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GLS INSIGHTS™

CLINICAL DEVELOPMENT AND GLOBAL HEALTH · BENCHMARK SERIES

The Future of Clinical Trials in Africa

From Opportunity to Execution

Building and Operating High-Performing Research Ecosystems

PART II OF III

PRINCIPLES OF EXECUTION

ECOSYSTEMS

CONVERGENCE

EARLY DEVELOPMENT

QUALITY

TRUST

SUSTAINABILITY

Guosa Life Sciences

Advancing Life Through Better Medicine

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Where Part I Left Off

Part I made the strategic case for Africa. It documented a large and widening representation gap, a continent carrying roughly a quarter of the global disease burden while hosting about 4% of clinical trials, and argued that closing it is one of the most consequential opportunities in global health. It introduced the principles that anchor this series: that representative science drives better medicine, that ecosystems outperform sites, that human capital is the decisive advantage, that trust is strategic infrastructure, and that future patients are future markets. It also closed on a warning: the 2025 withdrawal of major external research funding exposed how much of the continent's capacity remains donor-dependent and financially fragile.

Part II turns from why to how. Recognizing Africa's importance is the first step; realizing it requires an operational discipline that goes beyond site selection and project management. This report addresses the execution questions Part I deferred: how regulatory convergence is reshaping the operating environment, where African science should sit in the development chain, how ecosystems perform under the pressure of a live health emergency, which therapeutic opportunities are emerging, and how to finance capacity that lasts. It carries Part I's threads forward rather than restating them: including the North African ecosystems, the therapeutic opportunities, and the sustainable-financing question reserved from the first report.

A Note on Method and Sources

As in Part I, quantitative claims are referenced to primary sources, intergovernmental and regulatory bodies, peer-reviewed literature, and named institutions, current to 22 July 2026. Forward-looking and commercial estimates are identified as such. Three developments that post-date Part I are integrated here because they materially change the execution picture: the WHO–AMA Framework Agreement for Collaboration signed at the Seventy-ninth World Health Assembly in May 2026, the June 2026 Statement of Cooperation between the African Medicines Agency and the United States FDA, and the 2026 Bundibugyo Ebola outbreak in the Democratic Republic of the Congo and Uganda.

Executive Summary

Execution in Africa has changed faster than most operating models have. Study performance is no longer determined primarily by selecting capable investigators and qualified sites; it is determined by the maturity of the surrounding ecosystem: regulatory collaboration, laboratory networks, referral pathways, digital readiness, workforce depth, community trust, and supply-chain resilience. Sponsors increasingly compete not for sites but for trusted ecosystems capable of delivering predictable quality.

Two structural facts define the execution agenda. First, African clinical research remains concentrated in late-phase studies and infectious disease: of the small share of global trials the continent hosts, most are in Phases III and IV[1], which means representativeness enters the evidence chain near its end rather than its source. GLS Institute argues that the next stage of maturity is to move upstream, into early-phase and first-in-human development, a position we set out as the GLS Early Development Thesis™. Second, regulatory convergence is rapidly becoming the backbone of predictable execution: the African Medicines Agency is operationalizing reliance mechanisms across the continent, signed a Framework Agreement for Collaboration with the WHO in May 2026, and in June 2026 signed a Statement of Cooperation with the United States FDA[2][14].

The stakes are not abstract. As this edition was finalized, a Bundibugyo Ebola outbreak in the DRC and Uganda: declared a public health emergency of international concern on 17 May 2026, with 2,473 confirmed cases and more than 1,000 confirmed deaths in the DRC as of 22 July 2026, and no licensed vaccine or treatment for the strain[7][8]: was being met with an emergency research response: a WHO-coordinated therapeutics protocol inside the outbreak zone, accelerated preparation of continental trial sites, and fast-tracked early-phase vaccine development beginning outside the continent. It is the clearest possible demonstration that trial-ready ecosystems are not a commercial luxury but a component of global health security.

