Health Policy Watch questions sent to Africa CDC

Part 1 (Sent 12 November at 10.37am SAST)

1. **Governance**

- Who are the members of the Governing Board of Africa CDC?
- Which member states are on the Governing Board of Africa CDC, and how were they chosen?
- Dr Kaseya's term ends in February 2027. What is the process of appointing a new Director General?

2. **Leadership of Dr Jean Kaseya**

- Has there been high staff turnover among senior executives at Africa CDC since Dr Kaseya took office?
- Has Dr Kaseya ever threatened any senior female diplomat with violence at any public meeting?
- Has Dr Kaseya ever been suspended or been asked to take leave following an altercation with an AU diplomat?
- Several staff members claim that Dr Kaseya does not allow discussion of his decisions. Is this true?
- Has Dr Kaseya reassigned several senior staff members without consulting with them?
- Are the three regional directors that the AU Administrative Tribunal ordered to be reinstated in May still operating as regional directors? What is the role of the "special regional representatives of the Director-General" appointed in the same regions as the three directors? How does their appointment fit within the structure approved by member states?
- Has the DG appointed 14 country directors? If yes, what selection criteria were used to select these countries? Are they part of the structure approved by member states?

3. **CPHIA 2026**

- What is the budget for CPHIA 2026, and which donors are supporting the conference financially?
- Some young people granted fellowships claim these have been withdrawn. Is this true?

4. **Achievements**

- What are the top three achievements of Africa CDC since Dr Kaseya took office?
- What is the current annual budget of Africa CDC?

Part 2: Further questions (sent 13 November at 12.27pm)

I received a petition from "senior Africa CDC staff" last night. I am sure you have seen it, but attach it FYI. They are petitioning the Governing Board of the Africa CDC not to use a staff appraisal of the DG completed in April as the basis for evaluating the DG and recommending that he be reapointed. Does Africa CDC have any comment on this document?

Finally, I would appreciate a copy of Africa CDC's last audited financial statements.

Africa CDC:
RESPONSES TO HEALTH WATCH POLICY

1. Governance

Board members and how they are chosen.

Per Article 10 of the Africa CDC Statute, the Board, which is answerable to the Committee of Heads of State and Government (CHSG), shall be composed of:

1. nineteen (19) members, as follows: Ten (10) Ministers of Health representing the five (5) Regions of the African Union, two per Region nominated by their Region. Each minister shall, in the performance of their duties, consult ministers of health in their Region through the ministerial consultative forum in the RCCs;
2. One (1) Representative of the Chairperson of the Commission;
3. The Commissioner responsible for health and humanitarian affairs in the Commission;
4. Four (4) nominees of the Chairperson of the Commission representing the private sector, Regional Financing Mechanism and the environment sector, in consultation with the Chairperson of the Board;
5. One (1) Representative of Regional Health Organizations on a rotational basis;
6. One (1) nominee of the Chairperson of the Commission representing the animal health sector, in consultation with the Chairperson of the Board ; and
7. One (1) nominee of the Chairperson of the Commission representing the Civil society, in consultation with the Chairperson of the Board.

Currently, the Board is complete except for the two nominations from Northern Africa. These remain outstanding for reasons beyond Africa CDC's control, linked to political considerations within the Region.

It is worth underlining what this composition means in practice. Africa CDC does not choose its own Board. The ten Ministers of Health are nominated by their Regions, and the other members are designated by the Chairperson of the Commission or sit by virtue of their office. The Board as a whole answers to the CHSG. The Director General therefore has no say in who sits on the body that oversees the institution he leads. This is a safeguard that Member States deliberately built into the Statute.

The composition is also deliberately broad. Alongside the Ministers of Health, the Statute gives seats to the private sector, the Regional Financing Mechanism, the environment sector, the animal health sector, Regional Health Organizations and civil society. Africa CDC is therefore overseen not only by governments but by the wider community that it serves, in line with a One Health approach.

As for the two outstanding seats, the nomination belongs to the Region concerned and not to Africa CDC. The Secretariat cannot nominate on behalf of a Region, and it cannot impose a deadline on sovereign Member States. In the meantime, the Board continues to meet and to discharge its functions: it met as recently as last week, when it received the presentation attached to this response.

Appointment of the Director General.

