CEPI

African Phase I Clinical Trial Units:

Request For Information (RFI) Summary

Review of 45 completed RFI questionnaires, using CEPI 'African Phase I Clinical Trial Units' template

Prepared 15 July 2026

Contents

1. Executive summary

Overall picture

CEPI published a Request for Information (RFI) on 15 June 2026 and the call closed on 3 July 2026. An eight-section RFI questionnaire template provided by CEPI focused on capabilities for phase I units including:

- Site overview
- Geographical reach and population access
- Previous relevant phase I experience
- Facilities and infrastructure
- Quality system
- Regulatory and Ethics Compliance
- Clinical and scientific expertise
- Participant safety and risk management

CEPI received 60 questionnaires and a team of 3 people, experienced with clinical development, performed an initial screening. Excluded from this analysis included:

- 5 Site Management Organisations (SMOs)/ Contract Research Organisations (CROs):
- 8 sites +1 CRO with either no phase I experience at all or within the past five years;
- 1 site in the DRC about to start phase I (please see below):
- 1 site that did not give permission to share their responses with developers and/or make it publicly available
- Individual consultants offering clinical trial services such as monitoring

In total, 45 Phase I sites across 17 African countries are reflected in this summary. Three countries are heavily represented: Kenya, South Africa and Uganda account for 21 of 45 sites, with most other countries represented by one to three sites. Central Africa (just Gabon) and North Africa (none at all) are unrepresented in this RFI pool.

Response quality is uneven: total answer length varies roughly 15-fold between the shortest and longest submissions, and a handful of sites left specific fields blank.

This information is a limited snapshot of phase I clinical trial capabilities in Africa. It was self-reported and not verified by CEPI. Developers planning to conduct trials must perform their own due diligence processes, including feasibility assessments and pre-study site visits.

Capability strengths

- Broad prior experience with epidemic-prone pathogens: 39 of 45 sites cite work on at least one of Ebola, Marburg, Lassa, MERS, MPXV, Rift Valley fever, chikungunya, Zika or cholera, most commonly Ebola (27 sites).
- A largely standardised technology base: REDCap (42 sites) and Medidata/Rave (a further large majority) dominate EDC platform choice, which should ease sponsor integration regardless of site chosen.
- Quality-system language is reasonably mature in a majority of submissions: GCLP is referenced by 29 of 45 sites and ISO certification (9001, 13485 or 15189) by 23 of 45, generally in the context of laboratory or biobanking operations.

- Community engagement infrastructure is common: 28 of 45 sites describe a community advisory board or community health worker network, which matters for recruitment and retention in outbreak-response trial designs as well as regions with high levels of vaccine hesitancy.
- A meaningful subset (23 of 45) names a specific regulator they have worked with or been inspected by (MHRA, FDA, EMA, WHO, SAHPRA, NAFDAC or similar), and of those, 12 explicitly describe a clean or no-major-findings inspection history.

Key gaps

- Regional concentration: outside Kenya, South Africa and Uganda, most countries have only one or two participating sites, so there is limited redundancy if a preferred site in those countries is unavailable.
- Biosafety level is unclear for 4 of 45 sites (see Facilities and Infrastructure). For any pathogen requiring BSL-3, this needs direct confirmation with those 4 sites rather than assumption.
- Formal joint/expedited regulatory-ethics review experience (the AVAREF mechanism used across several African countries during COVID-19 and Ebola responses) is explicitly named by only 5 of 45 sites, though more may have used it under a different description.
- Quantified detail is inconsistent: about half the sites give a numeric bed count, around half give a numeric staff count, and 27 of 45 give a numeric regulatory/ethics review timeline. The rest describe these qualitatively, which limits like-for-like comparison.
- A small number of sites left specific yes/no fields entirely unanswered (see Data reliability note and the Regulatory and Ethics Compliance and Participant Safety sections below), which should be further investigated by developers before these are used for decisions.