Part II sets out how sponsors build and operate these ecosystems: through regulatory convergence, an early-development posture, designed-in quality, responsible data governance, a sharpened reading of therapeutic opportunity, and, the lesson of 2025, financing that is diversified and locally anchored rather than dependent on any single source. The organizations that master execution will not simply run more studies; they will help determine the representativeness, resilience, and reach of the evidence base itself.

Six Principles of Execution

Part I set out why Africa matters. These six principles govern how to execute there. They extend, rather than replace, the strategic principles of Part I.

Ecosystems Outperform Sites™

Performance follows the maturity of the surrounding ecosystem, regulators, laboratories, referral pathways, workforce, and trust, not the capability of any single site. Execution has evolved from site management to ecosystem management.

Regulatory Convergence Creates Predictability™

Reliance, recognition, and harmonization, now extending to cooperation with the WHO and the US FDA, are turning a fragmented approval landscape into a source of timeline predictability and a genuine competitive differentiator.

The GLS Early Development Thesis™

Africa's participation is concentrated in late-phase studies. The frontier of maturity is upstream: early-phase and first-in-human development that captures representativeness at the source of the evidence chain.

Quality Is Designed, Not Inspected™

Quality is most effective when embedded in study design, through risk-based quality management, centralized monitoring, and analytics, rather than assessed retrospectively through monitoring alone.

Trust Is Strategic Infrastructure™

Community trust is operational infrastructure. It governs recruitment, retention, adherence, data quality, and, as outbreak response shows, the speed at which an ecosystem can mobilize under pressure.

Sustainable Capacity Outlasts Single Studies™

The 2025 funding shock proved that donor-dependent capacity is fragile. Durable performance depends on diversified, locally anchored financing and capability that survives the end of any one program.

SECTION I

Why Execution Strategies Must Change

Traditional operating models assume that successful execution depends mainly on choosing capable investigators and qualified sites. That assumption is increasingly incomplete. Modern study performance is shaped by the maturity of the surrounding ecosystem, and successful sponsors now evaluate regional regulatory collaboration, laboratory networks, referral pathways, digital readiness, workforce depth, community engagement, and supply-chain resilience as a single interdependent system.

The implication is a shift in the unit of management. Execution has moved from site management to ecosystem management. A capable investigator embedded in a weak ecosystem will underperform; a strong ecosystem makes ordinary sites reliable. This is why sponsors increasingly compete less for individual sites and more for trusted ecosystems able to deliver predictable quality over time.

> **EXECUTIVE INSIGHT**
> *Sponsors no longer compete only for sites. They compete for trusted ecosystems capable of delivering predictable quality and enduring partnerships.*

The GLS Clinical Development Delivery Model

Delivery in this model flows from sponsor strategy through the ecosystem to impact, each stage dependent on the one before it. Operational excellence is the link in the middle, not the whole chain.

Figure 1. The GLS Clinical Development Delivery Model. *Source: GLS Institute. A descriptive device, not a separate mark.*

SECTION II

Regulatory Convergence as Execution Infrastructure

For sponsors, the single most consequential change in Africa's operating environment is regulatory. A landscape that once required separate, sequential approval in every country is consolidating into a system of reliance, recognition, and harmonization. This is not an administrative footnote; it is execution infrastructure that directly shapes timelines, cost, and predictability.

The Continental Backbone: the African Medicines Agency

The African Medicines Agency (AMA), whose treaty entered into force in November 2021 and had been ratified by 31 member states by the end of 2025, is being implemented in phases, Foundation (2024–2025), Expansion (2026–2030), and Maturity (2031 onward)[3]. Its design is deliberately suited to Africa's legal diversity: continental coordination combined with voluntary national implementation, enabling progressive convergence without overriding national sovereignty[3]. Its first Director-General, Delese Mimi Darko, previously led the Ghana FDA, the agency that became the first in the world to license the R21 malaria vaccine.

