-exchange risk, and provide manufacturers with the predictability required to plan production and invest in scale-up.
- A detailed assessment of these solution pathways is underway outlining short-, medium-, and long-term actions is currently under final validation by stakeholders. Implementation of this roadmap will strengthen supply-chain resilience, reduce production costs, and reinforce the foundations for a competitive and sustainable African health products manufacturing ecosystem.

4.5.4 Access to Finance

Advancing vaccine, medicine, and diagnostics manufacturing across Africa requires sustained, predictable investment not only in production facilities, but also across the broader enabling ecosystem including skills, quality systems, regulatory readiness, and supply chains. Over the past two years, substantial progress has been made in mobilising financing for African health product manufacturing, reflecting growing confidence in the continent's manufacturing agenda and its long-term market potential.

Key financing commitments secured to date include:

- **The Gavi African Vaccine Manufacturing Accelerator (AVMA)**: a **USD 1.2 billion** innovative financing mechanism designed to support African vaccine manufacturers over a **10-year period**, providing predictable demand-linked incentives to accelerate scale-up and sustainability.
- **Afrexim Bank's USD 2 billion pledge** to finance African health product manufacturing, supporting both manufacturing capacity and associated value-chain investments.
- **A joint European Union (Team Europe Initiative) and Gates Foundation partnership**, mobilising **USD 1 billion** to support health product manufacturing across the continent.
- The African Development Bank (AfDB) has launched a $6 billion initiative to transform Africa's health sector, with a specific focus on developing local pharmaceutical manufacturing capacity and modern health infrastructure. This investment is divided into two $3 billion programs: one for quality health infrastructure across the continent and another for develop-

ing local pharmaceutical manufacturing capacity in Africa. The AfDB also created the African Pharmaceutical Technology Foundation to help African countries access intellectual property and technical expertise for local medicine and vaccine production.

In addition to these flagship commitments, additional financing is in the pipeline, including instruments specifically targeting small and medium-sized manufacturers, a segment consistently identified by African manufacturers as underserved despite its critical role in building a diversified and resilient manufacturing base.

At the global level, the **G20 High-Level Independent Panel on Pandemic Prevention, Preparedness, and Response** recommended a series of financing reforms directly relevant to Africa's manufacturing agenda. These include:

- The establishment of a capital fund to underpin regional pooled procurement mechanisms, strengthening demand certainty and market formation; and
- The creation of at-risk financing instruments to enable rapid procurement of medical countermeasures at the onset of a health threat ("day zero" financing).

In parallel, the European Union is advancing the creation of a blended finance facility to support African manufacturers and associated infrastructure, combining concessional and commercial capital to better align financing terms with the long investment horizons and risk profiles of health product manufacturing.

Despite this progress, important gaps remain particularly in marking shaping interventions, working capital, scale-up finance, and patient capital aligned to industrial timelines. Continued efforts are therefore required to ensure that financing instruments are coherent, complementary, and accessible, and that they are effectively linked to market-shaping mechanisms, pooled procurement, and regulatory readiness. Closing these gaps will be essential to translate political commitment and early investments into commercially viable, competitive, and sustainable African manufacturing capacity.

4.5.5 Talent and Workforce Development

Africa's ambition to build a competitive and sustainable health products manufacturing ecosystem depends fundamentally on the availability of a skilled, specialised, and future-ready workforce. Currently, the continent employs an estimated **2,000–3,000 full-time equivalents (FTEs)** across vaccine research and development, manufacturing, and related functions. To meet the African Union's ambition to produce approximately **2.7 billion vaccine doses annually by 2040**, it is estimated that **9,000–14,000 FTEs** will be required across manufacturing, quality control, regulatory affairs, R&D, and supply-chain management.

Recognising this gap, Africa CDC has prioritised systematic workforce development as a core pillar of the manufacturing agenda. In 2025, Africa CDC established **Regional Capacity and Capability Networks (RCCNs)** to foster structured collaboration among academia, research institutions, manufacturers, and regulatory authorities. The RCCNs are designed to serve as regional platforms for coordinated skills development, knowledge transfer, and the creation of talent pipelines. The designated RCCN secretariats are:

- East Africa: African Biomanufacturing Institute – Rwanda
- West Africa: Institute Pasteur Dakar – Senegal
- North Africa: Unified Procurement Authority (Egypt) and Institute Pasteur Maroc – Morocco
- Southern Africa: Council for Scientific and Industrial Research (CSIR) - South Africa

The RCCNs are composed of institutions representative of multiple countries within its respective regions and will be responsible for the implementation of relevant priority training programmes to develop the workforce for biomanufacturing, research and development, and regulatory affairs.

Fellowship Programmes

To address immediate skills gaps and accelerate leadership development, Africa CDC has launched two targeted fellowship programmes:

Structured Industrial Fellowship Programme in Vaccine Manufacturing

Fifteen (15) fellows from Algeria, Angola, Cameroon, Egypt, Ethiopia, Ghana, Kenya, Nigeria, Rwanda, Senegal, South Africa, Tanzania, Uganda, Zambia, and Zimbabwe have been recruited and placed in active vaccine manufacturing companies **in** Egypt (5 fellows), Senegal (5 fellows), and South Africa (5 fellows)**.** The programme provides 12 months of hands-on, experiential learning across core manufacturing functions.

