RESOLVE TO SAVE LIVES

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Preparing to save lives

Boosting civil society advocacy for domestic investment in epidemic preparedness

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Since 2018, Resolve to Save Lives (RTSL) and the Global Health Advocacy Incubator (GHAI), in partnership with over a dozen African civil society organizations, have worked to increase domestic funding for epidemic preparedness. These efforts have produced key wins in nine countries and led to a budding ecosystem of civil society organizations equipped as advocates across the continent — showcasing that securing political commitments and increased national investments in epidemic preparedness is possible when civil society mobilizes strategically. (See map on page 4).

Key wins, 2018-2025

Nigeria (Federal)

- Federal epidemic preparedness budgets up 1/3 since 2021. Near tripling of Nigeria CDC budget from ₦1.5B to 4.4B (US$4.1M to 4.8M) since 2019

Kano state (Nigeria, subnational)

- Establishment and two-thirds increase in epidemic preparedness budget from ₦300M to ₦500M over the span of 3 years (US$ 777 K to 556K) Establishment of Kano CDC, with ₦1B (US$1.1M) budget in 2024.

Lagos state (Nigeria, subnational)

- Creation of an epidemic preparedness budget line, increasing over the span of 2 years to ₦3.2B (US$ 3.5M) after some inital ups and downs.

Senegal

- Tripling of budget for the Public Health Emergency Operations Center from CFA 50M to CFA 150M (US$ 87K to 256K)

Uganda

- UGX 57.8M (US$ 15.4M) newly budgeted and dedicated to COVID-19 response and epidemic preparedness (2024)

Nigeria / Ethiopia / Ghana

- Establishment of epidemic preparedness funds at local level in 50 localities

Program origins

The need for additional domestic health funding has long been recognized; in the 2001 Abuja Declaration, African leaders pledged to spend 15% of their budgets on the health sector. Yet, while the HIV/AIDS crisis and the West Africa Ebola epidemic spurred international financial and technical support to improve outbreak responses capabilities in African countries, these important advances did not, in most cases, lead to increased domestic funding epidemic preparedness. Public health budgets have remained heavily subsidized by bilateral and multilateral donors, leaving epidemic preparedness and response under-resourced and vulnerable to shifts in external funding priorities.

Despite significant upgrades to epidemic preparedness and response systems due to intra-continental solidarity, dedicated domestic public health workers, and external support as documented in the Epidemics That Didn't Happen (ETDH) series, the largest portion of funding has remained focused on response rather than preparedness. And while there has been some donor funding for preparedness, particularly for increased surveillance capacities or training for field epidemiologists and response teams, the majority of international support has remained focused on responding to epidemics. Domestically, funds would often only be allocated once an outbreak had happened, despite clear evidence that preventing outbreaks from becoming epidemics is far more cost effective than responding once an outbreak has spread.[1] The clear next step was to focus on preparedness. It was in this context that in 2018, RSTL and GHAI began to explore the feasibility of increasing domestic investment in preparedness.