Two Bridges: the WHO–AMA and AMA–US FDA Agreements

In May 2026, at the Seventy-ninth World Health Assembly, the WHO and the AMA signed a Framework Agreement for Collaboration advancing harmonization, convergence, and reliance across African regulatory systems[14]. One month later, in June 2026, the AMA and the United States FDA signed a Statement of Cooperation establishing a formal framework for regulatory information exchange and convergence[2]. Signed by Director-General Darko and Mark Abdoo, the FDA's Associate Commissioner for Global Policy and Strategy, it builds on the FDA African Medicines Agency Liaison Office (AMALO) at the US Embassy in Kigali. For sponsors, the practical significance is direct: structured information-sharing and the prospect of African regulators relying on FDA assessments reduce duplication and improve predictability for programs spanning both jurisdictions. The agreements arrive as Africa's pharmaceutical market is projected to exceed USD 50 billion by 2030[2], underscoring why coordinated oversight matters commercially as well as scientifically.

Regional Blocs and Reliance in Practice

Beneath the continental layer, regional harmonization is already operational. In 2025, seven of Africa's leading national regulators, Ghana's FDA, Nigeria's NAFDAC, the Rwanda FDA, Senegal's ARP, South Africa's SAHPRA, Tanzania's TMDA, and Zimbabwe's MCAZ, signed a reliance memorandum committing to work-sharing and mutual recognition of assessment reports[4]. These are seven of the eight African authorities assessed at WHO maturity level 3; Egypt is the eighth. They build on established mechanisms such as the East African Community initiative and the SADC ZaZiBoNa program. External validation is visible too: Ghana attained WHO maturity level 3 and Regional Centre of Regulatory Excellence status, after which industry-sponsored trial participation in the country more than tripled[5].

North Africa: Completing the Map

Part I reserved North Africa from its profiles. It belongs here, because Egypt is one of the three countries that together host roughly 70% of African clinical research. Egypt regulates trials through the Egyptian Drug Authority under a modern legal framework, Clinical Trials Law No. 214/2020 and its executive regulations, applying ICH E6 Good Clinical Practice[12]. A large, partly treatment-naive population, a high cardiometabolic and oncology burden, and an experienced investigator base at academic hospitals such as Ain Shams, Cairo University, and Alexandria University make it one of the continent's most active environments, particularly in oncology. Egypt's maturity reinforces a central point: "Africa" is not one ecosystem, and execution strategy must read its regions distinctly.

Table 1. Africa's regulatory architecture for sponsors: layers of convergence.

Layer	Mechanism	What it means for execution
Continental	African Medicines Agency (AMA); WHO–AMA Framework Agreement (2026); AMA–US FDA cooperation (2026)	Reliance on FDA and peer assessments; information-sharing; reduced duplication across jurisdictions
Regional, East	EAC Medicines Regulatory Harmonization	Joint assessment and work-sharing across Kenya, Tanzania, Uganda, Rwanda and partners
Regional, West	ECOWAS / WA-MRH; NRA reliance MoU	Strengthening institutional capacity across Ghana, Nigeria, Senegal and others
Regional, South	SADC ZaZiBoNa	Collaborative registration anchored by SAHPRA and regional regulators
National (exemplars)	Ghana FDA (ML3 / RCORE); SAHPRA; NAFDAC; EDA (Egypt)	Mature national authorities applying ICH-GCP; reference points for reliance

EXECUTIVE INSIGHT

Regulatory convergence should be read as a strategic opportunity, not an administrative development. The sponsors who engage it early: continental, regional, and now trans-Atlantic — convert a former barrier into predictability.

SECTION III

The GLS Early Development Thesis™

Africa's clinical research is concentrated at the wrong end of the development chain. The studies the continent hosts are predominantly late-phase, Phases III and IV, and weighted toward infectious disease[1]. The consequence is structural: when African populations enter only at the late stage, representativeness is added near the end of the evidence chain rather than built in at its source. The continent that contributes under 2% of the genomic data in research[1] is largely absent from the early-phase work where dose, safety, and biology are first characterized.

GLS Institute's position is that the next stage of ecosystem maturity is to move upstream, into early-phase and first-in-human development. Early-development capability is the difference between an ecosystem that *executes other people's science* and one that *originates its own*. It is also where representativeness is most scientifically valuable: characterizing pharmacology and safety in the populations who will ultimately use a therapy, rather than extrapolating to them afterwards.