Biomanufacturing Leadership Fellowship Programme

Five (5) fellows already employed in vaccine manufacturing companies have been selected to undergo advanced training to prepare them to become future leaders of Africa's biomanufacturing industry**,** with a focus

on strategic management, regulatory navigation, and scale-up operations.

Next Phase Priorities

In the coming year, Africa CDC will focus on fully operationalising the RCCNs, strengthening their institutional capacity, and expanding their ability to deliver world-class training programmes in health product manufacturing. This includes developing standardised curricula, expanding industry placements, and deepening collaboration with regulatory authorities and manufacturers.

Together, these efforts aim to build a sustainable continental talent pipeline, ensuring that Africa has the skilled workforce required to support manufacturing scale-up, drive innovation, and achieve long-term health security and manufacturing sovereignty.

4. 5.6 Market Visibility

Africa CDC, through the Platform for Harmonised African Health Products Manufacturing (PHAHM), is leading the development and institutionalisation of a continental, consolidated database of African health product manufacturers. The platform systematically maps manufacturers across the full value chain, including vaccines, therapeutics, diagnostics, active pharmaceutical ingredients (APIs), excipients, packaging materials, and medical devices, providing the most comprehensive picture to date of Africa's manufacturing capacity. To date, more than 574 manufacturers have been mapped across 34 AU Member States.

In partnership with the Gates Foundation, AUDA-NEPAD and partners, Africa CDC is leading a new platform - African Manufacturing Market Intelligence & Network Analysis (AMMINA) to further scale the approach across all 55 AU Member States, ensuring that the data are maintained as a continental public good under African Union governance.

This approach safeguards data sovereignty ensures consistency and quality of information and enables the platform to be leveraged strategically to strengthen Africa's health and industrial sovereignty.

The primary objective of the platform is to ensure full visibility of African health product manufacturers to AU Member States and regional and continental institutions. By closing long-standing information gaps, the platform enables buyers, regulators, financiers, and policymakers to identify qualified African manufacturers and integrate them into procurement, regulatory, and investment decisions.

Beyond visibility, the market intelligence platform is designed to equip AU Member States, Regional Economic Communities (RECs), AU institutions, Development Finance Institutions (DFIs), and partners with actionable insights on:

- Where manufacturing capacity exists or is emerging.
- Which product categories require targeted support.
- Where regulatory, financing, or market-shaping interventions are needed to accelerate scale.

By transforming fragmented and opaque information into shared continental intelligence, the platform strengthens demand aggregation, supports pooled procurement, guides financing decisions, and reduces transaction costs for both African manufacturers and buyers. In doing so, it plays a critical role in translating political commitment into effective market participation and commercial uptake of African-made health products.

4.5.7 Africa's Pooled Procurement Mechanism (APPM)

Before the APPM, Africa lacked a unified procurement mechanism and a market-shaping mechanism. Each Member State purchased vaccines and diagnostics independently, often at higher prices, with long lead times and limited bargaining power. At its 37th Session of the Assembly in February 2024, AU Member States adopted the landmark decisions (AU/Dec.877(XXXVII)) mandating the Africa CDC to establish and operate the **African Pooled Procurement Mechanism (APPM)** as a decisive step to improve access and support African manufacturing.

The African Pooled Procurement Mechanism (APPM) has entered its start-up phase, marking a major milestone in operationalising a continental platform to improve access to quality-assured health products and support African manufacturing. The design phase has been completed, core systems are in place, and pooled procurement has been initiated for ten priority SRMNCH products requested by ten AU Member States, alongside emergency procurement for countries facing critical stock-outs.

During this start-up phase, Africa CDC laid the foundation for a fully functional mechanism by establishing key operational systems, including a Quality Management System, updated procurement procedures, and the recruitment of technical experts in market intelligence, logistics, quality assurance, and finance.

Pooled procurement of the ten priority SRMNCH products is well underway. Anchored in partnership with the United Nations Economic Commission for Africa (UNECA) and supported by UNFPA, the initiative has the potential to reduce prices by 30–40% while achieving over 90% product availability. Demand aggregation has been completed, supplier negotiations are advancing, and the first procurement cycle will be completed in early 2026.

In parallel, the APPM is supporting emergency procurement for countries experiencing acute stock-outs of essential health products. This has generated unprecedented demand for speed and scale, requiring innovative procurement and financing approaches and additional operational support.

The APPM's product portfolio is rapidly expanding, and AU Member States are actively signing the APPM Memorandum of Understanding to facilitate participation. The online digital interface is being launched to support transparent engagement, demand submission, and supplier interaction. Consultations have also been held with AfCFTA and customs authorities to facilitate the smooth cross-border movement of health products.

Efforts are underway to fully capitalise the APPM capital fund, which will reduce advance payment requirements for countries and enable volume guarantees and strategic contracting with manufacturers. The G20 High-Level Panel on Pandemic Prevention, Preparedness, and Response (PPPR) strongly recommended the establishment of such a capital fund in its November report, further strengthening the case for resource mobilisation. Contributions to the capital fund are expected to come from Member States, the African Development Bank, the Judith Nielsen Foundation, Unitaid, the World Bank

Regional Economic Communities (RECs) have provided strong strategic and technical support to the design, establishment, and implementation of the APPM. Collaboration on technical specifications, demand quantification, and procurement coordination will be critical to mutual success.

