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REPORT OF THE COMMISSION ON THE ESTABLISHMENT OF THE AFRICAN CENTRE FOR DISEASE CONTROL AND PREVENTION

REPORT OF THE COMMISSION ON THE ESTABLISHMENT OF THE AFRICAN CENTRE FOR DISEASE CONTROL AND PREVENTION

1. At the African Union Special Summit on HIV and AIDS, TB and Malaria (ATM) in Abuja in July 2013, the Heads of State and Government took cognizance of the need for an African Centres for Disease Control and Prevention (African CDC) to conduct life-saving research on priority health problems in Africa and to serve as a platform to share knowledge and build capacity in responding to public health emergencies and threats. The Assembly requested the Commission to work out the modalities of establishing an African Centres for Disease Control and Prevention.

2. The request was reaffirmed in decision Assembly/AU/Dec.499 (XXII) of the 22nd Ordinary Session of the African Union (AU) Assembly held in Addis Ababa, Ethiopia, in January 2014 that stressed the urgency to establish the Centre. The decision further requested the AU Commission, working in collaboration with the Government of Ethiopia and other interested Member States, to submit a report to the Assembly by January 2015 that will include the legal, structural and financial implications of the establishment of the Centre.

3. At the 1st African Ministers of Health meeting jointly convened by the Commission and WHO held in Luanda, Angola, from 16 to 17 April 2014, the Ministers committed themselves to the:

i) *implementation of AU Decision Assembly/AU/Dec.499 (XXII) that stresses the urgency of establishing the African Centre for Disease Control and Prevention (ACDC) while taking cognizance of the existing regional centres of excellence;*

ii) *creation of a multinational task force by May 2014 to define the modalities and work out the roadmap for the establishment of the ACDC, including the legal structural and financial implications relating to the Centre;*

4. The Ministers then requested the Commission and WHO, in collaboration with relevant stakeholders, to provide technical support towards the establishment of the *African CDC.*

5. The Ebola outbreak in West Africa has underlined the need for action and is providing the impetus to speed up the establishment of the African CDC for early detection, preparedness and response. Hence, at the 16th Extraordinary Session of the African Union Executive Council meeting on Ebola held in Addis Ababa, on 8 September 2014, the Council decided inter alia to request the Commission to: *Take all the necessary steps for the rapid establishment of an African Centers for Disease Control and Prevention, pursuant to Assembly Decision/AU/Dec.499 (XXII) on the establishment of the Centre; and ensure the functioning of the ACDC, together with the establishment of regional centres by mid-2015.*

6. In line with the above mandate from the Policy Organs of the Union, this Report is submitted for the consideration and endorsement of the Assembly through the Executive Council.

African Centers for Disease Control and Prevention (African CDC)

REPORT OF THE COMMISSION

ON

THE MODALITY, STRUCTURE AND FINANCIAL IMPLICATIONS FOR THE ESTABLISHMENT OF AFRICAN CDC

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LIST OF ACRONYMS

African CDC	African Centres for Disease Control and Prevention
AFENET	African Field Epidemiology Network
ASEOWA	African Union Support to Ebola Outbreak in West Africa
ASLM	African Society for Laboratory Medicine
AU	African Union
AUC	African Union Commission
CCDC	China Centres for Disease Control and Prevention
DHIS	District Health Information System
DSA	Department of Social Affairs
EBS	Event-Based Surveillance
ECDC	European Union Centres for Disease Control and Prevention
EOC	Emergency Operations Centre
EPHO	Essential Public Health Operations
EPR	Emergency Preparedness and Response
EWAR	Early Warning and Response
FELTP	Field Epidemiology and Laboratory Training Program
GOARN	Global Outbreak Alert and Response Network
IANPHI	International Association of National Public Health Institutes
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IM	Incident Management
IMS	Incident Management System
NPHI	National Public Health Institution
OLC	Office of the Legal Counsel
PAHO	Pan-American Health Organization
PRC	Permanent Representatives' Committee
SHOC	Strategic Health Operations Centre
RC	Regional Centres
US CDC	United States Centres for Disease Control and Prevention
WHO	World Health Organization

AFRICAN CENTERS FOR DISEASE CONTROL AND PREVENTION

I. Introduction

1. The transmission of diseases of epidemic proportion within and across countries has necessitated the strengthening of our disease prevention and control capacities within Africa. Trans-border, transnational and intercontinental cooperation, which has now become the benchmark for effective control and prevention of communicable diseases in the 21st century, remains the most cost effective approach. Furthermore, the epidemiology of these diseases varies from country to country and from one region to another.

2. Both communicable and non-communicable diseases are significant contributors to preventable morbidity and mortality in Africa. Additionally, Africa continues to be challenged by frequent natural and man-made emergencies that often lead to disasters.

3. Member States have put significant efforts into the containment and minimization of the negative impact arising from these diseases, conditions and events by adopting and implementing strategic policies. These include disease surveillance, control and prevention as well as health systems strengthening and disaster preparedness and response resulting in significant progress. Specific measures that have been put in place include the implementation of the Integrated Disease Surveillance and Response (IDSR) strategy, the International Health Regulations (IHR 2005) and other resolutions and initiatives for control and prevention of emergencies.

4. Despite the progress made, challenges still remain in addressing disease prevention and control such as poor infrastructure and human capacities, weak disease surveillance systems and laboratory investigation services as well as delayed and inadequate preparedness and response to health emergencies and disasters.

5. Taking into account all these challenges faced by the African continent and the necessity for an accountability framework for health security and hence protecting citizens of Africa and beyond, there is an urgent need to put in place a structure to support African countries in their efforts to effectively respond to emergencies, address complex health challenges and build needed capacity.

6. The African Centres for Disease Control and Prevention (African CDC), as an African-owned institution, will provide a strong platform for technical coordination, ultimately strengthening public health prevention, surveillance and interventions across the continent. Furthermore, the proposed African CDC will build capacity to respond to public health emergencies including outbreaks, man-made and natural disasters and public health events of regional and international concern.

II. Mandate

7. At the African Union Special Summit on HIV and AIDS, TB and Malaria (ATM) in Abuja in July 2013, the Heads of State and Government took cognizance of the

need for an African Centres for Disease Control and Prevention (African CDC) to conduct life-saving research on priority health problems in Africa and to serve as a platform to share knowledge and build capacity in responding to public health emergencies and threats. The Assembly requested the Commission to work out the modalities of establishing an African Centres for Disease Control and Prevention.

8. The request was reaffirmed in decision **Assembly/AU/Dec.499 (XXII)** of the 22nd Ordinary Session of the African Union (AU) Assembly held in Addis Ababa, Ethiopia, in January 2014 that stressed the urgency to establish the Centre. The decision further requested the AU Commission, working in collaboration with the Government of Ethiopia and other interested Member States, to submit a report to the Assembly by January 2015 that will include the legal, structural and financial implications of the establishment of the Centre. The African CDC would be an entity established to support African countries in reducing their disease burdens, especially from communicable diseases, responding to emergency situations, and capacity building.

9. At the 1st African Ministers of Health meeting jointly convened by the Commission and WHO held in Luanda, Angola, from 16 to 17 April 2014, the Ministers committed themselves to the:

i) implementation of AU Decision Assembly/AU/Dec.499 (XXII) that stresses the urgency of establishing the African Centre for Disease Control and Prevention (ACDC) while taking cognizance of the existing regional centres of excellence;

ii) creation of a multinational task force by May 2014 to define the modalities and work out the roadmap for the establishment of the ACDC, including the legal structural and financial implications relating to the Centre;

10. The Ministers then requested the Commission and WHO, in collaboration with relevant stakeholders, to provide technical support towards the establishment of the African CDC.

11. The 2014 Ebola outbreak in West Africa has underlined the need for action and is providing the impetus to speed up the establishment of the African CDC for early detection, preparedness and response. Hence, at the 16th Extraordinary Session of the African Union Executive Council meeting on Ebola held in Addis Ababa, on 8 September 2014, the Council decided inter alia to request the Commission to:

Take all the necessary steps for the rapid establishment of an African Centers for Disease Control and Prevention, pursuant to Assembly Decision/AU/Dec.499 (XXII) on the establishment of the Centre; and ensure the functioning of the ACDC, together with the establishment of regional centres by mid-2015, including the enhancement of the early warning systems to address in a timely and effective manner all the health emergencies and the coordination and harmonisation of health domestic regulations and interventions as well as the exchange of information on good experiences and best practices.

A. Steps Taken By the Commission

12. In line with the above mandate from the Policy Organs of the African Union, the Commission with the financial and technical support of the United States Centers for Disease Control and Prevention (US CDC) and technical inputs from WHO AFRO, took the following steps:

- At the 1st African Ministers of Health meeting jointly convened by the AUC and WHO held in Luanda, Angola, from 16 to 17 April 2014, the Commission presented the decisions of the Assembly taken in July 2013 and January 2014. The Ministers committed themselves to the implementation of the AU Decision Assembly/AU/Dec.499 (XXII) and decided to put in place a multinational Task Force to define the modalities and work out the roadmap for the establishment of the African CDC.