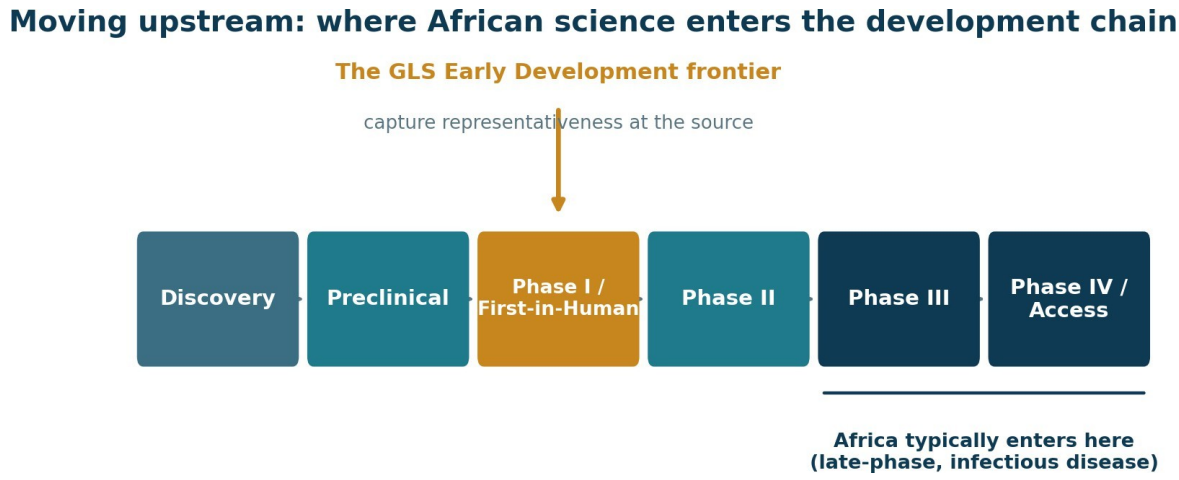

Figure 2. Where African science enters the development chain, and where the opportunity lies. *Source: GLS Institute.*

This is not aspiration without precedent. In January 2026, South Africa launched the BRILLIANT 011 first-in-human HIV vaccine trial in Cape Town: an African-led early-phase study, designed and run by African scientists and predominantly directed by African women, testing immunogens developed through international collaboration and first identified in African trial participants[6]. The 2026 Ebola response (Section IV) is a second test: it has accelerated trial-site preparation, GCP training and laboratory readiness on the continent, while the first Phase 1 vaccine studies for the outbreak strain began outside it, a precise illustration of the gap this thesis identifies. The capability exists; the thesis is that sponsors and ecosystems should treat early development as a deliberate strategy rather than an exception.

THE GLS PERSPECTIVE

An ecosystem that can only run Phase III is a destination for finished science. An ecosystem that can run first-in-human studies is a partner in creating it. Early development is where representativeness, and competitive advantage, begin.

SECTION IV

Execution Under Pressure: Health Security and the 2026 Ebola Outbreak

The clearest test of an ecosystem is an emergency. On 15 May 2026 the Democratic Republic of the Congo declared its seventeenth Ebola outbreak, caused by the Bundibugyo virus, a strain for which no licensed vaccine or specific treatment exists. The World Health Organization declared a public health emergency of international concern on 17 May, and Africa CDC declared a public health emergency of continental security the following day[7][8]. As of 22 July 2026, the DRC had confirmed 2,473 cases and more than 1,000 confirmed deaths; Uganda, which recorded a small cross-border cluster, discharged its final patient on 16 July and entered the 42-day countdown to declaring its outbreak over[8]. The DRC outbreak is unfolding in a conflict-affected region, and while contact tracing has reached roughly 82% of identified contacts, insecurity continues to constrain case-finding, a reminder that execution and context are inseparable.