Key variability

The clearest pattern across the dataset is not weak capability, it's inconsistent reporting. Years of operation range from 6 to over 90; inpatient bed capacity, where quantified, ranges from 2 to 125; and response depth ranges roughly 15-fold. This means two sites with genuinely similar capability could look very different in this dataset purely because of how thoroughly the form was completed. Any shortlisting exercise should weight narrative specificity and follow-up confirmation at least as heavily as the tick-box answers.

2. Data reliability

The questionnaire's Yes/No fields (24-hour coverage, hospital transfer agreements, DSMB experience, CRO relationships, expedited review experience, data-sharing consent) use tick-box graphics. On several files the tick appears next to "No" even though the accompanying free text is clearly affirmative and detailed. This is a rendering artefact of the form, not a respondent error. Practically, almost every site answers Yes to these questions once free text is accounted for, so the tick-box fields have limited power to discriminate between sites; the narrative answers carry the real signal. Treat any single tick-box answer as provisional until checked against the source PDF.

3. Portfolio overview

Geographic distribution of the 45 responding sites, by country:

Country	Sites	Site names
Kenya	8	LUMUMBA; KEMRI Wellcome Trust; CREATES; KAVI ICR; KEMRI Center Global Health Research; KEMRI KCRC; KEMRI WRAIR; VIBRI Phase I Clinical Trial Unit
South Africa	7	Aurum; Desmond Tutu Health Foundation; FARMOVS; PHRU; SAMRC; Wits RHI Shandukani; Wits Vaccine and ID Analytics
Uganda	6	Uganda Virus Research Institute; Baylor College Med Childrens Foundation; JCRC; MRC-UVRI-LSHTM; MUWRP; UVRI-Clinical Research Program Initiative (UVRI-CRP)
Burkina Faso	3	GRAS; INSTech; IRSS/CRUN
Ghana	3	Kintampo HRC; NMIMR; Navrongo HRC
Rwanda	3	CFHR; Rinda Military and Teaching Hospital; UGHE AVEGA.Phase 1
Ethiopia	2	AHRI; Wolaita Sodo University CTU
Mali	2	Center Vaccine Development; PMRTC
Tanzania	2	Ifakara Health Institute; NIMR Mbeya Referral Hospital
Zambia	2	CIDRZ; Center for Family Health Research
Gabon	1	CERMEL
Gambia	1	MRC LSHTM Phase I unit
Malawi	1	Blantyre Malaria Project
Mozambique	1	CISPOC
Nigeria	1	Institute Human Virology
Senegal	1	SMIT
Sierra Leone	1	Kambia Health Research Center LSHTM
Total	45	17 countries

Kenya, South Africa and Uganda together account for 21 of 45 sites (47%). The remaining 24 sites are spread across 14 countries, of which 7 (Gabon, Gambia, Malawi, Mozambique, Nigeria, Senegal, Sierra Leone) are represented by a single site each. Francophone West and Central Africa beyond Burkina Faso, Mali and Senegal, and countries such as Nigeria, the Democratic Republic of Congo and Cameroon, are largely absent from or thinly represented.

NOTE: The Centre for Tropical Diseases and Global Health (CTDGH), Universite Catholique de Bukavu, DRC, submitted a questionnaire to this RFI. The site has substantial experience in interventional research in infectious diseases. Studies completed to date have been later phase vaccine effectiveness trials. However, they are establishing a dedicated phase I capability through the ACCEPT-Africa platform, a project funded by the Mastercard Foundation via the EPSION programme, delivered in collaboration with the Pandemic Sciences Institute at the University of Oxford and managed through the Science for Africa Foundation. This site was not included in this analysis because they have not yet implemented Phase I studies.