APPM implementation is further strengthened through strategic partnerships with AU organs, including AUDA-NEPAD, the African Medicines Agency (AMA), and AfCFTA, as well as with UNICEF, Unitaid, UNFPA, the Global Fund, the World Bank, AfDB, and Afreximbank, among others. These partnerships provide essential technical, operational, and financial support, positioning the APPM as a central pillar of Africa's health market architecture.

Table 16: APPM Implementation Milestones (2022 - 2025)

Milestone	Date	Description	Outcome
Governance framework approved	Q1 2024	AU Assembly decision endorsed Africa CDC as lead agency	Legal mandate secured
Concept design completed	Q1 2025	Technical study with Expert Panel including Afrieximbank, UNECA, UNICEF, WHO, Gavi, Global Fund, PEPFAR, Unitaid and all RECs.	Feasibility confirmed
Operational Set-up	Q3 2025	Africa CDC established the set-up based on design, including MOUs, standard contracts, SOP, Quality policy, etc.	Operational sanctity
Category strategy validated	Q3 2025	Ten priority SRMNCH products have been identified, and the product scale-up phase	Operational focus defined
Framework agreements signed	Q4 2025	First procurement opportunities floated, supplier contracts executed	Market entry achieved
Regional onboarding begins	Q1 2026	RCC training for Member States	Scale-up phase launched
Industry onboarding begins	Q1 2026	Industry forums – virtual and in-person	Scale-up phase launched
Advisory Group	Q1 2026	Advisory Group to be established	Scale-up phase launched
APPM Platform and Dashboard	Q2 2026	The APPM platform for visibility and country and manufacturer will be launched including transparent operational status and catalogue.	Scale-up phase launched

A live dashboard, being piloted in early 2026, will provide real-time information on supplier performance, lead times, logistics tracking, procurement opportunities, and contract values.

4. 5.8 Events

African manufacturing of health products took centre stage in 2025, featuring prominently in dedicated sessions and side events across several major conferences, where political commitment, financial interests, and clear market signals to manufacturers were articulated. These included:

- The 2nd Vaccine and Other Health Products Manufacturing Forum for African Union Member States (February, Cairo, Egypt).
- World Local Production Forum (April, Abu Dhabi, UAE)
- Abu Dhabi Global Health Week (April, Abu Dhabi, UAE)
- World Health Assembly (May, Geneva, Switzerland)
- Africa Health ExCon (June, Cairo, Egypt)
- WHO AFRO Regional Committee Meeting (August, Lusaka, Zambia)
- World Health Summit (October, Berlin, Germany)
- 4th International Conference on Public Health in Africa (Durban, South Africa)
- 3rd Edition of the African Forum on Strengthening the Supply Chain of Health Products (FARCAPS) (November, Djibouti)
- The Ministerial Conference on Local Production of Medicines & other Health Technologies in Africa (November Aligers, Algeria)

These meetings are contributing to strategic dialogue, momentum, and tangible progress. As local manufacturing capacity increases, the focus of discussions is expected to evolve from policy and political alignment toward market creation, financing at scale, and integration into regional and global supply chains. Over time, the agenda will increasingly address issues such as cost competitiveness, long-term offtake agreements, quality assurance, export readiness, and the transition from donor-supported start-up phases to commercially viable operations.

4.5.9 Challenges

Despite significant progress, structural challenges persist in advancing local manufacturing of health products in Africa.

First, fragmented markets and unpredictable offtake continue to undermine investment. Intense price competition from well-established international manufacturers means African producers cannot compete on cost alone, particularly during early scale-up. This reality necessitates the deliberate and coordinated use of policy and market-shaping instruments, including pooled procurement, market-entry support, preferential purchasing, volume guarantees, and blended finance, to improve competitiveness. Compounding this challenge, the limited uptake of African-manufactured products by global procurement organisations constrains scale, slows learning curves, and weakens the commercial case for sustained investment.

Second, while political commitments to "Buy African" have gained momentum, translating these commitments into binding national industrial or procurement policies and purchasing decisions remains uneven. Africa's pharmaceutical market is the fastest growing globally, currently estimated at **USD 40–60 billion annually** and projected to reach **USD 350 billion by 2040**, with the potential to generate up to **16 million jobs**. Yet, despite a population exceeding **1.5 billion,** the continent hosts fewer than 600 pharmaceutical and medical device manufacturers, compared to approximately **5,000–10,000** in economies of comparable scale. This structural gap underscores the urgency of aligning demand, policy, and industrial development.

Third, skills and ecosystem constraints persist across the manufacturing value chain. Gaps in specialised workforce capacity, combined with limited access to technology, know-how, and product development ecosystems, continue to slow innovation and the accumulation of critical competencies. These challenges are compounded by complex, fragmented, and costly regulatory and quality-assurance requirements **that disproportionately burden emerging manufacturers, delay time-to-market**, and erode competitiveness.

Finally, African manufacturers face limited access to affordable, flexible, and patient capital. Many financiers remain oriented toward traditional infrastructure or short-cycle commercial investments, while health product manufacturing requires risk-tolerant financing due to high upfront costs and long return-on-investment horizons. The scarcity of such financing remains a fundamental structural barrier to the development of competitive, sustainable manufacturing capacity on the continent.

4.5.10 Economic & Security Impact

The combined effect of pooled procurement and manufacturing coordination delivered strategic dividends for Member States:

- **Improved access and affordability** through aggregated demand and reduced transaction costs.
- **Greater supply predictability** and response times during emergencies, reducing reliance on discretionary allocations.
- **Industrial and employment gains**, UNECA projects the African Pharmaceutical sector was expected to be worth US$259 billion by 2030, and this could potentially create up to 16 million jobs on the continent (direct and indirect).
- **Enhanced negotiating power** in global markets, as Africa engaged suppliers as a coordinated buyer rather than fragmented purchasers.