What makes this relevant to clinical development is that the response is, in part, clinical development. With no approved countermeasures, the Coalition for Epidemic Preparedness Innovations fast-tracked vaccine candidates from IAVI, Moderna, and the University of Oxford, and a WHO-coordinated trial protocol was deployed in the DRC to evaluate therapeutics during the outbreak[7][8]. The first Phase 1 study of the Oxford candidate opened in the United Kingdom rather than in the affected region. Africa CDC and WHO launched a six-month continental response plan, and preparedness work explicitly included identifying clinical trial sites, training health workers in Good Clinical Practice, and strengthening laboratory diagnostic capacity[7].

The execution lesson is unambiguous. Outbreak response is early-phase clinical development conducted under the worst possible conditions, and it cannot be improvised. It depends on capabilities that must be pre-positioned: a GCP-trained workforce, laboratory and diagnostic capacity, agile regulatory pathways, resilient supply chains, and, decisively, community trust deep enough to support enrollment and follow-up during a crisis. Every one of these is an ecosystem asset built in peacetime. That the first-in-human work for this strain began offshore is not a criticism of the response; it is the measure of the gap that pre-positioned early-development capability would close. Trial-ready ecosystems are therefore not only a commercial proposition; they are infrastructure for global health security, and the case for building them is strongest precisely when they are hardest to build.

> **THE GLS PERSPECTIVE**
> *An outbreak is an audit of everything an ecosystem built before it arrived. Workforce, laboratories, regulatory agility, and trust cannot be created mid-emergency. The continent's trial-readiness is, increasingly, the world's health security.*

A note on sensitivity and currency: the figures above describe an active emergency affecting real communities. They are presented to make an operational point about preparedness, not to reduce a humanitarian crisis to a business case. They are current as of 22 July 2026 and will change; readers should confirm the latest WHO and Africa CDC situation reports.

SECTION V

Therapeutic Opportunities

Part I promised a closer look at where the therapeutic opportunities lie. They are being reshaped by an epidemiological transition: as life expectancy rises and lifestyles shift, the burden of non-communicable disease in sub-Saharan Africa rose by roughly 67% between 1990 and 2017. WHO's Regional Office for Africa estimates that illness of all kinds cost the region more than 2.4 trillion international dollars in lost output in 2015, of which non-communicable diseases accounted for about 37%, on the order of 0.9 trillion international dollars a year[10]. Yet African trials remain concentrated in infectious disease. The gap between disease burden and research focus is itself the opportunity.

Sickle Cell Disease: a Burden the World Under-Studies

No therapeutic area illustrates the mismatch better than sickle cell disease. Sub-Saharan Africa carries an estimated 75–80% of the global SCD burden[9], yet most therapeutic innovation has been developed and trialed elsewhere. The opportunity is concrete and already moving: after Ghana reached WHO maturity level 3, industry-sponsored trial participation in the country more than tripled, with a notable rise in sickle cell studies[5]. A disease defined by African genetics is precisely the kind of area where representative early-phase research is both a scientific necessity and a strategic opening.

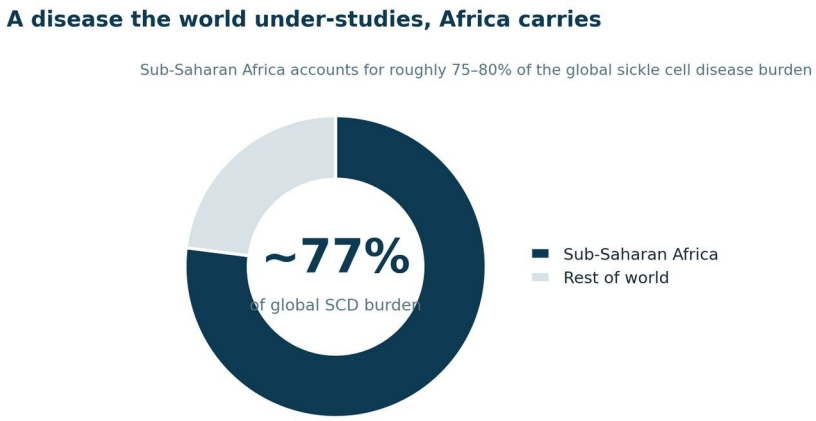

Figure 3. Sub-Saharan Africa's share of the global sickle cell disease burden. *Source: Global Burden of Disease 2021, via peer-reviewed analysis.*