- A Multinational Taskforce was established in June 2014. Sixteen (16) Member States were selected based on geographical representation among those that had indicated interest during the AUC-WHO joint meeting of Ministers of Health in April 2014 (3 per region plus Ethiopia in line with Decision Assembly/AU/Dec.499 (XXII)). The list of Members States and the Terms of Reference (TOR) for the Task Force are included in Annex 1 and 8.

- Conducted a rapid assessment of all CDC-type existing institutions in Africa from June to July 2014.

- Undertook a study visit to the US CDC in Atlanta from 6 to 9 August 2014 together with Experts from Member States that had nominated members to the Multinational Task Force in response to the Commission's Note Verbale of 30 June 2014

- The 16th Extraordinary session of the Executive Council on Ebola held on 8 September 2014 requested the Commission to fast-track the establishment of the African CDC and ensure its functioning by mid-2015

- A meeting of the Multinational Taskforce was convened from 29 to 30 October 2014 The Taskforce:

    - Analyzed the policies and required frameworks for the establishment and operation of the African CDC including a comprehensive terms of reference, minimum infrastructure, human resource capacity and capability to attain African CDC objectives;

    - Mapped a clear roadmap with clear timelines for the establishment and functioning of the African CDC by mid 2015;

    - Determined the financial implications for the establishment, operationalization and sustainability of the African CDC; and

- Defined the roles and responsibilities of AUC, Member States and other relevant stakeholders for supporting the African CDC establishment and operationalization.

III. African CDC: Vision, Mission, & Guiding Principles

A. Vision

A safer, healthier, integrated, and prosperous Africa, in which Member States can prevent disease, detect and respond together to crises of public health importance.

B. Mission

The mission of the African CDC is to address priority public health concerns in Africa first through prevention and where needed, through detection and response. The African CDC will also serve as a platform for Member States to share knowledge, exchange lessons learned, build capacity, and provide technical assistance to each other.

C. Guiding Principles

1. ***Leadership***: The African CDC will be an institution that provides strategic direction and promotes the best of public health practice within Member States through capacity building, promotion of continuous quality improvement in the delivery of public health services as well in prevention of public health emergencies and threats where possible, and when not possible, then in each Member State's ultimate response.

2. ***Credibility.*** The African CDC's strongest asset will be the trust it cultivates with its beneficiaries and stakeholders as a respected, evidence-based institution. It can play an important role in championing effective communication and information sharing across the continent.

3. ***Ownership***: The African CDC will be an African-owned institution. Member States will maintain national-level ownership of the African CDC simultaneously through an advisory role in the shaping of African CDC priorities and through direct programmatic engagement.

4. ***Convening entity:*** Due to the legal mandate received from the African Union Declaration, the African CDC will convene representatives of Member States if a public health issue has cross-border or regional implications. Once convened, the African CDC leadership can appeal through the AU organs for Member States to take appropriate action. It should leverage collaboration and engage countries in strong partnerships and networking.

5. ***Transparency:*** Open interaction and unimpeded information exchange between the African CDC and Member States is inherent to the mission of the African CDC.

6. ***Accountability:*** The African CDC will abide by accountability to Member States in its approach to governance and financial administration.

7. ***Value-added:*** In every strategic aim, objective, or activity, the African CDC should demonstrate how that initiative adds value to the public health activities of Member States and other partners.

D. Strategic Objectives

13. To reflect the dynamic continental environment in which the African CDC will operate, it shall pursue a phased implementation of the following Strategic Objectives:

1. Establish early warning and response surveillance platforms to address in a timely and effective manner all the health emergencies;

2. Support public health emergency preparedness and response

3. Assist Member States to address gaps in International Health Regulations (IHR 2005) compliance;

4. Support and/or conduct regional- and country-level hazard mapping and risk assessments for Member States

IV. African CDC Structure: Governance/Institution & Operations

14. The African CDC will be established as a Specialized Institution of the Union in accordance with Article 5(2) of the Constitutive Act. The Guiding Principles, Framework, Strategic Objectives, Structure, Mandate and Functions of the African CDC shall be defined in a Statute.

A. Governance Structure

15. The African CDC will have the following Governing structure (Figure 01)

i. Meeting of the African Ministers of Health;
ii. Governing Board;
iii. Advisory Council;
iv. African CDC Secretariat.

16. The African CDC Statute to be developed by the Legal Counsel will outline the composition and functions of the governing structure.

Division of Disease Control and Prevention

17. A Disease Control and Prevention Division shall be established in the Department of Social Affairs (DSA) to serve as a channel and a liaison between the Commission and the African CDC. This Division shall have a Head, senior policy and Policy officers as staff members.

Figure 1. Governance of African CDC

B. Framework of Activities and Operational Structure (Modus Operandi) of the African CDC

18. The African CDC must be an African-owned institution that adds value and is highly credible. The range of conditions and issues that the African CDC could

potentially tackle is large, but it should begin, in cooperation with Collaborating **Regional Centers (RC)**, by focusing on its key strategic objectives. It can expand after it is fully established and has shown its value. In addition to the guiding principles, the following framework is proposed:

1) Development of a shared perception on the continent that national public health threats have an impact on regional security and economic viability.

2) Work with WHO, other multi-sectoral partners such as the African Union specialized institutions and agencies, external partners such as the US CDC, the European Union CDC (ECDC), and the China CDC (China CDC), as well as African CDC Collaborating Regional Centers to pursue the phased implementation of its strategic objectives.

3) Facilitate easy access to critical information by (a) establishment of a continental data sharing agreement, (b) improvement of data quality and (c) development of interchangeable data elements that would help countries prepare for and respond to emergencies.

African CDC Collaborating Regional Centers (RCs)

19. In the day-to-day execution and implementation of its strategic objectives and activities, the African CDC will be supported by the collaborating RC**.** The reliance on RC may ultimately bring into reality an "African CDC without walls" that supports the continent at the point of need, rather than from a centralized, distant location. A minimum of five Collaborating Regional Centers will be identified at the launch of the African CDC in order to ensure each region (North, West, East, Central and South) within the continent is represented, though the number is expected to increase over time.

20. In view of the fact that the RCs represent existing entity that has met African CDC criteria (Figure 03) for selection as a Regional Centre, the leadership of the RC will not necessarily be a permanent staff of the African CDC. The leadership of the Collaborating Regional Center shall be designated as an **African CDC Regional Coordinator** within the African CDC organizational structure

21. It is recommended that RC selection be made by the African CDC Governing Board who will take into account the input of the Advisory Council. The following selection criteria[1] should be considered for those **organizations** or **agencies** wishing to be considered for Collaborating RC status.

- Technical proficiency and clear evidence of expertise in the Essential Public Health Operations[2] (EPHO) that are directly relevant to African CDC Strategic

[1] Criteria based on Accordia's Network of African Centers of Excellence (http://www.accordiafoundation.org/what-we-do/network-of-african-centers-of-excellence/index.html)

[2] See Annex 3. Essential Public Health Operations are key competencies or actions needed to improve the health of populations. The Pan American Health Organization developed a list of Essential Public Health Functions early in the 21st Century. Subsequent to that, the WHO European Regional Office published a list of Essential Public Health Operations (2011). *Global health in the 21st century. Ulrich Laaser, Helmut Brand. Glob Health Action. 2014; 7: 10.3402/gha.v7.23694. Published online 2014 February 13.*

Aims [e.g. surveillance of population health (EPHO 1) or monitoring and response to health hazards and emergencies (EPHO 2), see Annex 7];

- RC should either be:
  - An existing government institution,
  - An institution that provides substantial support to a government's public health effort;

- Clear synergy between the RC's programme objectives and the African CDC strategic aims which results in greater collective impact and capacity building.

22. Additional criteria are suggested in Figure 03. The overarching principle is that each RC should add value both to the execution of African CDC strategic aims. The Governing Board shall at periodic intervals of not less than 5 years revisit the collaborating status of Regional Centers such that if a given Regional Center fails to perform, it can be replaced with a more suitable Regional Center.

23. Furthermore, though the boundaries of the Regional Economic Communities do not directly correspond with the five geographic regions proposed for RC selection, the African CDC may wish to consider soliciting REC input on which regional public health institutions have demonstrated sustainability and previous success.

Figure 2. Suggested Criteria for Collaborating Regional Centers

24. While the African CDC should exercise strategic oversight by establishing an agenda and work plan based on the aforementioned strategic aims, the execution of these priorities will likely be guided by consensus and coordination between the RC and the relevant Ministries of Health in that region (Figure 02 proposes the operational relationship between the African CDC and the RC). When execution of the African CDC strategic agenda requires direct support from African CDC headquarters, the Coordinator of the RC should submit the request to the Director of

the African CDC. In any case, the African CDC shall establish clear procedures for cooperation and collaboration with the Regional Centers.