From a security perspective, this pillar reduces the risk that future crises will leave Africa at the back of the queue again. Beyond security, this pillar brings.

4.5.11 What's Next

Africa CDC has emerged as the central coordinator of Africa's biomanufacturing renaissance. For the first time, Africa's manufacturing pipeline has global visibility and policy coherence, anchored in continental data and demand aggregation. These efforts directly reduce dependency on imports and enhance health sovereignty. To consolidate Pillar 5, Africa CDC will focus on:

1. **Further operationalize PHAHM Secretariat with regional offices and a partnership coordination mechanism** to improve integration of continental activities for a strategic approach
2. **Scaling APPM participation:** Expanding product categories and Member State uptake to maximise purchasing power and savings.
3. **Deploy Market-Shaping Instruments to Support African Manufacturers:** Support African manufacturers until economies of scale and competitive pricing are achieved, including "buy-African" policy instruments and an **African manufacturing finance window,** capitalised by African DFIs and aligned to industrial scale-up timelines.

H. E Dr. Jean Kasseya at the Ministerial Conference on Local Production of Medicines and Other Health Technologies in Africa in Algiers, Algeria | 27–29 November 2025

Basic APPM Workflow

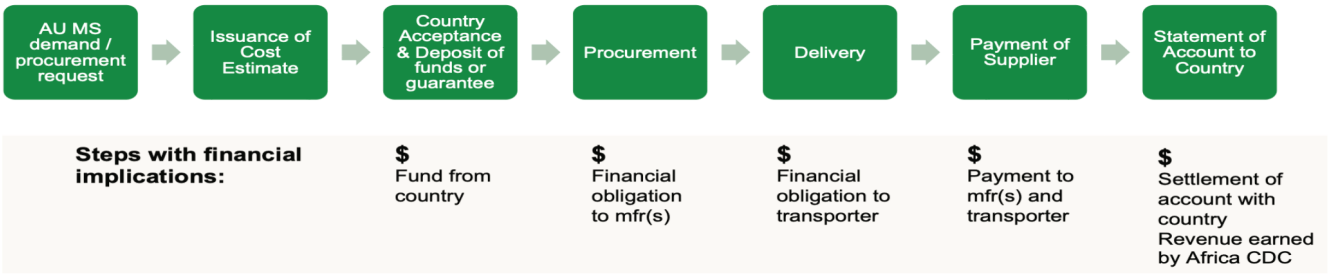


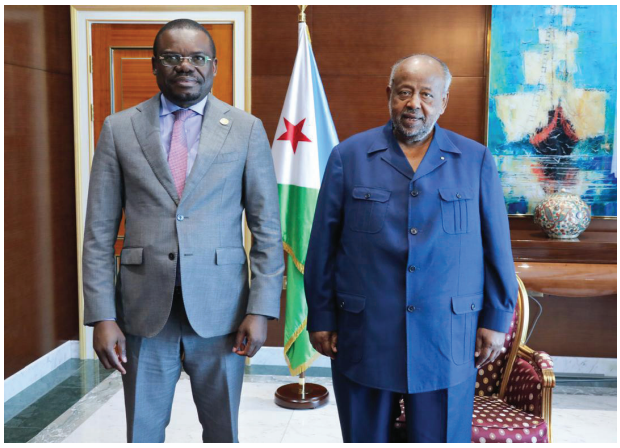
Figure 86: APPM Process Flow (2025

4. **Full capitalisation of the APPM capital fund:** Reduce advance payment requirements for countries and enable volume guarantees and strategic contracting with manufacturers.
5. **Linking procurement to preparedness:** Using pooled procurement to incentivise early investment in stockpiles and readiness.
6. **Deepening regulatory and quality systems:** Strengthening continental regulatory reliance and quality assurance to protect public trust.
7. **Sustaining manufacturing investment:** Aligning financing, procurement commitments, and workforce development to ensure long-term viability.
8. **Measuring impact transparently:** Publishing clear metrics on prices, delivery timelines, and savings to demonstrate value to Member States.

With all five AHSS pillars articulated and results demonstrated, the report now turns to how Africa CDC works with others.

At the 77th World Health Assembly, Africa CDC convened Ministers of Health and partners to discuss progress and bottlenecks of local manufacturing of health products.

Manufacturers of health product exhibit their know-how at the Africa Health Excon 2025 in Cairo, Egypt



Meeting of H. E Dr. Jean Kasseya with H.E Ismail Omar Guelleh President of the Republic of Djibouti on at FARCAPS 2025

SECTION 5

Partnerships that Deliver

Africa CDC's partnership model in 2025 reflects a deliberate shift: from fragmented, project-based collaboration to strategic compacts anchored in African priorities and delivery systems. Partnerships are treated as instruments of sovereignty and scale does not substitute for national or continental authority.

5.1 From Projects to Strategic Compacts

Africa CDC reframed partnerships around a simple principle: partners align with Africa's agenda, not the other way around. This approach reduces duplication, strengthens national ownership, and ensures that external resources reinforce continental systems rather than bypass them.