Five Site Management Organizations (SMOs)/Contract Research Organizations (CROs) provided responses but were not included in the analysis with site responses. The following is a self-reported high-level description of their services:

African Early Phase Clinical Research Network	Established in 2026; the network currently includes leading research institutions, academic medical centers, vaccine-development organizations, public health institutes, and clinical research units across Uganda, Kenya, Ghana, Nigeria, Mali, Senegal, The Gambia, Tanzania, Ethiopia and South Africa.
PPD Site Network	CRO in operation for 41 years; multiple phase I sites across the continent
Rwanda PACT Solutions	PACT operates through collaboration agreements with partner hospitals, which provide dedicated bed capacity for trial participants. Currently our sites include CHUK and CHUB. The sites are referral and teaching hospitals in South of Rwanda and at the central of the capital
South Africa TASK Phase I unit	A global CRO; The Phase 1 facility, TASK Clinical Research Centre (TCRC), is located in Cape Town; TCRC is a registered 24 bed hospital for the conducting of Early Clinical Development (ECD), PK and other in-patient trials
ACRN Network	Non-profit SMO/CRO; 59 sites in 14 countries; Phase I capability in Rwanda, Uganda, Kenya and Zimbabwe

Institutional maturity

44 of 45 sites gave enough detail to estimate years of operation (as an institution or clinical research unit, not necessarily years running Phase I studies specifically). The range is wide, from 6 to over 90 years, with a median of around 25 years:

- Under 10 years: 1 site
- 10 to 19 years: 9 sites
- 20 to 29 years: 16 sites
- 30 or more years: 18 sites

There is long-established research infrastructure: well-known regional networks and institutes (KEMRI and its programme-specific units in Kenya, the MRC/UVRI-LSHTM Uganda Research Unit, the SAMRC's HIDRU in South Africa, NIMR in Tanzania, AHRI in Ethiopia) mostly report several decades of operation, often tracing their origin to colonial-era or early post-independence public health institutes later adapted for clinical trials. A smaller group of newer entrants (for example Rwanda's University of Global Health Equity, founded 2015, and Mali's Center for Vaccine Development, established 2001) report shorter institutional histories but in some cases still substantial Phase I-specific experience through partnership arrangements.

Institutional age is not a reliable proxy for response quality or trial-readiness on its own: some of the most detailed, best-evidenced submissions come from newer or programme-specific units (e.g. Kenya's VIBRI, Uganda's UVRI-CRP), while a few long-established institutions gave comparatively brief answers. Maturity is worth noting as context, not treating as a scoring criterion in of itself.

4. Comparative findings by questionnaire section

Overview and prior Phase I experience (Sections 1 and 3)

Therapeutic focus is dominated by infectious disease across the whole set: HIV, TB and malaria are near-universal, and most sites layer epidemic-prone pathogen work on top of this base (see Executive summary for the pathogen breakdown). A smaller number of sites also cite non-communicable disease work (cardiovascular, sickle cell, diabetes), generally as a secondary rather than primary focus.

Depth of prior Phase I experience is where the submissions diverge most. Several sites (e.g. Uganda's MRC/UVRI-LSHTM unit, South Africa's SAMRC HIDRU and PHRU, Kenya's VIBRI) describe double-digit numbers of Phase I studies across vaccine, therapeutic and challenge-study designs, including named sponsor and CRO partnerships and, in a few cases, prior investigator-initiated trial sponsorship. Others report Phase I experience in general terms ("yes, several studies") without naming studies, sponsors or dates, which makes it hard to independently size their track record from the RFI alone. This is the section where a direct follow-up (a short reference list of named Phase I studies, sponsors and years) would sharpen the comparison most.

Geographic reach and community engagement (Section 2)

Roughly a third of sites operate across multiple physical research centres rather than a single site, which matters for recruitment reach and for redundancy if one facility is disrupted. Recruitment strategies described range from urban hospital-based catchment (common in South Africa and Kenya's city-based units) to longstanding rural surveillance and household-visit programmes (for example Uganda's MRC/UVRI-LSHTM sites in Masaka and Kyamulibwa, and Kenya's CREATES site in Nyando sub-county).

Community engagement infrastructure is described in some form by most sites; 28 of 45 explicitly mention a community advisory board or a community health worker network, generally linked to local government health structures. A small number of sites (1 to 2) gave minimal or no detail on this question, which is worth a direct follow-up given how central community trust is to outbreak-response trial recruitment specifically.