Collaboration with WHO and Other External Partners

25. The African CDC should work closely with the WHO Regional offices for Africa and Eastern Mediterranean to maximize synergies in bolstering local disease prevention and monitoring, improve laboratory diagnosis of pathogens, and to strengthen emergency response to outbreaks. The African CDC shall also closely work with the WHO in supporting the countries meeting the requirements showing they are adequately prepared to respond to emerging infectious threats.

26. Additionally, for the purposes of day-to-day collaboration, the African CDC could establish a **Council of Directors of African Health Networks**, that would provide opportunities for cross-cutting, synergistic programme activity. These networks include but limited to: African Field Epidemiologists Network (AFNET); African Society of Laboratory Medicine (ASLM), African Network for Diagnostic (ANDI), etc.

27. For certain partners whose scope of work closely resembles the strategic activities of the African CDC, a Memorandum of Understanding between the collaborating partner and the African CDC could help to outline shared priorities and the unique role that each entity can contribute in addressing them.[3]

[3] Regulation (EC) No. 851/2004 of the European Parliament and of the Council of 21 April 2004. Establishing a European centre for disease prevention and control.

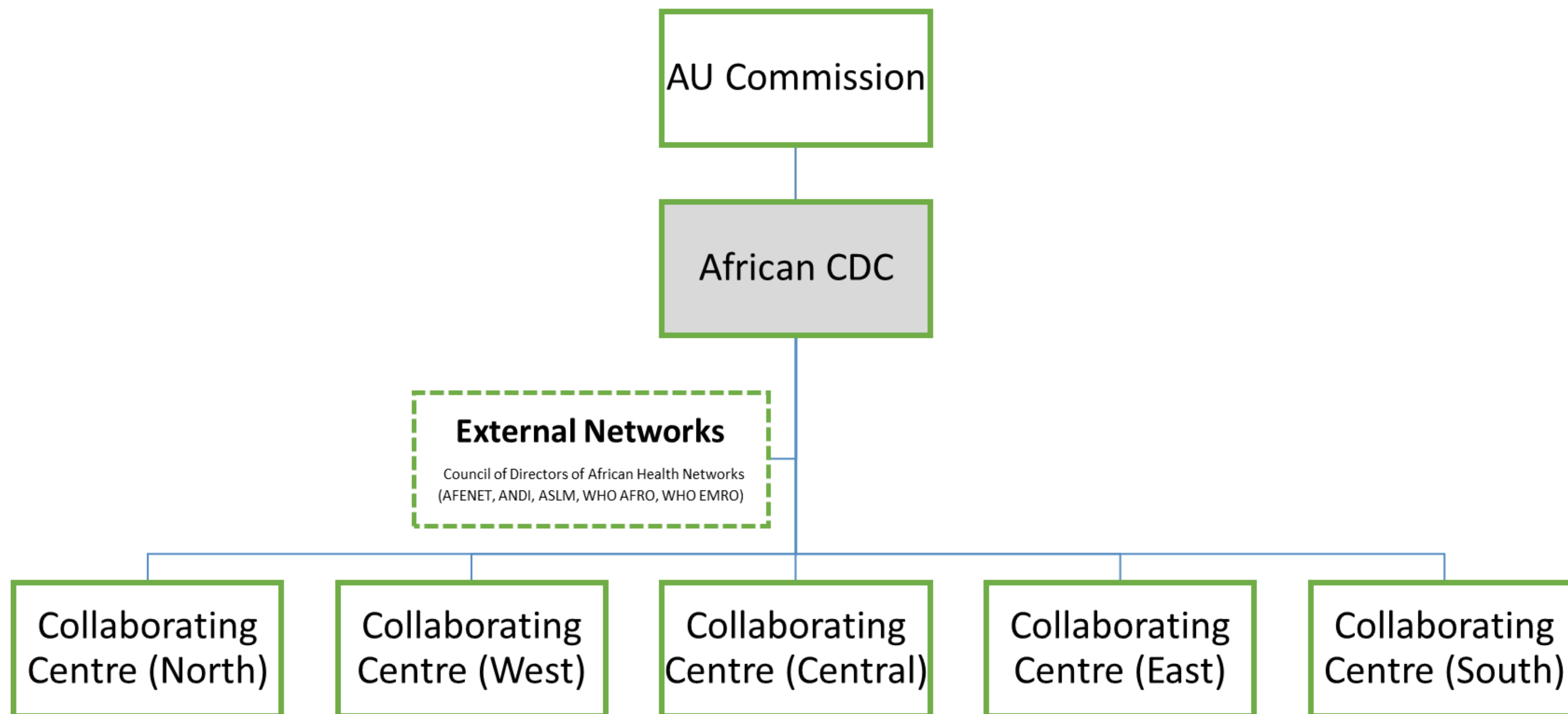

Figure 3. Operational Relationship of African CDC to Collaborating Regional Centres and Partners

V. African CDC Phases of Development (Proposed)

Phase 1

- **6 months—1 year**

28. After the African CDC Concept Document has been approved by the African Union Assembly, the mandate indicates that the African CDC must be launched by mid-2015. Given the AU hiring and recruitment calendar, as well as the elapsed FY2015 budget deadline, it will be challenging to staff the new African CDC through Regular Recruitment procedures.

29. Thus, the African CDC will likely need to acquire its staff (Managerial and Operational) through secondments from Member States and external partners.[4] Based on recommendations from the Multinational African CDC Taskforce, in Phase 1, the African CDC should first focus on **event-based surveillance** and supporting **emergency preparedness and response** through incident management and emergency operations center training in Member States.

Proposed Timeline for Phase 1

Timeline	Activity	Responsible Party
January 2015	African Union Assembly	
February 2015	Distribute requests for staff secondments from partners and Member States	DSA
March 2015	Draft African CDC Governing Statute; submit to STC on Justice & Legal Affairs	OLC & DSA
April 2015	Confirm staff secondments	
June—July 2015	Launch of African CDC	
July 2015	First strategic planning meeting of African CDC; Outline steps and timeline for accomplishing	African CDC Governing Board

[4] Field Epidemiology and Laboratory Training Program graduates from each of the five African regions could, for example, be hired as Epidemiologists on the African CDC Event-based Surveillance team. Their strong regional knowledte base and work experience could be of tremendous value in creating viable link between the African CDC and the Member States.

Timeline	Activity	Responsible Party
	Year 1 strategic aims (event-based surveillance; emergency preparedness and response)	African CDC Advisory Council
August 2015	Annual strategic and detailed work plan distributed to African CDC stakeholders Regular Recruitment period for AU Human Resources (submit TORs and Job Descriptions)	
January—June 2016	Hiring of regular staff commences	AHRM & DSA

Phase 1 (Year 2)

30. In year two, the African CDC should:

- Assist Member States in reviewing self-assessments of IHR compliance;
- Engage in hazard assessment and risk-mapping for the African CDC regions and Member States;
- Increase the number of Regional Coordinating Centres;
- Strengthen and promote activity within Collaborating Partner Networks.

Phase 2 (Years 3—5)

- Strengthen the African public health workforce through training and the development of public health workforce guidelines;
- Develop a legal charter with accompanying regulations that will inform lines of authority for African CDC Emergency Operations Center activity across the continent;
- Invest in physical infrastructure of an Emergency Operations Centre;
- Reassessment of African CDC strategic aims.

Phase 3 (Years 5—10)

- Promote and foster public health research;
- Strengthen primary and secondary prevention initiatives;
- Advocate for public health policies and governing statutes;
- Establish African CDC reputation as a “First-Look” resource for subject matter expertise, laboratories with special capabilities, and knowledge of continent-wide resources related to outbreak preparedness (vaccines, diagnostic reagents, test kits, personal protective equipment).

C. Human Resources and Infrastructure

31. This section provides an overview of the minimum human resources and infrastructure required to operate the African CDC as proposed in Section III.D.

Personnel

32. At a minimum, to achieve Year 1 objectives, eleven (11) staff members will be necessary, but as funds allow, up to twenty (20) would be ideal. Proposed organizational charts for the staffing structure are presented in Annex 5 and 6. **Depending on the governance structure approved by the AU Assembly, compliance with AU hiring policies may require alteration of the job descriptions, necessary qualifications, and salaries for each of the African CDC positions.,** Terms of Reference for each of these positions, when approved would be drafted.

33. The chart in Annex 5 represent the minimum needed to address the strategic aims outlined previously (specifically, event-based surveillance and emergency preparedness and response); the operations and personnel structure would be expected to surge to respond to an acute event (Annex 6).

1. Director
2. Deputy Director
3. Laboratory Scientist
4. Epidemiologist(s)
    a. Analyst of Event-Based Surveillance Data.
    b. International Health Regulations Advisor
5. Biostatistician
6. Health Economist
7. GEO Information Specialist(s)
8. Scientific Editor
9. Information and Communications Technology Officer(s)
10. Finance Officer
11. Resource Mobilization Officer
12. Administrator
13. Logistics Section Chief

VI. Legal aspects

34. The legal aspects will be described in the draft Statute document developed with the Office of the Legal Counsel.

VII. Infrastructure Requirements

35. The first initiatives of the African CDC will reflect the strategic aims described above. Given the limited resources and the mandate for launch by mid-2015, it is anticipated that the event-based surveillance and potential emergency preparedness and response programmes (*e.g.* Emergency Operations Centre) will occupy the same physical space. The required infrastructures are contained in Annex.6. Some of the

associated costs with the infrastructure needs are included in the proposed budget in Annex 7 and summary below.