Under Article 8bis (1) (d), Article 19 (5) and Article 19 (8), the Africa CDC Statute sets out the selection and appointment process of the Director General (DG). The appointment is endorsed by the AU Assembly on the recommendation of the Committee of Heads of State and Government.
The Director General serves a four-year term, renewable once. Dr Kaseya was appointed in February 2023. Any decision concerning the next term falls to the competent organs of the African Union.

For context, the current Director General was appointed through exactly this process. In Decision Assembly/AU/Dec.858(XXXVI) of February 2023, the Assembly took note of the report and recommendations of the CHSG, and appointed Dr Kaseya. The decision is public and is listed among the sources below. The same rules will apply to the next appointment.

2. Leadership

Senior staff turnover.

No. Africa CDC does not have a high turnover of senior staff. Per example, out of 2 Directors who left (one because he got another rewarding position and another for family reason), Africa CDC attracted and recruited 7 other directors from various organizations.
On the contrary of turn over, the institution is retaining its people and growing: it has expanded substantially over the past three years, from 262 staff in 2023 to 620 in 2026. This reflects its enlarged mandate, new functions and recruitment across the continent.
To be precise, this is an increase of 358 staff, or 137%, in three years. (see the chart below)

While other global and regional institutions are cutting positions, Africa CDC has more than doubled its workforce and attracts talent from across the world. This is thanks to DG Kaseya's leadership and his capacity to secure funding while articulating the vision of the continental agency. This is an organisation that people want to join, not one that people are leaving.

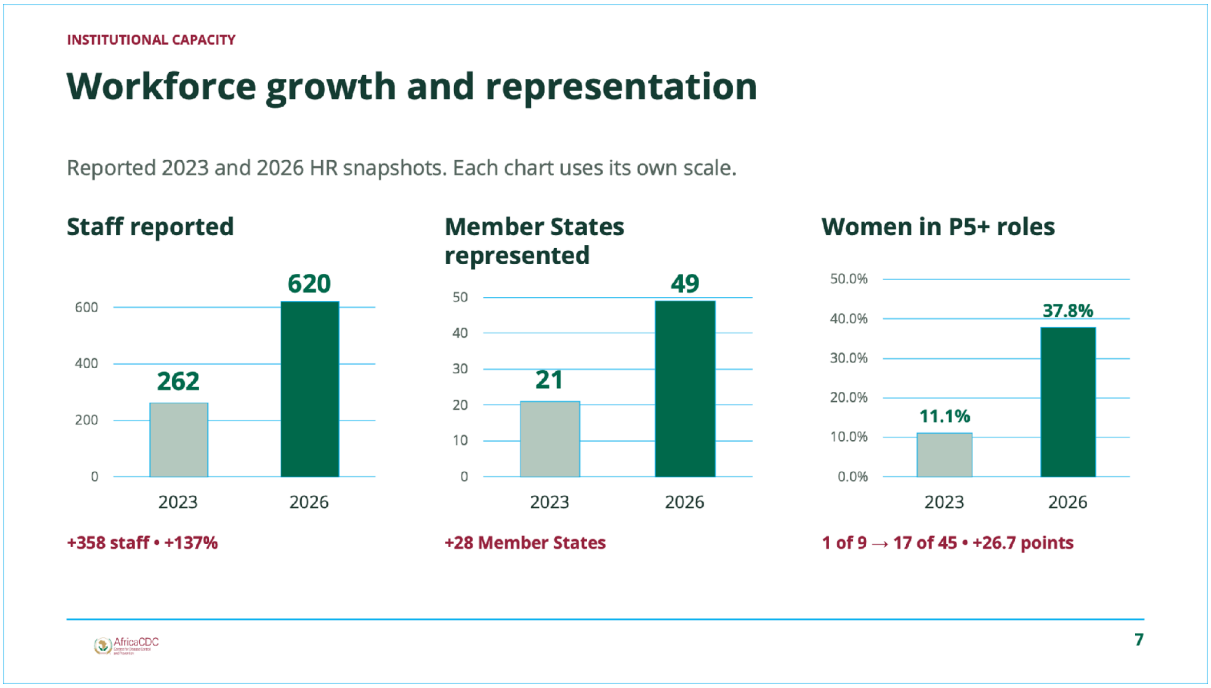
Growth on this scale also explains the movement that can be observed. Adding 358 staff in three years necessarily means many new appointments, new functions and internal moves. In any institution that grows this fast, some colleagues change roles, some complete fixed-term contracts and some move on to other opportunities. This is normal career movement; it is not high turnover and it is not a sign of instability. An institution with a retention problem could not have more than doubled its workforce and multiplied its senior cadre fivefold in three years.
The timing matters too. This growth has taken place while global health financing was contracting and many organisations were reducing their headcount. Partners do not entrust a growing share of their resources to an institution that they consider badly led, and experienced professionals do not leave established careers elsewhere to join one.