Facilities and infrastructure (Section 4)

Bed capacity

Where a numeric inpatient bed count was given (25 of 45 sites), capacity ranges from 2 to 125 beds, though the figures are not always like for like: some describe beds dedicated solely to Phase I work, others describe access to a shared hospital ward. One site (Kenya's KEMRI-CMR-RCTP Lumumba) explicitly states it has no dedicated inpatient capacity and relies on referral arrangements instead. The remaining 20 sites answered descriptively ("yes", or a narrative account of facilities) without a number, which limits direct comparison on this specific criterion.

Biosafety

In summary, 21 of 45 sites specify BSL-2 only, 13 specify a combined BSL-2/3 capability, 3 specify BSL-3 only, 2 specify BSL-1/2/3, 1 specifies BSL-1 only, 1 (Rwanda's UGHE) explicitly states it lacks dedicated BSL-3/4 capacity, and 4 sites (Kenya's CREATES, Rwanda's Rinda Military and Teaching Hospital, South Africa's Wits RHI Shandukani, Zambia's Center for Family Health Research) give no BSL specification in their submission. The table below lists every site, ordered from highest stated level to lowest, with 'Not specified' sites at the end. For any programme involving higher-consequence pathogens, BSL-3 (or WHO risk-group-3 equivalent) capacity should be confirmed directly with the site, since a written answer in an RFI is not the same as a verified facility audit or inspection.

BSL level	Country	Site
3	Burkina Faso	INSTech
2,3	Ethiopia	AHRI
2,3	Ethiopia	Wolaita Sodo University CTU
1,2,3	Gabon	CERMEL
2,3	Gambia	MRC LSHTM Phase I unit
1,2,3	Ghana	NMIMR
2,3	Kenya	KEMRI Center Global Health Research
2,3	Kenya	KEMRI WRAIR
2,3	Nigeria	Institute Human Virology
3	Senegal	SMIT
2,3	South Africa	Aurum
3	South Africa	PHRU
2,3	Tanzania	Ifakara Health Institute
2,3	Tanzania	NIMR Mbeya Referral Hospital
2,3	Uganda	JCRC
2,3	Uganda	UVRI-Clinical Research Program Initiative (UVRI-CRP)
2,3	Uganda	Uganda Virus Research Institute
2,3	Zambia	CIDRZ
2	Burkina Faso	GRAS
2	Burkina Faso	IRSS/CRUN
2	Ghana	Kintampo HRC
2	Ghana	Navrongo HRC
2	Kenya	KAVI ICR
2	Kenya	KEMRI KCRC
2	Kenya	KEMRI Wellcome Trust
2	Kenya	LUMUMBA
2	Kenya	VIBRI Phase I Clinical Trial Unit
2	Malawi	Blantyre Malaria Project
2	Mali	Center Vaccine Development
2	Mali	PMRTC
2	Mozambique	CISPOC
2	Rwanda	CFHR
2	Sierra Leone	Kambia Health Research Center LSHTM
2	South Africa	FARMOVS
2	South Africa	SAMRC
2	South Africa	Wits Vaccine and ID Analytics
2	Uganda	Baylor College Med Childrens Foundation
2	Uganda	MRC-UVRI-LSHTM
2	Uganda	MUWRP
1	South Africa	Desmond Tutu Health Foundation
No BSL-3/4 (facility explicitly states it lacks dedicated high-containment capacity)	Rwanda	UGHE AVEGA.Phase 1
Not specified	Kenya	CREATES
Not specified	Rwanda	Rinda Military and Teaching Hospital
Not specified	South Africa	Wits RHI Shandukani
Not specified	Zambia	Center for Family Health Research

Electronic data capture

Electronic data capture is close to standardised across the portfolio, and every one of the 45 sites names at least one recognised platform once the full range of products mentioned is

accounted for (see table below). REDCap is the closest thing to a common standard, named by 42 of 45 sites, followed by the Medidata product family (Rave, iMedidata, Medidata Clinical Cloud) at 33 and OpenClinica. Oracle is used by 14 sites (Oracle InForm, Oracle Clinical One).