5.1.1 Member States at the Centre

Member States are not partners among others; they are the owners of the Africa CDC. In 2025:

- Africa CDC prioritised partnerships that strengthen national institutions (NPHIs, PHEOCs, laboratories, financing systems).
- Country engagement was structured through national plans aligned with continental frameworks, reducing parallel implementation.
- Regional peer learning and solidarity were reinforced through RCCs and surge mechanisms.

Why it matters: Partnerships that bypass national systems weaken sovereignty and sustainability; those that strengthen them compound impact.

5.1.2 Multilateral and Bilateral Partnerships

Africa CDC deepened collaboration with multilateral and bilateral partners through clear role definition and alignment to AHSS pillars:

- Africa CDC acted as the continental coordinator, aligning partner investments to shared priorities.
- Emergency responses operated under unified incident management structures, reducing fragmentation.
- Financing and technical assistance increasingly flowed through Africa CDC systems, reflecting growing institutional trust.

This approach improved coherence, speed, and accountability, particularly during multi-country emergencies.

5.1.3 Philanthropy and the Private Sector

Engagement with philanthropy and the private sector shifted from ad hoc support to purpose-driven partnerships:

- Philanthropic investments were aligned with system-building objectives (financing reform, digital platforms, manufacturing).
- Private sector engagement focused on scalable solutions, logistics, digital tools, and manufacturing rather than isolated pilots.
- Risk-sharing mechanisms reduced barriers to private investment in public health goods.

Why it matters: Sustainable health security requires mobilising capital, innovation, and delivery capacity beyond public budgets.

5.1.4 South–South and Triangular Cooperation

Africa CDC strengthened South–South and triangular cooperation to diversify technical and financial partnerships:

- Peer exchange among countries with similar epidemiological and economic contexts accelerated learning.

- Triangular arrangements leveraged complementary strengths across regions and partners.
- This diversification reduced dependence on a narrow set of external actors.

5.2. Partnership Governance and Results

Partnerships were governed through:

- clear alignment to Africa CDC strategies and AU decisions;
- defined accountability and reporting frameworks.
- performance monitoring focused on results, not activity.

This governance discipline ensured that partnerships delivered measurable value faster response, stronger systems, and reduced fragmentation while protecting Africa CDC's autonomy.

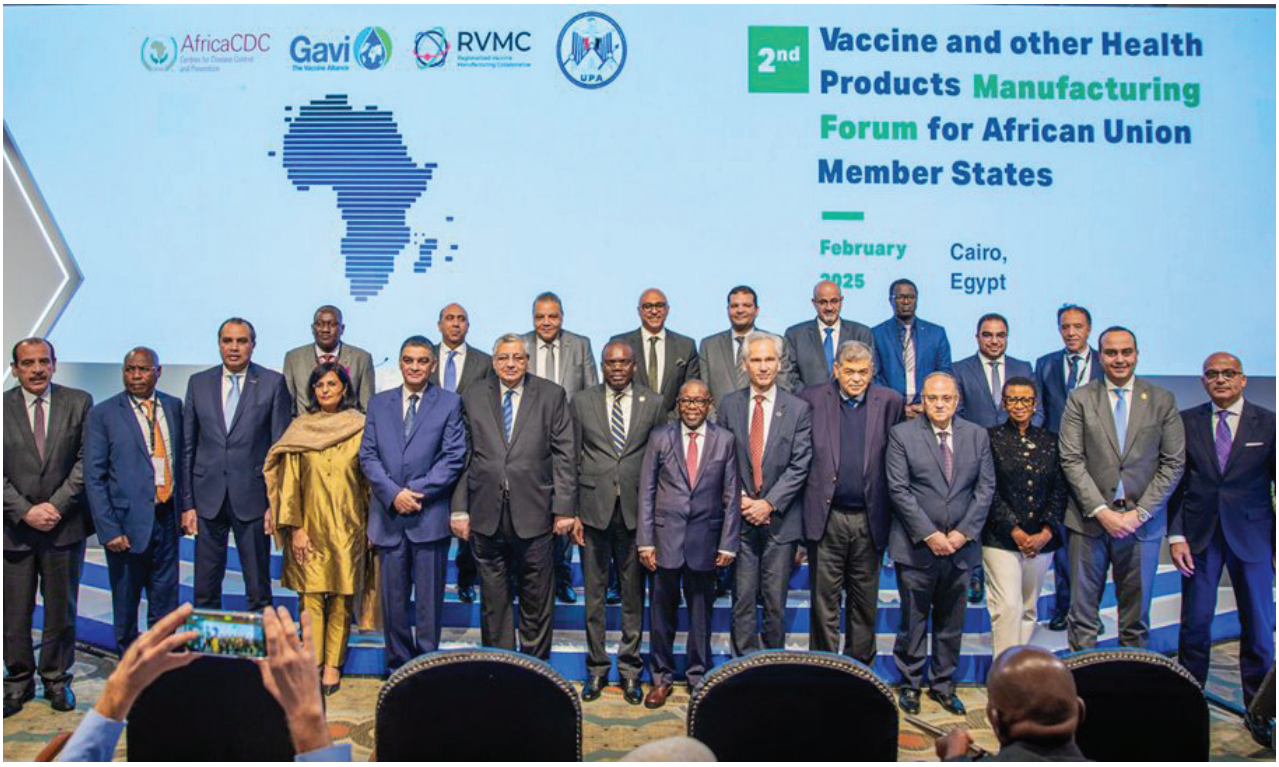
5.3 Looking Ahead

To sustain partnership effectiveness, Africa CDC will:

1. **Deepen strategic compacts** aligned with AHSS pillars and national priorities.
2. **Strengthen partner coordination mechanisms** to reduce transaction costs.
3. **Expand private and philanthropic engagement** in system-scale investments.
4. **Ensure transparency and accountability** to Member States in all partnerships.