In addition, under DG Kaseya's leadership, the number of Member States represented among Africa CDC staff more than doubled, from 21 in 2023 to 49 in 2026, making it a truly continental organisation. With 49 of the 55 AU Member States now represented, the workforce reflects the continent it serves. This matters operationally as well as symbolically: staff who know the languages, the health systems and the institutions of the countries they support are more effective when an outbreak occurs.

More importantly, he made sure that more women were appointed to senior positions: the share of women in P5 and above roles moved from 11.1% to 37.8%. In absolute numbers, this is a move from 1 woman among 9 senior staff in 2023 to 17 women among 45 in 2026. The senior cadre itself grew fivefold, and women took a far greater share of the new senior posts. We recognise that 37.8% is not yet parity and the effort continues, but the direction and the pace of change are clear.

Please see below the graph from the presentation made last week to the AU policy organs and the Governing Board. These are simply facts, and they are evidence of a continental organisation that is growing with a strong focus on gender and geographic balance and equity.

We would add that these figures were not prepared for this response. They were presented to the AU policy organs and the Governing Board, the bodies that hold Africa CDC to account, and they come from the institution's HR records. They can therefore be verified.



Has Dr Kaseya ever threatened any senior female diplomat with violence at any public meeting? Has Dr Kaseya ever been suspended or been asked to take leave following an altercation with an AU diplomat?

The Director General has never been suspended, sanctioned or placed on administrative leave since taking office in April 2023.
The African Union is governed by the AU Staff Regulations and Rules (AU SRR), as complemented by the Africa CDC Statute.
For ease of reference, the relevant provisions are AU SRR Rule 73 on Acts of Misconduct, Rule 74 on Disciplinary Procedures, and Rule 75 on Criminal Proceedings Instituted against an Elected or Non-Elected Official, Political Appointee, Special Appointee and Staff Member outside the Union. We have shared with you the AU SRR for easy reference.

The Director General, as an elected official, cannot be suspended or asked to take leave (by whom?) without a proper procedure that is written, with accusations formally formulated and known to the AU policy organs.
Under the AU SRR, the suspension of a Director General for misconduct follows due process and a written decision; it cannot be an oral instruction. No competent AU organ has issued any adverse finding against the Africa CDC Director General.

This point deserves emphasis because it makes the allegation verifiable. The suspension or enforced leave of the head of an AU institution is not a private matter. It would require a decision by a competent authority, notified in writing; someone would have to be designated to act in his place as Acting Director General; and the policy organs would know of it. None of this exists. There is no decision, no notification and no acting appointment made on such grounds, and the Director General has exercised his functions without interruption, including before the Governing Board and the AU policy organs last week.

If you have been shown a decision of a competent AU authority that says otherwise, we would be grateful if you could share it with us so that we can respond to it specifically. we are 100% sure that you will not share that because to our knowledge, no such document exists.
It may also be useful to ask for the document recording the disciplinary proceedings that are alleged. We are confident that your source will not be able to produce that, because no such proceedings have taken place.
Thereforee, this allegation is therefore baseless, unfounded, and only manipulation.

In addition, Article 8ter of the Africa CDC Statute states " *The Chairperson of the Commission shall exercise supervisory authority over the Africa CDC, which includes financial and administrative supervision*".
For this reason, it is the Chairperson who conducts the performance evaluation of the Director General of Africa CDC. The Chairperson of the AUC is a respected senior official of the African Union. He would not have rated the Director General of Africa CDC *"Outstanding Performance"* if the Director General's conduct were in question. Please see attached his performance appraisal from April 2026.