EDC platform	Sites	Notes
REDCap	42	Named across almost every site; the closest thing to a common standard in this dataset.
Medidata family (Rave, iMedidata, Medidata Clinical Cloud)	33	Second most common; several sites name more than one Medidata product.
OpenClinica	16	Open-source EDC, commonly named alongside a commercial platform.
Oracle family (Oracle InForm, Oracle Clinical One, or unattributed "Inform")	14	5 sites explicitly name Oracle; a further 9 name "Inform" which is the platform owned by Oracle.
EMMES (Advantage eClinical / AdvantageEDC)	7	Named where EMMES acts as CRO/data-management partner.
Veeva Vault CDMS	6	
Viedoc	6	
Castor	4	
DFdiscover family (DFexplore, Datafax, iDataFax)	5	Older eResearch Technology product line, still in use at a handful of sites.
MACRO (Ennov/InferMed)	2	
CRScube	2	
Medrio	2	
Nukleus	2	a smaller, less widely known platform.
ClinCapture	1	

Given how widely REDCap and the Medidata and Oracle families already appear, EDC compatibility is unlikely to be a major differentiator when choosing between sites; the smaller platforms (Nukleus, ClinCapture, Medrio, CRScube, MACRO) tend to appear at sites that also name a mainstream platform alongside them, rather than relying on the smaller platform exclusively.

Sample shipping and material transfer agreements

42 of 45 sites reference an MTA in some form. Of the 42, 28 name a specific reviewing or approving body (most often a national medicines/food and drug authority, a ministry of health, an institutional legal office, or the site's own ethics committee), and 24 give a stated turnaround time, ranging from about 2 weeks (e.g. Uganda's JCRC, The Gambia's MRC LSHTM unit) to 4-6 weeks (South Africa's FARMOVS) once an export permit is factored in. Due to the variability of responses, developers and/or users of this information are strongly encouraged to verify the MTA process and timeline as part of a feasibility assessment.

No site in this dataset describes an outright prohibition or ban on exporting samples; where restrictions are mentioned, they take the form of a required approval step (MTA sign-off, ethics or regulatory review, an export permit) rather than a bar on export itself. Four sites (Kenya's KEMRI KCRC, South Africa's FARMOVS, and Uganda's Virus Research Institute and MUWRP) explicitly state there are no barriers to shipping once the required approvals are in place.

Named international couriers appear across a substantial minority of sites: IATA-compliant packaging or shipping is referenced by 17 of 45, with World Courier, DHL, Marken and FedEx each named by a handful of sites as the carrier used for infectious substance shipment. Only 6 of 45 sites explicitly describe cold-chain or temperature-controlled shipping (dry ice, -80°C, or similar) in this section, which is worth checking directly for any pathogen or

sample type with strict temperature requirements, since the absence of a mention here doesn't necessarily mean the capability doesn't exist elsewhere in the site's operations. Response depth on this question varies enormously, from a two-sentence answer at several sites to detailed, multi-paragraph process descriptions at others (Ethiopia's AHRI, Kenya's VIBRI, South Africa's PHRU), consistent with the broader completeness pattern noted in the Executive Summary.

Quality systems (Section 5)

Quality system maturity, judged by the language used, is reasonably strong across the set: GCLP is referenced by 29 of 45 sites (mainly in the laboratory context) and ISO 9001, 13485 or 15189 certifications by 23 of 45. Most sites describe a structured SOP library covering recruitment, consent, data handling, adverse event management, sample handling and archiving, broadly consistent with the template's own prompt list, though the level of detail in how these SOPs are actually implemented and monitored varies considerably between a one-line list and a described QA/QC governance structure.