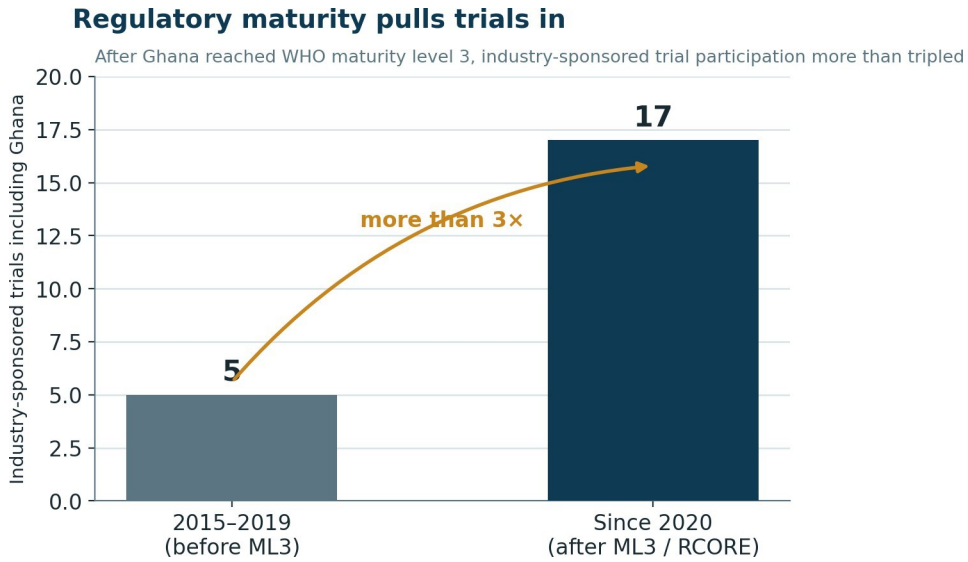

Figure 4. Industry-sponsored trials including Ghana, before and after WHO maturity level 3. *Source: Access to Medicine Foundation, 2025.*

Oncology, Cardiometabolic Disease, and Beyond

Cancer is now a formidable burden in sub-Saharan Africa, driven by rising incidence and longer life expectancy, and African patients more often present at later stages with poorer outcomes, a disparity that representative oncology trials could begin to close[11]. Cardiometabolic disease, women's health, and continued vaccine and infectious-disease leadership round out a diversifying opportunity set. The table below maps where Africa's burden and research interest are converging.

Table 2. Where therapeutic opportunity is concentrating.

Therapeutic area	Why Africa	Illustrative anchor
Sickle cell disease	~75–80% of global burden; defined by African genetics	Rising SCD trial activity in Ghana post-ML3
Oncology	Rising incidence; later-stage presentation; under-studied populations	AORTIC trial network; Egyptian oncology centers
Cardiometabolic	Large, partly treatment-naive populations; rapid NCD growth	Egypt, Nigeria diabetes/CVD burden
Vaccines & infectious disease	Established capability; health-security imperative	R21 malaria; BRILLIANT HIV; Ebola response
Women's & maternal health	High burden; strong community-engagement infrastructure	Noguchi and KEMRI-Wellcome programs

EXECUTIVE INSIGHT

The therapeutic opportunity is the inverse of the representation gap: the areas where Africa is most under-studied relative to its burden, sickle cell, oncology, cardiometabolic disease, are precisely where representative evidence is worth most.

SECTION VI

Quality, Data, and Digital Execution

Historically, monitoring was treated as the primary mechanism for ensuring study quality. Modern clinical development inverts that logic: quality is most effective when designed into a study rather than inspected after the fact. Risk-based quality management, centralized monitoring, digital oversight, analytics, and continuous improvement move quality assurance from a retrospective audit to a built-in property of the protocol.