VIII. Financial implications

36. Possible funding sources for the African CDC should be considered by the AU Assembly (January 2015).

37. The estimated budget for the establishment of the African CDC and for its functioning for 18 months is $**5, 114 732USD.**

N°	DESCRIPTION	2015	2016	TOTAL
1	Human Resources	950 111	1 840 221	2 790 332
2	Consultancies	196 000	392 000	588 000
3	Training (International courses)	103 333	206 667	310 000
4	Travel	74 667	149 333	224 000
5	Meetings, Workshops & Activities	330 000	380 000	710 000
6	Publications	35 000	45 000	80 000
7	Office Equipment	277 400	36 000	313 400
8	Communication and IT Equipment	33 000	66 000	99 000
	GRAND TOTAL	1 999 511	3 115 221	5 114 732

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African Centers for Disease Control and Prevention (African CDC)

REPORT OF THE COMMISSION

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ANNEXES

Annex 1: Multinational Taskforce Terms of Reference

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TERMS OF REFERENCE OF THE MULTINATIONAL TASK FORCE FOR THE ESTABLISHMENT OF AN AFRICAN CENTRE FOR DISEASE CONTROL AND PREVENTION

A. Background

Both Communicable and non-communicable diseases are significant contributors to preventable morbidity and mortality in Africa and that the continent continues to be challenged by frequent natural and man-made emergencies, often leading to disasters.

Member States have made significant progress and efforts in containing and minimising the impact of these diseases, conditions and events by adopting and implementing policies and strategies pertaining to disease surveillance, control and prevention as well as health systems and disaster preparedness and response. These include the implementation of the Integrated Disease Surveillance and Response (IDSR) strategy, the International Health Regulations (IHR 2005) and other resolutions and initiatives for control and prevention of emergencies.

Despite the progress made, challenges still remain in addressing disease prevention and control such as limited infrastructure and human capacities, weak disease surveillance and laboratory investigation services as well as delayed and inadequate preparedness and response to health emergencies and disasters.

Taking into account all these challenges faced by the continent of Africa and the necessity for the accountability framework for health security and hence protecting citizens of Africa and beyond, there is an urgent need to put in place a structure to support African countries to effectively respond to emergencies, obtain technical support to address complex health challenges and build the needed capacity.

In line with decision Assembly/AU/Dec.499 (XXII) of the 22nd Ordinary Session of the AU Assembly in January 2014 and the commitments during the first African Ministers of Health meeting jointly convened by the African Union Commission (AUC) and the World Health Organisation (WHO) held in Luanda, Angola, from 16 to 17 April 2014 stress i) the urgency of establishing the African Centre for Disease Control and Prevention (ACDCP) while taking cognisance of the existing regional centres of excellence and ii) the creation of Multinational Task Force comprised of the AUC, WHO, the Government of the Republic of Ethiopia and interested Member States to define the modalities and map out a road map for the establishment of the ACDCP including the legal structure and financial implications.

The ACDCP would be a reference centre to support and coordinate the work of national institutions in reducing their disease burden, especially by addressing communicable diseases, emergency situations and capacity building in African countries. Its establishment should therefore be guided by the country and sub-regional experiences of the Centres of Excellence.

B. Terms of reference

In collaboration with the Ministries of health of the members of the Multinational Task force, under the supervision of the AUC and WHO, the experts will carry out the following activities:

- Define clearly the mission of the ACDCP while taking cognisance of the existing regional centres of excellence and relevant health needs and priorities in Africa;
- Consider draft documents for the establishment of the ACDCP presented by the African Union Commission;
- Develop comprehensive terms of reference of the ACDCP;
- Propose required minimum infrastructure, human resource capacity and capability to attain ACDCP status;
- Define the organisational structure and the modus operandi of the ACDCP including its relationship with AUC and WHO as well as its linkage with regional and international institutions;
- develop a road map with clear timelines for the establishment of the ACDCP;
- Provide full financial implications for the establishment, operationalisation and sustainability of the ACDCP including required contributions of African countries and counterpart funding from partners;
- Propose list of potential partners to ensure multiple sources of funding for the ACDCP in order to guarantee sustained performance;
- Define the roles and responsibilities of AUC, WHO and other relevant stakeholders for supporting the ACDCP establishment, operationalisation and overall management after operationalisation.

C. Composition of the Multinational Task force

The Task Force shall be comprised of the AUC, WHO, US CDC and 16 Member States. Representatives from each Member State should be designated by the Ministry of Health. This latter should be senior scientists and have technical expertise and in-depth working experience in coordinating and management of public health research institutions.

Annex 2: Essential Public Health Services, Functions, or Operations

There are several definitions of the key competencies or actions needed to improve the health of populations. In 2000, the Pan American Health Organisation (PAHO) developed a list of Essential Public Health Functions; in 2009, the International Association of National Public Health Institutes developed a list of National Public Health Institutes Core Functions; and in 2011, WHO EURO published a list of Essential Public Health Operations (EPHO), which is often less well-known. Below is a summary of the WHO EURO EPHOs. This list (or similar lists from PAHO and IANPHI) is a tool to frame the selected African CDC activities. Under an ideal scenario, a mature CDC-type institution will pursue the ability to provide each item listed below to its citizens.

EPHO 1: Surveillance of population health and well-being

- Establishing and maintaining broad-based surveillance systems and registries of diseases and measures related to health;
- Data integration and analysis (including community health diagnosis) in order to identify population needs and risk groups and monitor progress towards health related objectives;
- Publication of data in multiple formats for diverse audiences.

EPHO 2: Monitoring and response to health hazards and emergencies

- Control of communicable disease;
- Control of environmental health hazards;
- Laboratory Support for Investigation of Health Threats;
- Planning, investigating and responding to public health emergencies;
- Designating an emergency response coordinator;
- Lessons learned, maintaining protocols and ensuring a roster of experts;
- Implementation of the International Health Regulations (IHR).

EPHO 3: Health protection operations (including environmental, occupational, food safety and others)

- Technical capacity for risk assessment;
- Enforcement of laws and regulations by public health authorities;
- Cooperation with other authorities responsible for law enforcement in issues related to public health (health protection).

EPHO 4: Health promotion operations (including addressing social determinants & health inequity)

- Conducting health promotion activities for the community-at-large or for populations at increased risk of negative health outcomes;
- Capacity of intersectoral action.

EPHO 5: Disease prevention (including early detection of illness)

- Primary prevention;
- Secondary prevention.

EPHO 6: Assuring governance for health and well-being

- Defining needs;
- Assessing & evaluating services;
- Application of evaluation findings.

EPHO 7: Assuring a sufficient and competent public health workforce

- Human resources planning;
- Standards;
- Education and accreditation.

EPHO 8: Assuring sustainable organisational structures and financing

- Public health policy planning;
- Evaluation of quality and effectiveness of personal and community health services;
- Financing of Public Health Services.