The logic is simple. The authority that exercises administrative supervision over the Director General is the same authority that evaluates him. In April 2026, that authority gave him the highest rating. In the same month, the Chairperson of the AU Commission, on behalf of African Heads of State and Government, recognised the Director General for exceptional achievement. Two months earlier, in February 2026, the AU Assembly had commended Africa CDC's leadership, governance and financial management under him. It is not credible that the supervising authority and the Assembly would publicly commend an official whom they had, in the same period, suspended or sent on leave for misconduct.

The account that has been given to you is not consistent with the AU SRR, the Africa CDC Statute or the documented record. In our view, the facts have been manipulated, and we are grateful for the opportunity to set them out.
We have shared the applicable rules, the Statute, the performance appraisal and the public decisions of the AU organs so that each point can be checked independently. We will gladly provide anything further that would help you verify the facts.

Several staff members claim that Dr Kaseya does not allow discussion of his decisions. Is this true?

No. Decision-making at Africa CDC is structured, collective and documented, and decisions are discussed at every level:
1. Every week, Directors and Heads of Division (HoD) meet to discuss organisational issues, and the report is shared with all senior management, including the DG. Issues are therefore first debated by the technical and managerial leadership, and the DG receives the outcome of that discussion.
2. Every week, the Senior Management Team (SMT) meets to analyse and discuss critical issues related to the organisation. This is where major questions are examined collectively.
3. Every month, there is an extended HoD meeting to evaluate the monthly performance and take appropriate decisions on the basis of results.
4. Every quarter, there is a quarterly review meeting that brings together about 150 senior and mid-level staff to evaluate the organisation's performance and discuss corrective measures. A leader who did not allow discussion would not convene 150 colleagues every three months to scrutinise performance and propose corrections.
5. Every year, there is an annual review meeting to evaluate the performance of the year and agree on the priorities for the following year.

Decisions are discussed at several levels, and all of these forums shape the direction taken by Africa CDC. Thanks to this rigorous process, Africa CDC is improving and making an impact, as you can read in the attached 2025 annual report. https://africacdc.org/download/annual-report-from-mandate-to-public-health-impact/
It is also why the DG is respected, was granted "Outstanding Performance" by the Chairperson of the AUC and received congratulations from the Executive Board and the AU Assembly of Heads of State and Government.

Two clarifications may help. First, consultation is not the same as indecision. Under the decisions of the AU Assembly, the Director General is the Chief Executive Officer of Africa CDC and answers to the Governing Board, the CHSG and the Assembly for results. After discussion, a decision has to be taken and someone has to be answerable for it. In an institution that manages public health emergencies, where delay costs lives, this is a duty and not a matter of style.
Second, in an organisation of 620 people it is normal that not everyone agrees with every decision. Disagreeing with the outcome of a discussion is not the same as having had no discussion. The results also speak for the method: budget execution does not move from 34% to 95%, and a directly managed portfolio does not grow from US$52 million to US$463 million, unless teams understand, own and implement the decisions that are taken.

Has Dr Kaseya reassigned several senior staff members without consulting with them?

Assignments and reassignments of staff at Africa CDC are made in accordance with the rules. Rules 33 to 43 of the AU SRR set out the provisions on the appointment, assignment and reassignment of staff. These AU SRR Rules are complemented by Articles 19, 20 and 21 of the Africa CDC Statute. We are sharing these provisions for ease of reference, as they describe the appointment process in the AU.

The underlying principle, common to international civil services, is that staff serve the organisation and not a particular post or duty station, and that assigning staff according to the needs of the service is a prerogative of management exercised within the rules.

Reassignments at Africa CDC are made within this framework. They follow from the reorganisation that inevitably accompanies an institution whose workforce has more than doubled: new functions, a growing country-level presence and priorities such as the Ebola response all require experienced staff to be placed where they are most needed. A reassignment is not a disciplinary measure.

Africa CDC has established several mechanisms for staff who have any concern. They can use the grievance mechanism, the Office of Internal Oversight, the staff counsellor and the whistleblower policy. Once one of these mechanisms is activated, the process starts immediately.
A staff member who believes that a reassignment was improper therefore has remedies inside the institution, including a whistleblower policy that exists precisely to protect those who speak up. These channels are open to every colleague, and any concern raised through them is examined on its merits.