Figure 5. Quality by Design. *Source: GLS Institute. A descriptive device, not a separate mark.*

Data and Genomic Governance

As development becomes more data-intensive, competitiveness will depend on the responsible stewardship of clinical data, genomic information, biospecimens, and intellectual property. This is not merely a compliance matter. Africa hosts the world's most genetically diverse populations yet contributes under 2% of genomic research data[1]; how that data is governed, with transparency, respect for national legislation and participant rights, and equitable benefit, will determine whether early-development science can be conducted on the continent at all. Responsible data governance is becoming a source of scientific credibility and competitive advantage, not a constraint on it.

Digital and AI as Complements, Not Substitutes

Electronic source documentation, remote and centralized monitoring, decentralized trial components, wearables, and AI-enabled analytics are expanding what is operationally possible. But digital transformation should complement, never replace, local expertise and community engagement. Technology extends the reach of a trusted ecosystem; it cannot manufacture trust where none has been built.

> **EXECUTIVE INSIGHT**
> *Designed-in quality and responsible data governance are not overheads. In an early-development ecosystem, they are the license to operate.*

SECTION VII

Sustainable Financing After the Funding Shock

Part I closed on the 2025 funding shock: the abrupt withdrawal of major external research funding, which hit South Africa hardest and exposed how much of the continent's capacity had been built on donor finance. Cumulative NIH investment in South African HIV and TB research alone had been estimated at roughly USD 2 billion over twenty years, and its withdrawal forced local institutions to assume leadership far faster than planned[13]. For an execution-focused report, the lesson is operational, not only financial: capability that depends on a single external source is not resilient capability.

The constructive response is a pivot toward diversified, locally anchored financing. Three levers are visible. Regulatory consolidation under the AMA is helping convert fragmented national markets into a continental one projected to exceed USD 50 billion by 2030[2], improving the economics of local investment. Local manufacturing is advancing, the Serum Institute of India is establishing vaccine production in Accra, shortening supply chains and retaining value on the continent. And reliance-based regulation reduces duplicative cost, freeing resources for capability rather than paperwork. None of this replaces external partnership; it rebalances it toward sustainability.

> **THE GLS PERSPECTIVE**
> *Sustainable capacity creates sustainable performance. The ecosystems that endure will be those financed to outlast any single sponsor, grant, or election, a lesson 2025 taught at considerable cost.*

SECTION VIII

Risks and Execution Headwinds

As in Part I, the case for execution is credible only if its obstacles are stated plainly. Four headwinds bear directly on delivery.

- **Financing fragility.** The 2025 shock is not fully resolved; capability built on narrow funding bases remains exposed, and the pivot to sustainable financing is early.
- **Instability and access.** The 2026 Ebola outbreak is unfolding in a conflict zone where insecurity has constrained case-finding and follow-up, a concrete illustration that security and humanitarian conditions can limit even well-designed execution.
- **Concentration and uneven maturity.** With roughly 70% of research in three countries and regulators at very different maturity levels, ecosystem strength is unevenly distributed; reliance mechanisms are promising but not yet uniformly mature.
- **Workforce retention.** Early-development ambition depends on specialized talent that is mobile and scarce; funding instability accelerates its loss.

THE GLS PERSPECTIVE

These headwinds do not weaken the execution case; they specify it. The advantage goes to sponsors who build for resilience, diversified financing, distributed capability, and trust, rather than for any single favorable condition.

The Sponsor Playbook

Translating the preceding sections into practice, organizations building long-term execution capability in Africa should:

1. **Evaluate ecosystems, not individual sites.** Assess regulatory maturity, laboratories, workforce, and trust as a system; site quality follows ecosystem strength.
2. **Engage regulatory convergence early.** Design for reliance, continental (AMA), regional (EAC, ECOWAS, ZaZiBoNa), and now trans-Atlantic (AMA–FDA), from the protocol stage.
3. **Build an early-development posture.** Where the science allows, bring first-in-human and early-phase work to African ecosystems to capture representativeness at the source.
4. **Design quality in.** Adopt risk-based quality management and centralized monitoring rather than relying on retrospective inspection.
5. **Govern data responsibly.** Treat genomic and specimen governance as a license to operate and a source of credibility, respecting national law and participant rights.
6. **Match therapeutic strategy to burden.** Prioritize areas: sickle cell, oncology, cardiometabolic — where Africa is most under-studied relative to its disease burden.
7. **Finance for sustainability.** Favor diversified, locally anchored funding and local capability over single-source, donor-dependent models.
8. **Treat trust as operational infrastructure.** Resource community engagement with the rigor applied to laboratories and data systems.