With partnerships positioned as delivery accelerators rather than parallel channels, the report now turns to reflection:

What risks did Africa CDC encounter, what lessons emerged, and how did leadership adapt in a constrained global environment?



Leaders at the 2nd African Vaccine and Other Health Products Manufacturing Forum,

SECTION 6

Risks, Lessons & **Adaptive Leadership**

Africa CDC's performance in 2025 was delivered in an environment defined by constraint, uncertainty, and heightened political scrutiny. This section presents a disciplined assessment of the principal risks encountered, the lessons drawn from them, and how Africa CDC adapted its leadership and operating model to sustain delivery under pressure.

6.1 Navigating Complexity in a Constrained Global Environment

The 2025 operating context combined multiple stressors:

- Epidemiological pressure: concurrent outbreaks across regions, often overlapping in time and geography.
- Fiscal tightening: shrinking discretionary space in national budgets and volatility in external assistance.
- Geopolitical fragmentation: supply-chain disruptions, export controls, and competition for scarce countermeasures.
- Institutional scrutiny: rising expectations placed on Africa CDC following its elevation as an autonomous AU organ.

These conditions required Africa CDC to operate simultaneously as an emergency responder, a system builder, and a political coordinator without the margin for error typically afforded to newer institutions.

6.2 Key Risks Encountered

Africa CDC confronted four categories of risk that required active management:

1. **Operational ris:** Rapid scale-up and emergency deployment increased exposure to coordination failures, delayed procurement, and overstretched staff.
2. **Fiduciary and reputational risk:** Growing resource flows and direct disbursement modalities raised the stakes for financial control, auditability, and transparency.
3. **Political risk:** Emergency decisions particularly declarations and allocation choices carried political implications for Member States and partners.
4. **Strategic drift risks:** The proliferation of initiatives and partner interests risked pulling Africa CDC away from its core mandate and AHSS priorities.

These risks were neither hypothetical nor episodic; they were structural features of Africa CDC's operating reality in 2025.

6.3 What We Learned

Three core lessons emerged from Africa CDC's experience:

- **Speed requires structure.**

Rapid response is only possible when governance, financing, and operational systems are pre-established. Ad hoc arrangements fail under pressure.

- Autonomy must be protected by discipline.

Institutional autonomy enhances effectiveness only when paired with strong internal controls, performance management, and transparent reporting.

- **Unity of voice multiplies impact.**

Africa's negotiating power and operational effectiveness increase significantly when Member States act through a single continental platform.

These lessons reinforced the rationale for AHSS as an integrated agenda rather than a collection of technical reforms.

6.4 How Africa CDC Adapted

Africa CDC responded to these lessons through adaptive leadership and institutional adjustment:

- Strengthened decision pathways to ensure emergency authority could be exercised quickly without bypassing governance.
- Tightened prioritisation around AHSS pillars to avoid dilution of focus.
- Reinforced internal controls and audit mechanisms to match expanded scale and visibility.
- Invested in leadership cohesion and staff resilience, recognising that sustained pressure affects institutional performance.

Adaptation was continuous, not episodic, reflecting a shift from reactive management to anticipatory governance.

6.5 Strategic Implication

The experience of 2025 confirms that Africa CDC's value lies not only in what it delivers, but in how it learns and adapts. Institutional resilience built through honest risk assessment, learning, and course correction is now a strategic asset.

For Member States, this means Africa CDC is increasingly capable of managing complexity without over-centralisation or loss of accountability. For partners, it signals a maturing institution that can absorb scale while maintaining strategic coherence.

With risks identified and lessons integrated, the report turns to the future:
What must Africa CDC prioritise in 2026 to consolidate gains and respond to a rapidly evolving risk landscape?

Section VII sets out the strategic priorities and political asks for the year ahead grounded in evidence, focused on delivery, and aligned with Africa's long-term health security and sovereignty goals.

SECTION 7

The Road Ahead: **2026 Priorities**

Africa CDC enters 2026 with a stronger mandate, clearer authority, and proven delivery capacity. The priority now is consolidation with acceleration: protecting institutional gains while moving decisively from episodic success to systemic, irreversible transformation in Africa's health security and sovereignty.

7.1 Strategic Priorities for 2026

Africa CDC's 2026 agenda is anchored in five strategic priorities that directly respond to the risks, lessons, and opportunities identified in 2025.

7.1.1. Lock in continental preparedness as a permanent public function

Preparedness must move from crisis-driven attention to routine governance. In 2026, Africa CDC will:

- Institutionalise preparedness benchmarks within national systems.
- Ensure that PHEOCs, laboratories, surveillance, and surge mechanisms are sustainably financed and staffed.
- Link preparedness performance to predictable financing triggers.

Objective: No country enters an outbreak without pre-positioned systems, plans, and financing pathways.

7.1.2. Scale AHSS delivery from platforms to systems

The AHSS agenda must mature from frameworks into fully integrated delivery systems. Africa CDC will:

- Deepen integration across the five AHSS pillars so that surveillance links seamlessly to financing, procurement, manufacturing, and digital systems.
- Reduce silos between emergency response and long-term system strengthening.
- Use scorecards and dashboards to track AHSS performance transparently at continental and national levels.