The issue related to the three regional directors.

This matter is handled by the Chairperson of the African Union Commission, it is not at the level of the Director General of Africa CDC. Indeed, on 20 July 2026, the Chairperson of the African Union Commission issued a formal decision redeploying the three regional directors to Africa CDC headquarters in Addis Ababa (see document attached).

As a reminder, the Chairperson of the African Union Commission exercises administrative and financial oversight of Africa CDC under Article 8 ter of the Statute.

The decision was made by the Chairperson of the AUC after due process and consultation. The attached document confirms this: it is a decision of the Chairperson of the Commission, not of the Director General. It is written, dated and formal, and it was taken by the authority that the Statute designates for administrative supervision. It also illustrates how the AU proceeds when a decision concerning senior staff is taken: through a formal written act.

We would add that a redeployment to headquarters is a change of duty station and not a dismissal. The three colleagues remain Africa CDC staff and, like all staff, they have access to the mechanisms described above.

Has the DG appointed 14 country directors? If yes, what selection criteria were used to select these countries? Are they part of the structure approved by member states?

Yes. Africa CDC is expanding its country-level presence to support Member States more directly. These positions are being filled through the ALD modality, pursuant to the various rules of the AU SRR shared with you.

The rationale is straightforward. Outbreaks begin in countries, and they are contained or lost there. A continental agency that is present only at headquarters and in regional centres learns of problems later, and supports Member States more slowly, than one with a senior representative working every day alongside the Ministry of Health and the National Public Health Institute. Country presence is standard practice among international health organisations.

Africa CDC, like any other AU organ, has both Member State-funded positions (the approved structure) and partner-funded positions (not in the approved structure).

The SRR allow any AU organ to recruit beyond the structure approved by the policy organs and financed by Member States, where partners fund the positions. You will also see that the DG has the authority to appoint special advisors, senior advisors and representatives at his discretion to meet the needs of the organisation.

Of Africa CDC's 620 staff, only 37 hold posts approved and paid for by Member States, owing to the financial constraints of the African Union. The other positions are financed by partners according to the needs of the organisation, as the SRR permit. It is clear that if Africa CDC had to rely only on the 37 posts paid for by the Member States, the organisation would not be able to carry out its mandate effectively; it would already have collapsed.

Put differently, about 6% of Africa CDC's workforce sits within the Member State-funded structure and about 94% is financed by partners. The question "are they part of the structure approved by Member States?" therefore applies not only to the country directors but to the great majority of the staff who run surveillance, laboratories, emergency response and every other programme.

Positions outside the approved structure are not irregular positions: they are a category that the rules expressly provide for, tied to partner funding. Because they are partner-funded, they also create no additional charge on Member States' assessed contributions.
With regard to the selection of country offices, considering the threat of the ongoing Ebola outbreak, priority was given to countries assessed to be at risk in order to ensure preparedness, and the ALD approach was used in accordance with the AU SRR.

The criterion was therefore epidemiological risk and not political preference. In an active outbreak, speed is decisive, and the ALD modality allows qualified personnel to be deployed quickly. Giving priority to at-risk countries is a decision about sequencing; it does not exclude other Member States.

3. CPHIA 2026

What is the budget for CPHIA 2026, and which donors are supporting the conference financially?

CPHIA is co-organised by the host Member State (Ethiopia this year), the African Union and Africa CDC under a host agreement signed by all parties. This host agreement does not specify a budget; it sets out the responsibilities of each entity that is party to it.

Generally, the host country takes on the larger share of responsibility without sharing the financial implications, because this is a sovereign decision of the country and is also linked to security, especially as Heads of State and Government are involved.
For CPHIA 2026, Ethiopia is making a major contribution, including in-kind support, and these are not ours to quantify or to disclose. The African Union and Africa CDC mainly cover travel and accommodation for some country officials, and some side events. This is how major intergovernmental conferences hosted by a Member State are normally organised.

In addition, Ethiopian Airlines, an Ethiopian Governmenet owned company, is providing support with several in-kind support including 20% deduction of airline ticket.

Registration and exhibition fees are another important source of financing, and some partners are covering individual side events linked to their areas of interest, as is done during major gatherings (WHA, UNGA, ...).