The GLS Sustainable Clinical Development Cycle

Done well, execution compounds: partnerships build trust, trust enables excellence, excellence produces representative evidence and impact, and the value generated is reinvested in the ecosystem that created it.

Figure 6. The GLS Sustainable Clinical Development Cycle. *Source: GLS Institute. A descriptive device, not a separate mark.*

Strategic Outlook and Looking Ahead

Africa's role in clinical development will be shaped not only by scientific capability but by the quality of partnerships, the depth of regulatory collaboration, the responsible adoption of digital tools, and sustained investment in people. Organizations that move from transactional execution to ecosystem stewardship, and that have the discipline to build early-development capability and finance it to last — will be best positioned to generate stronger evidence, improve predictability, and contribute to durable healthcare innovation.

Part III · The Future Architecture of Global Clinical Development: How Research Ecosystems Evolve — Outlook 2035.

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About the Author

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Charles Oviawe is a global clinical research executive and quality systems professional with more than two decades of experience supporting pharmaceutical, biotechnology, government, and global health organizations across the clinical development lifecycle.

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Before founding Guosa Life Sciences, he held senior quality assurance and research and development leadership positions with Pfizer, Acadia, Shionogi Inc., BeyondSpring, and Forest Laboratories, supporting global clinical development programs across multiple therapeutic areas and contributing to inspection readiness, quality systems implementation, and global regulatory compliance.

Through Guosa Life Sciences he has advised pharmaceutical sponsors, biotechnology companies, contract research organizations, academic institutions, and public health organizations on clinical operations, quality systems, regulatory strategy, pharmacovigilance, and global research capacity development.

He is the architect of the GLS Clinical Development Network and the African Early Phase Clinical Research Network, initiatives designed to strengthen evidence-based institutional qualification, foster scientific collaboration, and expand sustainable Phase I clinical research capacity across Africa and other emerging markets.

About GLS Institute

GLS Institute is the clinical development and global health research division of Guosa Life Sciences. Its benchmark publications examine the forces reshaping where and how medicines are developed, with the aim of advancing better life through better medicine.

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About Guosa Life Sciences

Advancing Global Clinical Development Through Local Expertise

Guosa Life Sciences is a global contract research organization and strategic consulting firm supporting pharmaceutical, biotechnology, medical device, diagnostic, and global health organizations throughout the clinical development lifecycle.

GLS delivers integrated services spanning Phase I through Phase IV clinical research, regulatory affairs, quality assurance, pharmacovigilance, laboratory oversight, biometrics, medical writing, project management, logistics, and strategic advisory services.

With headquarters in the United States and an operational footprint across Sub-Saharan Africa and Asia, together with strategic partnerships in Europe, the Middle East, and other emerging markets, GLS combines global quality standards with in-country operational expertise.

Core service areas

- Clinical operations
- Quality assurance and compliance
- Regulatory affairs
- Pharmacovigilance
- Medical and scientific affairs
- Data management and biostatistics
- Laboratory services
- Supply chain and logistics
- Project management
- Global health research
- Strategic consulting

Strategic initiatives

GLS Clinical Development Network (GLS-CDN). A collaborative operational network connecting qualified research institutions, investigators, laboratories, and operational specialists to support evidence-based institutional qualification and multi-country clinical development.

African Early Phase Clinical Research Network (AE-PCRN). A scientific collaboration focused on strengthening Phase I clinical research readiness, institutional capacity, and sustainable early clinical development across Africa through collaboration, training, and evidence-based institutional qualification.

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