On GCP specifically: the questionnaire asks directly about compliance with ICH-GCP E6(R3), and 29 of 45 sites reference the E6(R3) guideline by name in their answer rather than describing GCP compliance only in general terms. Response depth here follows the same pattern as elsewhere in the dataset: the shortest answers (Kenya's CREATES, Burkina Faso's INSTech) are one or two sentences, while the longest (Uganda's MUWRP, Ghana's NMIMR, Ethiopia's AHRI) run to several thousand characters describing a specific governance structure. Across the combined GCP-compliance and staff-training answers, 17 of 45 sites explicitly state that GCP certification is mandatory for trial staff, and 7 of those name a specific recertification cycle (most commonly every 2 or 3 years: Burkina Faso's IRSS/CRUN and Kenya's KAVI-ICR at 2 years, Rwanda's CFHR and South Africa's Wits Vaccine and ID Analytics at 3 years). The remaining sites describe GCP training as routine or ongoing without specifying whether certification is a formal requirement or how often it is renewed, which is worth confirming directly wherever GCP currency of staff is a selection criterion.

23 of 45 sites name a specific regulator they have been inspected by or worked with (MHRA, FDA, EMA, WHO, SAHPRA, NAFDAC or similar); of these, 12 explicitly state a clean or no-major-findings inspection history, and a further 13 mention findings or corrective actions without characterising the overall outcome. The remaining 22 sites describe inspection or audit activity without naming a specific authority, which may reflect completeness of the answer rather than an absence of inspection history, but is worth verifying directly where inspection track record is a selection criterion.

Regulatory and ethics compliance (Section 6)

27 of 45 sites gave a numeric estimate, generally in weeks, for regulatory and/or ethics review timelines; the rest described the process qualitatively. Where these are given, in-country ethics review timelines commonly cluster around 4 to 8 weeks, with several sites noting the option of expedited review for outbreak-relevant protocols.

Explicit experience with joint or expedited regulatory-ethics review during outbreak situations (the AVAREF mechanism used across parts of the continent during COVID-19 and prior Ebola responses) is named by only 5 of 45 sites, though the underlying tick-box answer for "expedited review experience" reads as affirmative for the large majority once free text is taken into account (see Data reliability note). This is a case where the specific named mechanism is a stronger and more verifiable signal than the general tick-box answer. A handful of sites (Gabon's CERMEL; Mali's PMRTC; Rwanda's CFHR; Uganda's Baylor Children's Foundation) left this field unclear, and two (Zambia's Center for Family Health Research; Burkina Faso's INSTech) gave a checkbox answer that reads as a genuine No, not contradicted by supporting text; both are worth a direct confirmation.

Clinical and scientific expertise (Section 7)

Around 26 of 45 sites gave specific numeric staff figures (research physicians, nurses, pharmacists, laboratory personnel); figures range from small teams of a handful of staff at single-site units to double-digit multidisciplinary teams at the larger, multi-centre organisations. The remainder described staffing qualitatively without headcounts, which again limits direct comparison.

Data management and biostatistics support is delivered through an external partnership (rather than fully in-house) at roughly 20 of 45 sites; this is a normal and common model in this sector, not inherently a weakness, but it is worth knowing which partner is involved where data quality or turnaround speed is a concern. Existing relationships with local or regional CROs are reported by the large majority of sites once free text is accounted for; only Nigeria's Institute of Human Virology and Zambia's Center for Family Health Research gave a checkbox answer reading as a genuine No.

Participant safety and risk management (Section 8)

Once free text is accounted for (see Data reliability note), the substantial majority of sites report 24-hour medical coverage, hospital transfer agreements and DSMB experience. Three sites (South Africa's HIDRU and Wits RHI Shandukani; Zambia's Center for Family Health Research) have a checkbox answer for 24-hour coverage reading as a genuine No; the same Zambian site is also the only one reading as a genuine No on hospital transfer agreements, though its free-text answer elsewhere in the same section describes named ambulance providers and tertiary hospital transfer arrangements in detail, an internal inconsistency worth resolving directly with the site rather than taking either answer at face value.