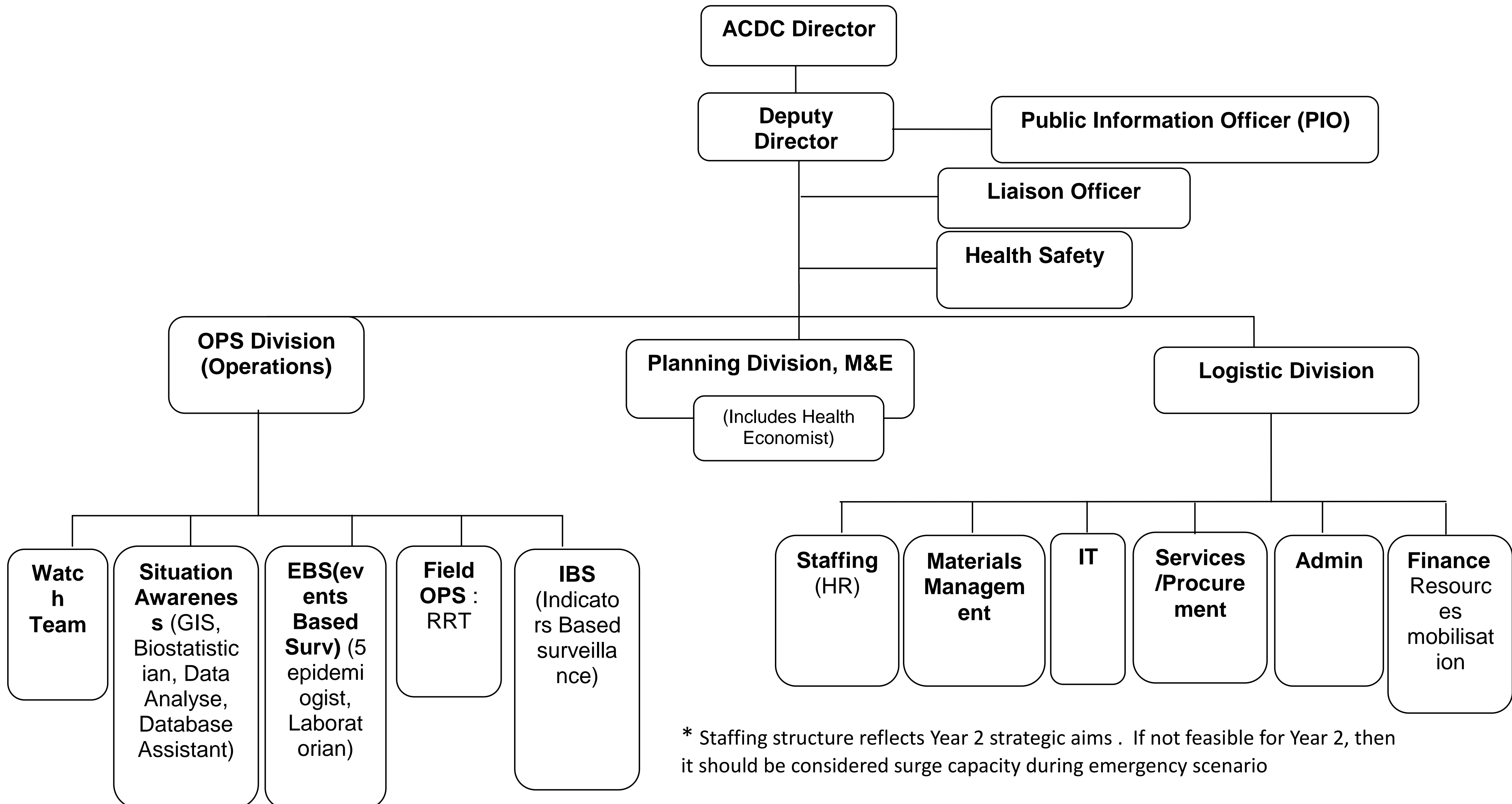
EPHO 9: Advocacy, communication and social mobilization for health

- Strategic and systematic nature of public health communication, developed with an understanding of the perceptions and needs of different audiences;
- Dissemination to different audiences in formats and through channels which are accessible, understandable and usable;
- Advocacy for the development and implementation of healthy policies and environments across all government sectors (health in all policies);
- Public health communication training and capacity development;
- Public health communication evaluation.

EPHO 10: Advancing public health research to inform policy and practice

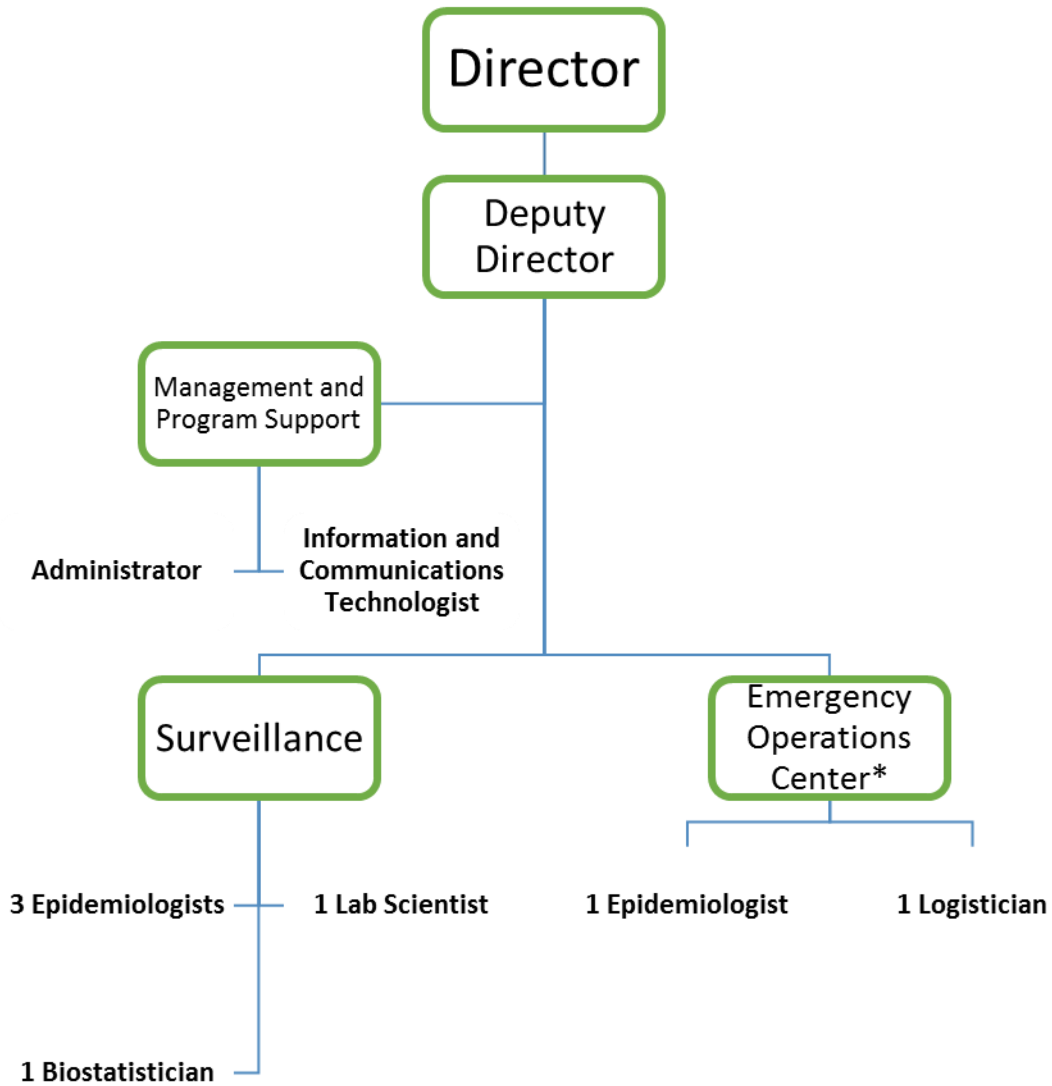
- Capacity to initiate or participate in timely epidemiological and public health system research;
- Fostering innovation;
- Health information to support decision making.

Annex 3: Operations and Personnel*



* Staffing structure reflects Year 2 strategic aims . If not feasible for Year 2, then it should be considered surge capacity during emergency scenario

Annex 4: Minimum Operations and Personnel*



* Staffing structure reflects Year 1 non-emergency scenario

Annex 5: Surveillance Within Early Warning and Response Systems

The early warning components of conventional routine public health surveillance systems must be sensitive enough to detect signals at the earliest possible stage. Traditionally, most surveillance systems rely upon **Indicator-Based Surveillance** (IBS). This Annex provides a summary of Indicator- and Event-Based Surveillance (Figure 2) which are complementary sources of information within Early Warning and Response systems (EWAR).

IBS is defined as the systematic collection, monitoring, analysis, and interpretation of structured data, *i.e.* indicators, that is produced by a number of well-identified, predominantly health-based formal sources. However, this system primarily relies upon information collected passively in health facilities, and is focused on communicable disease with a high epidemic potential and/or for which highly effective control measures, such as immunisation exist. There is an inherent delay in the relay of information from the point of the signal to those with the responsibility to initiate a response. Furthermore, it often focuses on a limited number of **known** health risks that are described through established case definitions which are either disease-specific or syndromic. Emerging or unknown pathogens may therefore be missed, as might rapidly escalating outbreaks or non-communicable events due to other agents (*e.g.* toxicological contaminants).

EBS is defined as the organised collection, monitoring, assessment and interpretation of mainly unstructured ad hoc information regarding health events or risks, which may represent an acute risk to human health. The information originates from multiple, often not-predetermined sources both official and unofficial, including rumours reported by the media or ad hoc reports from informal networks. The information collection process is mainly active and carried out through a systematic framework specifically established for EBS purposes.