Objective: Make AHSS operational, measurable, and politically reviewable.

7.1.3. Secure supply through market-shaping at scale

In 2026, Africa CDC will accelerate the shift from access risk to supply security by:

- Expanding participation in the African Pooled Procurement Mechanism (APPM).
- Anchoring procurement commitments to preparedness planning.
- Aligning financing, regulatory reliance, and demand aggregation to de-risk local manufacturing.

Objective: Ensure timely, affordable access to quality-assured countermeasures before emergencies peak.

7.1.4. Embed digital intelligence and data sovereignty

Africa CDC will move decisively from platforms to a continental health intelligence ecosystem by:

- Integrating surveillance, laboratory, logistics, and financing data.
- Finalising data-sharing and governance frameworks that protect sovereignty while enabling real-time action.
- Strengthening cybersecurity and resilience of digital systems.

Objective: Enable faster, smarter, and more accountable decision-making across the continent.

7.1.5. Consolidate Africa's leadership in global health governance

Africa CDC will continue to strengthen Africa's collective voice by:

- Institutionalising Africa CDC's leadership role in global health architecture reforms.
- Ensuring that global mechanisms reinforce continental and national systems.
- Positioning health security as a strategic pillar of Africa's economic and geopolitical engagement.

Objective: Move from participation to sustained leadership in shaping global health rules.

7.2 What Africa CDC Asks from Member States and Partners

Delivering the 2026 agenda requires deliberate political and institutional support.

From Member States

Africa CDC calls on Member States to:

- Sustain political backing for Africa CDC's autonomy and authority.
- Embed preparedness and AHSS priorities in national budgets and development plans.
- Support data sharing under agreed governance frameworks.
- Participate actively in pooled procurement and continental financing mechanisms.

Key Message: Continental security depends on collective commitment and national ownership.

From Partners

Africa CDC asks partners to:

- Align financing and technical support with AHSS priorities and national plans.
- Channel support through continental and national systems rather than parallel platforms.
- Invest in long-term system building, not only emergency response.
- Support Africa-led market shaping and manufacturing scale-up.

Key Message: Partnership effectiveness is measured by system strength, not project count.

SECTION 8

Africa CDC Support to **Member States through the RCCs**

To ensure effective support to Member States, Africa CDC's five Regional Collaborating Centres (RCCs) served as critical regional hubs, translating continental priorities into context-specific action. Through coordinated leadership, technical delivery, and strategic partnerships, the RCCs strengthened health security, governance, and operational readiness across the continent. As the primary platforms for coordination and engagement with RECs and strategic partners, the RCCs advanced pandemic preparedness, surveillance, laboratory systems, and emergency response, while reinforcing political alignment and institutional capacity at both regional and country levels. The achievements outlined below illustrate the distinct yet complementary contributions of each RCC in delivering measurable public health impact and advancing Africa CDC's mandate across all regions and Member States.

8.1.1 Central Africa Regional Collaborating Centre (CA-RCC)

The Central Africa Regional Collaborating Centre led the development of a regional integrated biological sample transport strategy and co-developed a joint regional roadmap with the effective participation of ten technical and financial partners and regional organisations, reinforcing collective action for health security. Governance mechanisms were further strengthened through the establishment of a new ReSCo bureau during the second Steering Committee (COPIL), alongside sustained advocacy for data-sharing agreements, increased domestic financing for health interventions, and enhanced cross-border and inter-country collaboration, governance, coordination, and operational delivery across the region. The fourth regional technical committee meeting validated the joint plan with Regional Economic Communities (RECs) and endorsed

ReSCO Central Africa Meeting, 2025

4th ReSCO Convening of the Southern Africa Region

a revised RISLNET operational framework, consolidating governance for epidemic preparedness and response.

Operationally, CA-RCC advanced learning, implementation, and service delivery by facilitating knowledge exchange among nearly 150 public health experts from Central Africa and beyond on the role of community health workers in epidemic response and on lessons from COVID-19 vaccination campaigns. Complementary efforts included producing three regional newsletters and monthly epidemiological bulletins, aligning Member States' priorities, and developing a joint biennial roadmap with RECs and strategic partners towards a resilient regional health security agenda.

8.1.2 Eastern Africa Regional Collaborating Centre (EA-RCC)

The Eastern Africa Regional Collaborating Centre significantly strengthened regional public health leadership, coordination, and service delivery across Eastern Africa. Through ReSCo and ReTAC, the RCC supported the endorsement of key regional frameworks, including the Health Financing Framework, facilitated the election of new leadership, and strengthened regional advocacy through strong engagement with Africa CDC Headquarters. Eastern Africa was positioned as a regional hub for global health dialogue by co-hosting the first Eastern Africa Regional Global Health Summit, which advanced discussions on pandemic preparedness, prevention and response, financing, and equity, with high-level participation from nine of the fourteen Member States.

Political and diplomatic engagement was further strengthened through the establishment of a Regional Diplomatic Corps platform to mobilize sustained political will, resources, and technical support for Africa CDC priorities. The EA-RCC also advanced its institutional footprint and operational effectiveness by formally engaging the Government of Kenya on official recognition and progressing land allocation for a

EA-RCC Director handing over RCC credentials formally to the Government of Kenya

permanent regional hub. Strategic partnerships were deepened through the development of Joint Action Plans with key partners and alignment of regional initiatives with five Regional Economic Communities, while technical engagement expanded to all fourteen Member States, including new operational entry into Eritrea and Sudan.