For this reason, Africa CDC does not hold a single consolidated "CPHIA budget" that could be communicated at this stage. A large part of the cost consists of contributions made directly by the host Government, including in kind contribution,.

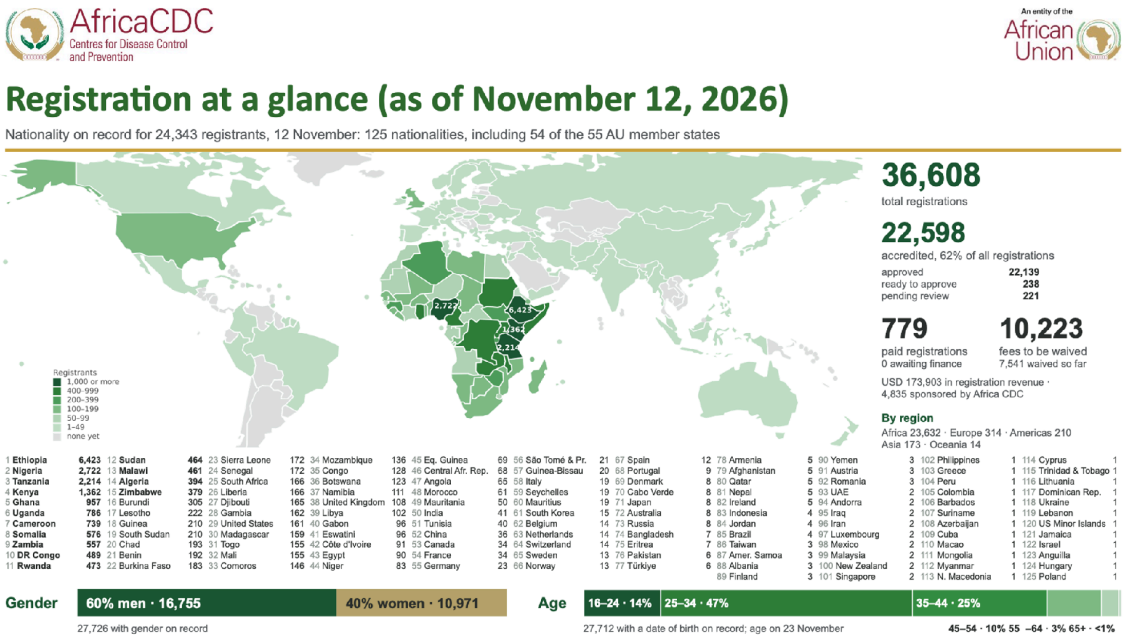
Africa CDC will submit an audited report to AU Member States after the event, once all figures have been consolidated. This is the right moment for financial accountability. The final figures for an event of this size depend on actual attendance, final invoices and the reconciliation of contributions from several parties, and none of these is known before the event closes. Publishing partial estimates beforehand would be less accurate, not more transparent. The audited report is the guarantee that the full picture will be examined by the Member States to whom Africa CDC answers.

Some young people granted fellowships claim these have been withdrawn. Is this true?

This CPHIA is already a success in terms of registration for attendance. Africa CDC set an ambitious target for this edition: a maximum of 30,000 in-person participants, including 4,000 young people, and more than 100,000 attending virtually.

To measure that ambition: the inaugural edition of CPHIA, in 2021, attracted 2,500 participants.
As you can see from the figure below, dated 12 November (two weeks before the event), 36,608 people from 125 countries around the world have already registered and are willing to attend.

The same figure shows who is coming. Among registrants with a nationality on record, 54 of the 55 AU Member States are represented and 23,632 people are from Africa.



Young Africans are not being kept away from CPHIA 2026. Africa CDC was targeting 4,000, but more than 12,000 young people have expressed their wish to attend. To bring the list within the capacity that Africa CDC can afford, priority was given to young people who have accepted abstracts or who are speaking at side events and parallel sessions.

Demand was therefore three times the number of places planned, and a selection was unavoidable. The criterion applied is objective and based on merit: priority goes to young people who have an active role in the programme, because their abstract was accepted or because they are speaking. This is the criterion that best serves both the young scientists concerned and the quality of the conference.

Those who could not be sponsored to travel are not excluded from the conference either, since it can be followed virtually.