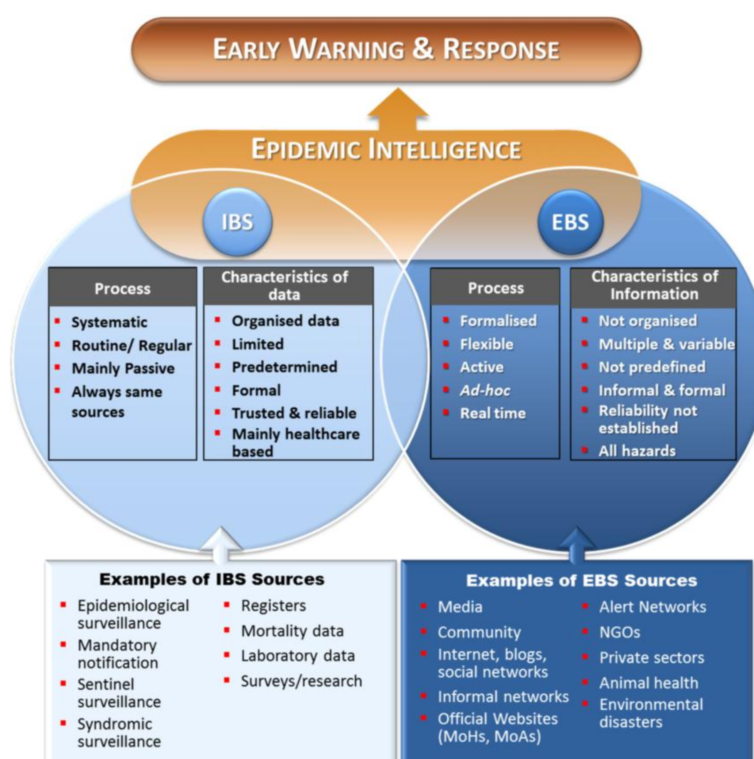


Figure 4. Early Warning and Response Framework

Annex 6: Detailed Equipement of an EOC middle size

Item description (incl. manufacturer and model number)	Total Number of units	Vendor	Cost	Total Cost	Remarks
Conference Room Table	1	Modern Office	$ 1,899.00	$ 1,899.00	
PWR/Data Module	5	Modern Office	$ 348.00	$ 1,740.00	Power, 2ea, Telephone and Data will be run to each of the five modules.
Chairs	13	ibExpress	$ 541.99	$ 7,045.87	
Executive Desk	1	ibExpress	$ 1,671.00	$ 3,342.00	Incident Manager.
Executive Chair	3	ibExpress	$ 427.00	$ 1,281.00	Incident Manager, Deputy & Chief of Staff offices.
Chairs	4	ibExpress	$ 541.99	$ 2,167.96	Incident Manager, Deputy & Chief of Staff offices.
Optiplex 9020 Small Form Factor	28	Dell (Desktop)	$ 1,120.00	$ 35,840.00	
Graphic Card	5	PNY GeForce GT 520	$ 68.00	$ 340.00	F/U/W Dell 9020, IM, Deputy, CoS, AV Console & AV Rack.
Latitude E7240		Dell (Laptop)	$ 1,802.00		
Monitor, Computer	31	Dell P2014H LED, 20"	$ 172.00	$ 5,504.00	Dual Monitor, AV Console and Rack.
Keyboard	28	Logitech	$ 48.00	$ 1,536.00	
Mouse	28	Logitech	$ 32.00	$ 1,024.00	
Wireless Keyboard & Mouse AV Console	1	Logitech K520	$ 65.00	$ 65.00	
Telephone (IP)	28	Polycom 335	$ 139.95	$ 3,638.70	AV Console.
Telephone (IP)		Nortel 1220	$ 142.00		
Desktop Printer	12	HP LaserJet 400 Color M451dn	$ 365.64	$ 4,387.68	
Desktop Printer		HP LaserJet Ent 600 M602x	$ 1,140.11		
Color Printer		HP Color LaserJet CP6015	$ 7,744.00		
Large Color Printer/ Copier	1	Canon C5045	$ 12,623.00	$ 12,623.00	
Shredder	1	SEM	$ 2,164.67	$ 2,164.67	
Eight Zone Clock		BRG	$ 3,614.00		
Four Zone Clock	3	BRG	$ 1,875.00	$ 5,625.00	IM, Deputy offices & Conf Rm.
AV Monitor 42"		NEC E424	$ 650.00		
Fixed ThinStall		Chief	$ 106.16		
AV Monitor 46"	3	NEC	$ 1,750.00	$ 5,250.00	

Fixed ThinStall	3	Chief	$	127.00	$	381.00	
AV Monitor 55"	2	NEC X552S	$	2,373.98	$	4,747.96	
Fixed ThinStall	2	Chief	$	141.79	$	283.58	
Amplifier	1	Crown CTS 4200	$	1,800.00	$	1,800.00	
Amplifier		Crown CRCTS8200	$	1,939.00			CTS8200A Amp 160W@8 ohms 8 CH/REG.
Speakers	6	JBL Control 23	$	349.00	$	2,094.00	
Projector	1	NEC NP-PA500U-13L	$	4,571.00	$	4,571.00	
Ceiling Plate	1	RPA Elite Universal	$	249.00	$	249.00	
Screen		Electric Access V53" x 92					
Screen	1	Fixed 53" x 92"	$	1,289.00	$	1,289.00	
Ceiling TV Mount	1	Premier Ceiling Mount	$	194.13	$	194.13	Monitor Ceiling Mount (ECM3763S).
Mounting Plate	1	Premier Mount Plate	$	129.42	$	129.42	Ceiling Mount Plate (PP-12).
Pole	1	Premier Adjustable Pole	$	97.07	$	97.07	NPT Adjustable Suspension Adapter (APP-2446).
Whiteboard	3	Magnetic Whiteboard 67"	$	575.00	$	1,725.00	
Interactive Whiteboard		Smart 77" w/Projector	$	5,453.38			
Interactive Whiteboard		Smart 87" w/Projector	$	8,355.15			
Surge Protector	12	American Power Conversion (APC)	$	17.99	$	215.88	
Power Strip	2	Middle Atlantic PD-920D	$	145.93	$	291.86	Strip Eight Outlets.
Curtain & Ron	16	TBD		TBD			
AV Rack, 5-29 54 1/2 H x 26" D	1	Middle Atlantic	$	715.00	$	715.00	
Smoked Plexiglas Front Door DOP-5-29	1	Middle Atlantic	$	415.00	$	415.00	
Pair of Side Panels TSP 5-29-26DC, Wood Dark Cherry	2	Middle Atlantic	$	245.00	$	245.00	
Top, Fits 5-29-26, Wood Dark Cherry	1	Middle Atlantic	$	520.00	$	520.00	
RAP29-Middle Atlantic Rear Access Pan	1	Middle Atlantic	$	103.00	$	103.00	
Fan Kits (Rear Door)	2	Middle Atlantic Rack Fan Kit (RAP-29)	$	113.00	$	113.00	
Panels, Blank	1	Middle Atlantic VT1-CP12	$	120.00	$	120.00	
Panels, Blank	1	Middle Atlantic VT2-CP12	$	140.00	$	140.00	

Rack Screws	1	Middle Atlantic	$ 49.00	$ 49.00	
Lace Bars	1	Middle Atlantic	$ 99.00	$ 99.00	
Caster (5WLR) Four Locking	1	Middle Atlantic	$ 99.00	$ 99.00	
Video Teleconference		Cisco Telepresence Codec C40	$ 16,447.99	$ 16,447.99	
Video Teleconference	1	Polycom HDX 7000	$ 11,394.00	$ 11,394.00	
Video Teleconference		LifeSize Room 220	$ 16,999.90		
Crestron AV Control Processor AV3	1	Crestron	$ 2,558.00	$ 2,558.00	
10" Control Panel	1	Crestron	$ 1,304.35	$ 1,304.35	
Table Top Kit	1	TSW-1050, BLK Smooth	$ 137.67	$ 137.67	
12" Control Panel	1	Crestron V12-Tilt-B	$ 1,000.00	$ 1,000.00	
Graphic Engine	1	Crestron DGE-1	$ 3,750.00	$ 3,750.00	
Crestron DM-MD16x16-RPS	1	Crestron	$ 12,745.00	$ 12,745.00	Rack Mountable w/Redundant Power Supply.
Input Card	13	Crestron DMC-DVI/RGB	$ 875.00	$ 11,375.00	Desktop/Laptop Display.
Input Card	2	Crestron DMC-HD HDMI	$ 875.00		Video Teleconference.
Input Card	1	DMC-VID-BNC Composite	$ 725.00	$ 725.00	Tuner/Satellite Feed.
Output Card	1	DMCO-55	$ 920.00	$ 920.00	Feed to Projector and Monitors.
Output Card	1	DMCO-44	$ 875.00	$ 875.00	
Tuner	2	232-ATSC + 1 Tuner	$ 810.00	$ 1,620.00	Purchase with rack mount kit.
UPS for AV Rack	1	Tripp-Lite SM2200RMDVTAA	$ 1,908.48	$ 1,908.48	
Misc. Cables, Connectors & Tool Box	1	TBD	$ 7,000.00	$ 7,000.00	Audio Visual Integrator will purchase a cable, connectors and a tool box required to complete the job, excess materials and the tool box will remain with customer.
Audio Visual Integration & Programming	1	TBD	$ 17,000.00	$ 17,000.00	Local audio visual integrator to Inventory, install, test, and provide basic operator training. Lastly provide drawings in AutoCAD.
IT Rack	1	42U Server Cabinet Rack	$ 3,275.00	$ 3,275.00	Perforated Front (Locking) & Rear Door, Side Panels, Cooling Fans, Power Strip, Screws, Shelving & Caster.
Server	1	HP ProLiant DL380p Gen8	$ 10,505.00	$ 10,505.00	Server configures properly to complete installation.
Server	1	HDD HP 146GB SAS 6Gb s	$ 359.00	$ 359.00	Server configures properly to complete installation.