8.1.3 Southern Africa Regional Collaborating Centre (SA-RCC)

The Southern Africa Regional Collaborating Centre substantially advanced regional health security, preparedness, and governance through coordinated technical support, strengthened institutions, and targeted investments across Member States. At the governance and strategic level, the SA-RCC strengthened regional coordination through the successful convening of the 4th ReSCo and 8th ReTAC meetings, the full operationalisation of RISLNET and the Regional Cholera Control Task Force, and the endorsement of a finalised RISLNET work plan, supported by new leadership appointments. Regional institutional capacity was further reinforced through the endorsement and dissemination of the second edition of the Framework for the Development of National Public Health Institutes (NPHIs) and the appointment of a Regional Ministerial Champion to advance NPHI establishment.

Strategic leadership was strengthened by designating regional Ministers of Health as champions for Climate and Health Financing and the Lusaka Agenda, and by adopting Africa CDC's Green Book – Rethinking Health Financing in a New Era, which promotes reforms in health financing, governance, and service delivery. Resource mobilisation efforts secured USD 45,000 from IFRC to support finalisation of the Southern Africa Regional Cholera Task Force and USD 16,000 from PATH to convene a high-level side event on sustainable health financing for NPHIs, generating actionable regional recommendations. Alignment with Regional Economic Communities and key stakeholders was consolidated through the endorsement of a joint action plan for 2026, while the successful launch of the first Regional Museum marked a milestone in strengthening regional health knowledge, heritage preservation, and institutional identity.

8.1.4 Northern Africa Regional Collaborating Centre

The Northern Africa Regional Collaborating Centre made significant progress in strengthening regional health security, governance, and collaboration across North Africa. Foundational governance structures were established through the inauguration of ReSCo, with consensus on Egypt as the host of the Northern RCC and the appointment of Tunisia and Algeria as Chair and Vice Chair, respectively. Regional representation was further strengthened by Morocco and Libya participating in the Africa CDC Governing Board.

Health security governance was strengthened through the launch of RISLNET and its governance framework, and the appointment of Morocco and Mauritania as Chair and Vice Chair. The RCC also advanced the agenda on health security and sovereignty, advocating accelerated local manufacturing to reduce external dependence and enhance system resilience. This

Regional leaders, Ministers of Health, and partners advancing coordinated public health action during the WA-RCC inaugural ReSCo and 2nd ReTAC meetings in Abidjan, Côte d'Ivoire.

included co-hosting the Second Local Manufacturing Meeting in Egypt (USD 500,000) and facilitating strategic contributions, including 800,000 boxes of baby formula donated by Egypt.

Coordination and partnership mechanisms were further strengthened through the establishment of the North Africa Health Partnership Coalition, with IOM elected as Chair and the World Bank and EMPHNET as Co-Chairs, and the development of a joint action plan to optimise resources and reduce duplication. Resource mobilisation efforts secured USD 150,000 from UKHSA to support surveillance activities in early 2026, 10,000 doses of Remdesivir from Eva Pharma, and ongoing engagement with the World Bank MENA region to mobilise additional financing.

Knowledge management and peer learning were advanced through two regional knowledge exchange clusters hosted in Morocco and Egypt, focusing on local manufacturing, pathogen genomics, hepatitis C elimination, antimicrobial resistance, primary health care, and digital health. Building on these successes, the NA-RCC received a formal request from Libya to deploy an expert from Egypt to support knowledge transfer and develop a replicable action plan for the triple elimination of HIV, viral hepatitis, and syphilis, underscoring the RCC's growing role as a catalyst for regional cooperation and technical excellence.

8.1.5 West Africa Regional Collaborating Centre (WA-RCC)

The West Africa Regional Collaborating Centre, through the effective delivery of statutory and technical platforms, including ReSCo, ReTAC, RISLNET, and ECHO, the RCC enabled routine decision-making, strengthened partner alignment, and coordinated joint action under the Africa CDC operational framework. These mechanisms reinforced collective ownership of regional priorities and improved the coherence of cross-border and inter-country public health responses.

Collaboration with ECOWAS, other RECs, and technical partners was significantly deepened, positioning the WA-RCC as the central hub for public health coordination in the region. This included the establishment of JAP between ECOWAS and the Regional Centre for Surveillance and Disease Control (RCSDC), strengthening institutional collaboration on surveillance and disease control.

The RCC also facilitated effective information sharing and coordinated action with both ECOWAS and non-ECOWAS Member States, ensuring inclusive regional engagement.

Through regional stakeholders' forums, the RCC further strengthened partnerships by fostering a culture of shared accountability, strategic alignment, and collective action among Member States, RECs, and technical and funding partners. Partner engagement became more structured and outcome-oriented, improving alignment of investments with regional priorities and reducing duplication of interventions. Collectively, these efforts enhanced the efficiency and impact of public health initiatives, enabled faster and more coordinated cross-border responses, and consolidated the WA-RCC's role as the principal convening and coordination authority for regional public health security in West Africa.

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Africa CDC is a continental autonomous health agency of the African Union established to support public health initiatives of Member States and strengthen the capacity of their public health institutions to detect, prevent, control and respond quickly and effectively to disease threats.

An entity of the African Union

Safeguarding Africa's Health

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