Regrettably, resources do not allow us to accommodate everyone who applied. We understand the disappointment of those who could not be supported, and we regret it.

Because mistakes can happen for this kind of conferences, if a young person holds a written confirmation of sponsorship that he or she believes was later withdrawn, we invite them to bring the specific case to our attention so that it can be checked individually.

4. Achievements

Africa CDC is not an NGO. It is the continental platform and umbrella, the public health agency of Africa, which provides oversight on all public health issues.
It is an autonomous institution of the African Union, a status granted by the AU Assembly in February 2022 (Decision Assembly/AU/Dec.835(XXXV)), and it is governed by a Statute

adopted by Member States. Its achievements are therefore reported to, and assessed by, the Member States that gave it its mandate.

To give you an idea of its achievements, we have attached the PowerPoint presentation made to the Governing Board last week. It shows the immense progress made in various areas, which is helping this continent to move forward. The presentation does not cover every area, such as our role in leading the response to the Ebola outbreak and the many areas linked to sustainable financing, local manufacturing and the APPM, the digital agenda, the reform of the global health architecture and so many others.

In summary, and following the AHSS agenda and the manifesto of DG Kaseya when he was a candidate for this position, we can group the successes and achievements into four categories:

1. *Institutional turnaround.* Huge improvement in terms of HR management, transparency and accountability. Budget execution rose from 34% in 2022 to 95% in 2025, and the directly managed grant portfolio from US$52 million to US$463 million. In February 2026 the AU Assembly commended Africa CDC's leadership, governance and financial management under the Director General. To put these figures in perspective: at 34%, two thirds of the resources entrusted to the institution were not being turned into programmes; at 95%, almost every dollar is delivered. The directly managed portfolio has grown almost ninefold and has diversified from 7 to 44, as the chart below shows, while voluntary contributions from AU Member States are increasing. Partners and Member States do not multiply their commitments to an institution whose governance they doubt.
2. *Health security delivered through continental emergency leadership.* Africa CDC made the first Public Health Emergency of Continental Security declarations, for mpox and Ebola, and set up the joint Africa CDC–WHO Incident Management Support Team (IMST) that is leading all public health emergencies in Africa by strengthening laboratory capacity, surveillance, the health workforce, financing, the availability of commodities, the coordination of cross-border activities, NPHIs, PHEOCs, the digitalisation of outbreak response and the involvement of communities and various partners. The operationalisation of the Africa Epidemics Fund and its impact is a major success story. Capacity has grown with it: the number of countries with pathogen genomics capacity rose from 7 in 2020 to 46 in 2026, and Africa CDC now leads 48 continental research projects, from none before.
3. *Health sovereignty delivered.* This includes concrete results in terms of the digital agenda, local manufacturing, the operationalisation of the African Medicines Agency, the success of the African Pooled Procurement Mechanism, and several initiatives regarding health financing in Africa. Together, these address the structural weakness that COVID-19 exposed, when Africa waited at the back of the queue for vaccines and supplies: the capacity to produce, regulate, procure and finance health products on the continent itself.
4. *Recognition of its leadership at global level.* Africa CDC has been appointed to represent all other regional health organisations worldwide on the WHO Task Force on Global Health Architecture Reform. This is recognition by its peers. It is consistent with the strong support expressed by the AU Assembly in February 2026 for Africa CDC's representation in major global health initiatives, and with the ambition of positioning Africa as a co-architect of the global health architecture and not only a beneficiary of it.

Thank you for giving Africa CDC the opportunity to respond. We remain available to provide any further document or clarification that you may need, and we would be grateful if these responses could be reflected in your reporting.

Sources:

- Revised Statute of Africa CDC
- Governing Board nominations, 4 November 2026
- Assembly decision on the appointment of the Director General, 2023
- AU Assembly decisions, February 2026
- Decision on the operationalisation of Africa CDC as an autonomous institution, February 2022
- Africa CDC statement on the outcomes of the 39th AU Assembly, February 2026
- Official launch of CPHIA 2026, May 2026
- Recognition of Director General Dr Jean Kaseya for Exceptional Achievement: https://africacdc.org/news-item/africa-cdc-welcomes-au-recognition-of-director-general-dr-jean-kaseyas-outstanding-exceptional-achievement/