Switch	1	Cisco Catalyst 2960-X 48	$ 2,298.00	$ 2,298.00	Switch configures properly to support computers and telephones.
Server UPS	1	APC Smart-UPS X-3000VA	$ 1,560.00	$ 1,560.00	
Router	2	Cisco 2801 Voice Bun 24	$ 2,210.00	$ 4,420.00	
LAN Cable	3	1000ft Plenum	$ 354.00	$ 1,062.00	
Internet Lease		TBD	$ 7,000.00	$ 7,000.00	2MB - 1 Year.
VSAT		TBD	$ 22,000.00	$ 22,000.00	
IT Integration & Configuration	1	TBD			Information technology integrator to build, install, test and provide drawings in AutoCAD.
Electrical Wiring	1	35 Dual AC Outlets	TBD		Facility Wiring, Breaker Box and all other miscellaneous materials necessary to complete the job. Note: Eight outlets to be place at the conference room table, recessed modules.
Lighting	1	New wiring, fixtures and switches.	TBD		Install new lighting throughout the facility, paying special attention to the lighting in the conference room.
Total				**$ 259,400**	

Annex 7: Detailed Budget

ESTIMATED BUDGET OF THE ESTABLISHMENT OF THE AFRICAN CDC (18 MONTHS)

	DESCRIPTION	Quanttity (18 Months)	Unit Price/Month	2015	2016	TOTAL
1	**Human Resources**					
1.1	ACDC Director (P6-5)	1	11 731	70 386	140 772	211 157
1.2	ACDC Deputy Director (P5-5)	1	10 217	61 301	122 601	183 902
1.3	Epidemiologists (HQ) (P4-5)	5	8 900	267 000	534 000	801 000
1.4	Laboratory Scientist (P4-5)	1	8 900	53 400	106 800	160 200
1.5	Ressource Mobilization Officer (P4-5)	1	8 900	53 400	106 800	160 200
1.6	Information and Communications Technology Officer(P4-5)	1	8 900	53 400	106 800	160 200
1.7	Finance Officer (P4-5)	1	8 900	53 400	106 800	160 200
1.8	Administrator (P4-5)	1	8 900	53 400	106 800	160 200
1.9	Biostatistician (P4-5)	1	8 900	53 400	106 800	160 200
1.10	Health Economist (P4-5)	1	8 900	53 400	106 800	160 200
1.11	GEO Information & GID Mapping Specialist (P4-5)	1	8 900	53 400	106 800	160 200
1.12	Scientific Editor (P4-5)	1	8 900	53 400	106 800	160 200
1.13	Logistics and Procurement Officer (P4-5)	1	4 000	24 000	48 000	72 000
1.14	Secretary (GS A4)	1	1 082	6 492	12 984	19 476
1.15	Site cleaners	2	861	10 332	20 664	30 996
1.16	Air Ticket for Recruitment of international Staff	15	2 000	30 000		30 000
	Sub-total			**950 111**	**1 840 221**	**2 790 332**
2	**Consultancies**					
2.1	Short-term Consultancy	12	25 000	100 000	200 000	300 000
2.2	Long-term Consultancy	6	48 000	96 000	192 000	288 000
	Sub-total			**196 000**	**392 000**	**588 000**
3	**Training (International courses)**					
3.1	Regional short term Training	10	15 000	50 000	100 000	150 000
3.2	International short term Training	8	20 000	53 333	106 667	160 000
	Sub-total			**103 333**	**206 667**	**310 000**
4	**Travel**					
	Routine activities (meetings, conferences, experiences exchanges, training, etc.)					
4.1	Africa regional trips	9	2 500	15 000	30 000	45 000
4.2	International trips	9	5 500	33 000	66 000	99 000
	Ressources mobilization					
4.3	Regional Travel	5	2 500	8 333	16 667	25 000

4.4	International Travel	5	5 500	18 333	36 667	55 000
	Sub-total			**74 667**	**149 333**	**224 000**
5	**Meetings, Workshops & Activities**					
5.1	Annual Strategic Planning Meeting	2	80 000	80 000	80 000	160 000
5.2	Biannual Consultative Advisory Meeting	4	50 000	100 000	100 000	200 000
5.3	Joint African Union and WHO AFRO Ministerial Meeting	2	100 000	100 000	100 000	200 000
5.4	Pledge meeting with Partners	3	50 000	50 000	100 000	150 000
	Sub-total			**330 000**	**380 000**	**710 000**
6	**Publications**					
6.1	Annual ACDC Strategic Plan	2	10 000	10 000	10 000	20 000
6.2	Annual Advisors' Assessment Report	2	10 000	10 000	10 000	20 000
6.3	Publications – for the weekly public health bulletin		Forfait	15 000	25 000	40 000
	Sub-total			**35 000**	**45 000**	**80 000**
7	**Office Equipments**					
7.4	Office details equipments (cf. equipments Budget)			259 400		259 400
7.5	Consumables (ink, paper, office equipment, etc.)	18	1 000	6 000	12 000	18 000
7.6	Office maintenance	18	2 000	12 000	24 000	36 000
	Sub-total			**277 400**	**36 000**	**313 400**
8	**Communication and IT Equipments**					
8.1	Telephone expenses	18	2 000	12 000	24 000	36 000
8.2	Internet services & connectivity	18	2 500	15 000	30 000	45 000
8.3	Public information	18	1 000	6 000	12 000	18 000
	Sub-total			**33 000**	**66 000**	**99 000**
	GRAND TOTAL			**1 999 511**	**3 115 221**	**5 114 732**

1. All budget estimates are based on African Union Commission rates;

2. Short-term Project Staff position are those funded through extra-budgetary support to the AUC and/or secondments from partner organisations; ACDC Programme staff are envisioned to be African international hires, while the administrative staff are envisioned to be local hire;

3. For short-term consultancies, we proposed to have 4 in the first 6 months and 8 in the next 12 months of the phase 1; this line item is intended to provide funding support for experts who will work alongside African CDC regular hires during the launch phase; these experts can be considered advisors who assist staff members with execution of their job duties and responsibilities

4. For long-term consultancies, we proposed to have 2 in the first 6 months and 4 in the next 12 months of the phase 1; this line item is intended to provide funding support for experts who will work alongside African CDC regular hires during the launch phase; these experts can be considered advisors who assist staff members with execution of their job duties and responsibilities

5. Trainings will be for the benefit of newly-hired African CDC staff to equip them to carry out their job duties and responsibilities

6. African regional travel: Estimated at 9 Trips In Region (3 in the 6 first months and 6 in the 12 next months) for 2 staff = 18 trips; estimated each trip at $2500 ($1500 for air ticket and $1000 for DSA);

7. International travel: 9 International Trips (3 in the 6 first months and 6 in the 12 next months) for 2 staff = 18 trips; estimate each trip at $5500. ($3000 for ticket and $2500 for DSA);

8. ACDC Consultative Advisory Meeting is planned to be held in Addis Ababa, Ethiopia, with approximately 20 participants receiving financial support to travel and attend meeting, and a total of 40 participants;

9. ACDC publications will be produced in four languages: English (40 percent), French (40 percent), Portuguese (10 percent), and Arabic (10 percent);

10. Equipment is based on the proposal of the Assessment mission and are the requirements for the establishment of an EOC middle size. Consumables and office maintenance are routine expenditures.

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Annex 8: African CDC Multinational Task Force (Member States + Relevant Partners) who attended 29—30th October 2014 Taskforce Meeting in Addis Ababa

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40.	**Mr Tawanda Chisango**	AWA Program Advocacy & Partnership Expert	**AUC**	**Email: Chisangot@africa-union.org**	
41.	**Mr Sabelo Mbokazi**	Senior Policy Officer	**AUC**	**Email: MbokaziS@africa-union.org**	
42.	**Dr Naftal Kilenga**	Head of Division Medical Services	**AUC**	**Email: kilengan@africa-union.org**	Cell: 0912032706
43.	**Dr Tajudeen Raji**	Pediatrician	**AUC**	**Email: Tajudeenr@africa-union.org**	
44.	**Dr Mary Tapgun**	Head clinical services division	**AUC**	**Email: tapgunm@africa-union.org**	

Annex 9: Terms of Reference of the staff

1. Director

An exceptional professional, with a degree equivalent to Doctor of Medicine, Doctor of Osteopathy, or Doctor of Philosophy, who must be able to provide scientific leadership in formulating, implementing, and evaluating both event and indicator-based surveillance. This individual should also possess a robust epidemiological research background which is made evident by a distinguished record in the design, execution, and publication of original scientific research as well as expertise in review of the merit of other scientific publications. In addition to these technical qualifications, the Director will have evidence of past leadership and management experience in global health policy and programme issues specific to the African continent.