DSMB experience is described in substantive terms by most sites that answered the question, including several with direct DSMB membership experience, not just participation in DSMB-overseen trials. Two sites (Burkina Faso's GRAS; Gabon's CERMEL) left this field, and the related data-sharing consent field, unclear. Occupational health and safety protocols specific to highly contagious pathogen work (staff vaccination, post-exposure prophylaxis, incident reporting) are described in some form by nearly all sites, though the level of operational detail again varies considerably between a one-word "yes" and a fully described protocol.

5. Cross-cutting themes

A small number of patterns recur across every section of the questionnaire, rather than being specific to any one topic. Naming them together here is more useful than leaving them scattered.

- Self-reported data is skewed affirmative. Once free text is accounted for, almost every site answers Yes to the questionnaire's compliance-type questions (24-hour coverage, hospital transfer, DSMB experience, CRO relationships). This is expected of any self-completed RFI and isn't itself a red flag, but it means these binary fields carry little power to distinguish between sites; the narrative detail behind each answer is doing the real work, and that detail is where sites diverge sharply.
- Technology is standardised; reporting of physical infrastructure is not. REDCap and Medidata dominate EDC choice almost universally, but the same consistency doesn't extend to how sites describe bed capacity, staff numbers or BSL level: some give precise figures, others give a qualitative account or a bare "yes". Any comparison on infrastructure criteria needs direct follow-up to be reliable.
- Response depth is the strongest single signal in the dataset. The roughly 15-fold range in submission length correlates loosely with how quantified and specific the

answers are throughout: sites that wrote longer answers to Section 1 tended to also give numeric bed counts, named regulators, and specific staff figures elsewhere. This suggests thoroughness is a property of the submission (and perhaps of who completed it and how much time they had) more than a property of any one section.

- Regional concentration reflects existing research infrastructure, not necessarily current capability elsewhere. Kenya, South Africa and Uganda's dominance of this dataset lines up with where large, long-running, internationally co-funded research programmes (KEMRI, the Wits/SAMRC network, the MRC/UVRI-LSHTM unit) have operated for decades. Sites in thinner-represented countries are not necessarily less capable; they may simply sit outside these established networks, or outside this particular RFI's distribution list.
- Epidemic-pathogen experience is broad but unevenly evidenced. Most sites (39 of 45) can point to relevant pathogen experience, but the strength of that evidence ranges from a named, dated, sponsor-attributed clinical trial (Gabon's CERMEL on Ebola vaccine Phase 1/2; Senegal's SMIT on Ebola ChAd3) to a general, unattributed claim of "experience with outbreak pathogens". Named studies are a far stronger signal than a general claim and are worth asking for specifically wherever the RFI answer doesn't already provide them.
- Checkbox extraction is inherently unreliable for this document type. The correction made to the biosafety table (see Facilities and Infrastructure) is a specific instance of a general point: any tick-box or short categorical answer in these PDFs should be treated as a starting hypothesis to verify against the free text and, ideally, the site directly, not as a settled fact.

6. Notable sites

The sites below stand out for specific reason(s) drawn directly from their submission, not as an overall ranking. They span 12 countries and are listed in alphabetical order by country. The purpose of this RFI was not to recommend or endorse particular sites.

Country	WHO Maturity Level*	Site	Notable strength
Ethiopia	3	AHRI	Established in 1970 through Norwegian and Ethiopian government collaboration; describes a dedicated internal audit and inspection-readiness function as part of its quality system, one of the more structured governance descriptions in the set.
Gabon	Not confirmed	CERMEL	Ran Africa's first Phase 1 trial of the rVSV-vectored Ebola vaccine, with named Phase 1 and Phase 2 paediatric follow-on trials during and after the West African Ebola epidemic; BSL-1/2/3 combined laboratory capability.
Ghana	3	NMIMR	The only site describing a full BSL-1/2/3 laboratory range within one institution, including dedicated facilities for clinical, environmental and zoonotic sample streams.
Kenya	Not confirmed	VIBRI Phase I Clinical Trial Unit	One of the more detailed submissions in the dataset (over 3,000 words on sample shipping and MTA process alone), evidencing a mature, well-documented operating model. However, this is a newer consortium and phase I experience needs further evaluation.