This individual must demonstrate, through previous professional experience:

- High degree of public health prominence and expertise, and a distinguished record of accomplishments in public health;
- Strong leadership experience in creating a vision; setting direction in an organization; and recruiting, developing, and retaining good, diverse staff;
- Senior management experience in directing and managing an organization, including establishing strategic plans and policies, developing and presenting budgets, organizing and prioritizing issues, and evaluating programme accomplishments;
- Proven ability to deal effectively with high-level officials from a diverse range of national contexts, governmental public health agencies, scientific and academic communities, national and international medical and health-related organizations, diverse private sector organizations, and non-governmental groups, media, and the public at large;
- Proficiency in one of the AU working languages; knowledge of other working languages is desirable.

2. Deputy Director

The qualifications of the Deputy Director are similar to those of the African CDC Director in terms of academic credentials, public health expertise, and diplomatic and interpersonal skills. Regarding managerial and programme management experience, the Deputy Director's capacity should exceed that of the Director because the Deputy traditionally provides overall leadership in day to day operations (including administration and financial management, and strengthening internal mechanisms and systems) to ensure that the organization performs its role optimally using a results based approach.

3. Laboratory Scientist

The Laboratory Scientist must possess a degree commensurate with a full four-year course of study leading to Bachelor's or higher degree in an academic field related to laboratory technology, preferably with a focus on biology, or chemistry. He or she must have five (5) years minimum work experience in government, private, or non-profit sectors. This individual must also demonstrate professional expertise in the following:

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- Clear success in providing technical assistance and capacity-building support in resource-limited settings;
- Development of laboratory strategic planning documents;
- Development of quality improvement procedures necessary to obtain external accreditation;
- Willingness to work collaboratively with independent or semi-autonomous laboratory groups throughout the African continent to make progress in the strategic activities of the African CDC as they relate to laboratory technology;
- Supervision of laboratory technicians and aides;
- Familiarity with the management of cooperative agreements, as well as the application of performance indicators to initiatives resulting from these agreements;
- Proficiency in one of the AU working languages; knowledge of other working languages is desirable.

4. Epidemiologist(s)

The African CDC will seek up to five (5) individuals who can serve in these roles:

a. **Analyst of Event-Based Surveillance Data**. This individual must possess a Masters or Doctoral-level professional degree in an academic field related to health or allied sciences, preferably in human, veterinary, or zoonotic biology. Demonstrated proficiency in distillation, interpretation, and verification of unstructured scientific and popular data. Ability to work collaboratively in a multi-disciplinary team. Proficiency in at least two of the AU working languages due to the need to review foreign-language media reports, blogs, and websites.

b. **International Health Regulations Advisor**. This individual must possess a Masters or Doctoral-level professional degree in an academic field related to health or allied sciences. Previous work experience in a Ministry of Health, World Health Organisation country office, or similar public health agency is mandatory.

5. Biostatistician

The Biostatistician must possess a degree commensurate with a full four-year course of study leading to Bachelor's or higher degree in an academic field related to statistics, applied mathematics, or mathematics. Strong organizational and analytic skills are mandatory. An ability to communicate statistical concepts to other public health experts as well as non-scientist government officials is desirable. The individual must also demonstrate professional expertise in the following:

- Excels in use of statistical analysis packages (*e.g SPSS,* SAS, Stata, or R) and basic database programs (*e.g.* Microsoft Excel);
- Proficiency in one of the AU working languages; knowledge of other working languages is desirable.

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6. Health Economist

The Health Economist must have a Masters' or Doctoral-level degree in economics or a related discipline. The individual should have a strong background in quantitative analysis and scientific writing. At least three to four years of prior work experience in health policy analysis is desirable. Additional qualifications include:

- Demonstrated evidence of scientific accomplishment (academic reports or publications);
- Familiarity with the unique policy aspects of public health within various sectors (government, non-profits, etc.);
- Proficiency in one of the AU working languages; knowledge of other working languages is desirable.

7. Scientific Editor

The Scientific Editor will serve as a Technical Writer-Editor for the African CDC. He is responsible for developing and editing technical documents to accurately communicate scientific information to various audiences. He must have a Masters' or Doctoral-level degree in scientific publication or a related discipline, and at least 5 years of professional experience in delivering relevant activities related to scientific editing. His major duties and responsibilities are the following:

- Writes and/or edits scientific documents and other general or technical materials. Analyzes the subject matter and audience in order to plan clear and accurate presentation of materials;
- Adapts the style and format of the product to the medium or publication in which it will appear. Performs final review of materials for technical accuracy, style, proper organization, emphasis, and editorial aspects before release;
- Writes factually accurate materials and/or edits for factual content. These materials include scientific reports, regulations, newsletters, journal articles, press releases, training materials, brochures, interpretive handbooks, pamphlets, Web-based documents guidebooks, scholarly works, reference works, speeches, or scripts;
- Produces material by gathering and verifying data, writing and/or editing reports and pamphlets, and developing and presenting information that is clear and meaningful to the intended audience;
- Writes or edits technical, high-visibility, high priority projects and materials, such as charters, master plans, reports of research findings; scientific or technical articles; news releases and periodicals; regulations in technical areas; technical manuals, specifications, brochures, and pamphlets; and/or speeches or scripts on scientific or technical subjects with full authority to make editorial decisions necessary to comply with the particular purpose and intended uses of the publications;
- Provides guidance and direction regarding publications in support of scientific/medical subject-matter area, such as the natural or social sciences or other fields. Assists in the production of scientific materials on specific topics. Gathers and verifies data and facts; writes and/or edits technical material such as reports, press, releases, journal articles, Web-based documents, fact sheets and pamphlets; and develops and presents information that is clear and meaningful to the intended audience.

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8. GEO Information Specialist(s)

The GEO Information Specialist must possess a degree commensurate with a full four-year course of study leading to Bachelor's or higher degree in an academic field related to geospatial data and systems, at least 2 or 3 years of professional experience in delivering relevant maps to a variety of sectors (including government, military, non-profit, and private). This individual should have technical proficiency in capturing, post processing, analyzing, and reporting geographically referenced information. Additional qualifications include:

- Knowledge of cartography;
- Familiarity with database management;
- Extensive skill with GIS technologies, including ArcGIS software;
- Knowledge of geospatial data and systems;
- Proficiency in one of the AU working languages; knowledge of other working languages is desirable.

Enabling Functions

9. Information and Communications Technology Officer(s)

The African CDC will seek out (up to) two Information and Communications Technology Officers who are capable of setting up, managing, and troubleshooting the computer and internet network and information management that accompanies an electronic surveillance system. Additionally, proficiency in one of the AU working languages though knowledge of other working languages is desirable.

10. Finance Officer

The Finance Officer should possess a degree or diploma documenting formal training in accounting and financial planning. Prior work experience in leadership positions in which the individual managed large, high-value budgets in the government, private, or non-profit sectors is mandatory. This work experience should include day-to-day financial stewardship as well as long-range investment management. The individual must also demonstrate competence in certain skills or evidence of the following qualities:

- Proficiency using financial or analytic software necessary to track fund allocation and disbursement;
- Ethical conduct;
- Meticulous, detail-oriented approach to solving problems;
- Proficiency in one of the AU working languages; knowledge of other working languages is desirable.

11. Resource Mobilization Officer

The Resource Mobilization Officer must possess a degree commensurate with a full four-year course of study leading to Bachelor's or higher degree in an academic field related to operations management. Given the strategic directions of the African CDC, the officer should have leadership experience arising from prior emergency response events. This individual must also demonstrate professional expertise in the following:

- Budget planning and management;

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- Skill in the maximum and efficient use of resources;
- Analytic skills necessary to track allocated resources and their impact;
- Strategic planning for an evolving organisation;
- Proficiency in one of the AU working languages; knowledge of other working languages is desirable.

12. Administrator

The Administrator must possess a degree commensurate with a full four-year course of study leading to Bachelor's or higher degree in an academic field related to operations management. This individual should have prior professional experience working at the executive-level with government, for-profit commercial, or the non-profit sector. This experience should include management experience in managing organizational work plans, executing decisions made by leadership, archiving official documents, organizing and prioritizing issues. The individual must also demonstrate competence in certain skills or evidence of the following qualities:

- Diplomatic, collaborative engagement with senior officials, especially in high-pressure environments;
- Strong organizational skills;
- Meticulous, detail-oriented approach to solving problems;
- Proficiency in one of the AU working languages; knowledge of other working languages is desirable.

13. Logistics Section Chief

The Logistics Section Chief is responsible for the management of logistics and finance related activities directly applicable to support the Incident Management System (IMS) staff during an emergency response.

- Manage all response logistical support requirements;
- Provide travel support (both International and Domestic);
- Coordinate additional space/facility requirements for the response;
- Coordinate shipping and aircraft to support operations;
- Provide deployment equipment and supplies;
- Order material/services procurements;
- Provide laboratory and medical supplies to teams;
- Submit logistics input for the Incident Action Plan (IAP) and recurring SITREPs;
- Attend recurring incident management meetings;
- Coordinate logistics activities with partner organizations;
- Participate in After Action Reviews following an IMS activation;
- Observe all logistics staff for status;
- Plan for the possibility of extended operations;
- Plan for the possibility of providing logistical support to multiple simultaneous responses.

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