Country	WHO Maturity Level*	Site	Notable strength
Mali	Not confirmed	Center for Vaccine Development – Mali	Operates under a long-standing partnership with the University of Maryland's Center for Vaccine Development and Global Health, PATH and WHO, with named sponsor/CRO oversight arrangements.
Nigeria	3	Institute of Human Virology Nigeria	The only Nigerian site in this dataset; describes a named Phase I HIV vaccine study (PI: Abimiku) and a 540-participant sero-discordant couple cohort, with BSL-2/3 capability.
Senegal	3	SMIT (Fann)	Named, dated ChAd3 Ebola Zaire vaccine trials in adults and children (GSK-sponsored, 2015-2017) alongside a long-standing infectious disease hospital base covering Ebola, cholera and measles.
South Africa	3	PHRU	The most detailed submission in the dataset (around 90,000 characters); its MIRAH laboratory describes validated BSL-3 live-virus neutralisation work using SARS-CoV-2, extending to other viral pathogens of trial interest.
Tanzania	3	Ifakara Health Institute	Institutional history dating to 1956, among the longest of any site in this dataset, with combined BSL-2/3 laboratory capability.
Uganda	Not confirmed	MRC/UVRI-LSHTM Uganda Research Unit	One of the longest-running research units in the set, with decades of rural cohort and surveillance infrastructure in Masaka and Kyamulibwa alongside its Phase I trial capability.
		JCRC	Established in 1991 specifically in response to Uganda's HIV epidemic; one of the few sites to explicitly describe both BSL-2 (pharmacy) and BSL-3 (TB/virology) laboratory facilities.
Zambia	Not confirmed	CIDRZ	Describes a BSL-3 category-3 TB culture lab capability alongside a general BSL-2 lab. A broad Phase I/II vaccine trial portfolio (HIV, TB, rotavirus) run with multiple named sponsors including HVTN.

* Reaching WHO maturity level 3 signifies that a country's regulatory system is considered stable, well-functioning, and integrated. This means there is a robust system in place to ensure the quality, safety, and efficacy of vaccines available to the population, which is crucial for public health.

This is NOT an exhaustive list; it reflects what stood out most clearly from responses in Sections 1 to 8 of the questionnaire, and other sites may have comparable strengths that were simply described less distinctively or less quantifiably in their submission.

7. Conclusions

What this analysis does not do

CEPI did not score or rank sites. Scoring would require weighting criteria (for example, the relative importance of bed capacity versus biosafety level versus prior vaccine experience), and sites should be selected by developers/sponsors. CEPI did not verify any claim made in the questionnaires against external sources (regulatory databases, inspection records, publication history); everything above is a structured read-out of what respondents wrote, not independent verification of it.

Methodology note

CEPI Clinical Development experts screened the RFI questionnaires and performed QC checks. 45 completed RFI questionnaires (PDF) were parsed against the fixed question set used by the CEPI template, matching each question's text as an anchor and extracting the answer that followed it. Where the same information could be compared, structured signals (years of operation, bed counts, BSL level, named EDC platforms, named regulators, tick-box answers) were extracted separately by Claude AI, using pattern matching and checked against the source text; two rounds of correction were applied after direct review against the PDFs found gaps in the initial biosafety-level extraction (see Facilities and Infrastructure). Percentages and counts throughout this document are drawn from this extraction and are only as reliable as that process

The accompanying database, generated from the same underlying data as this summary document, can be used as one of many tools by developers to search for African Phase I capabilities, according to their own criteria. Other factors such as cost, existing sponsor relationships, language, time zone, current site availability, etc, are not reflected in this RFI.

8. Appendix

Refer to the RFI Questionnaire template as well as the searchable database.