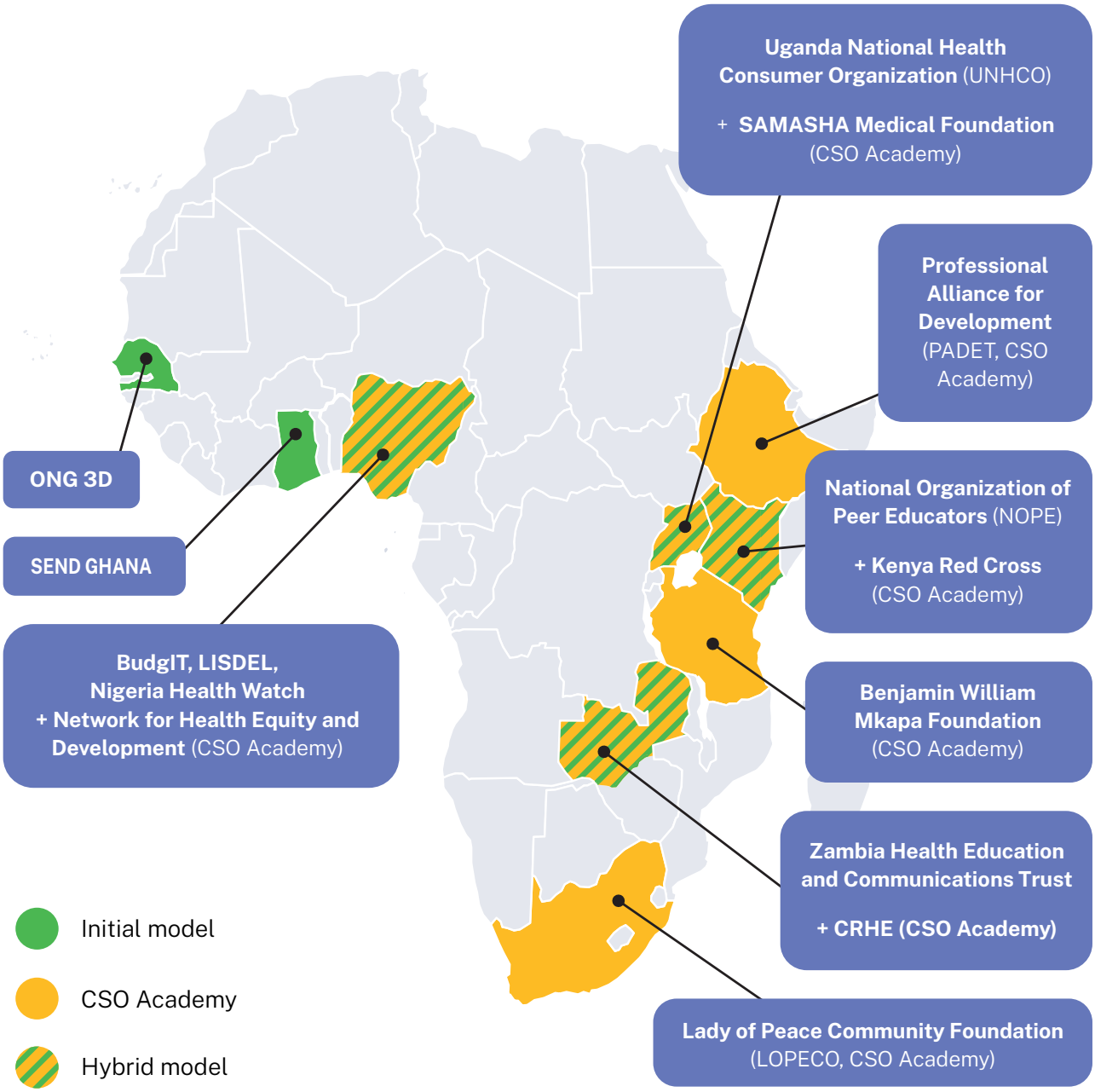
It was nil. Zero. This year, even for response [Kalu Woreda] didn't allocate any budget.

But after having a discussion they understood the need and urgency for allocating for epidemic preparedness and response. Now they say they understand the use of preparedness and that is why they allocated this budget.

– Yemisirach Tadesse Timihirte
Program Manager,
Professional Alliance
for Development

1 https://www.fic.nih.gov/News/GlobalHealthMatters/january-february-2021/Pages/peter-daszak-pandemic-prevention.aspx#:~:text=The%20cost%20of%20COVID%2D19,be%20about%20100%20times%20less.

Partners



Countries didn't know how much was being spent on epidemic preparedness, and very little of it was domestic money.

This motivated us to test an advocacy model to see if we could get results, including having governments investing in their own preparedness.

– **Marine Buissonnière**, Senior Advisor, Prevent Epidemics, Resolve to Save Lives

Key activities and outcomes

Activities		Results
	2018	
Budget advocacy begins in support of the **Nigeria** CDC (NCDC)	January	
Budget advocacy begins in support of **Senegal**'s Emergency Operations Center 2019	June	
	2019	
	January	**Nigeria** approves US$4.1M for NCDC
	2020	
	August	**Senegal**'s Emergency Operations Center budget nearly triples to US$256K
Budget Advocacy begins in Kano State, **Nigeria**	September	
Budget advocacy begins in **Ghana**	September	
	2021	
	January	**Nigeria** allots $30M to health security at the federal level Kano State allocates $777,000 to Epidemic Preparedness and Response (EPR) 44 localities allocate a total of $228,000 to EPR
	January	Three districts in **Ghana** allocate a total of US$40K for EPR (from US$OK)
Budget Advocacy begins in Lagos State, **Nigeria**	April	
Launch of **Budget Advocacy Framework for Epidemic Preparedness**	September	
	2022	
	January	**Nigeria**, Lagos State creates a new El budget line (allocates US$12.2M, later reduces it to US$109K)
Launch of **Budget Advocacy Toolkit for Epicemic Preparedness**	June	
	2023	
	January	Three districts in **Ghana** increase EPR budgets by 330%, 260%, 46% Two more district establish EPR budget lines totaling US$26.7K (from US$OK)
Budget acvocacy (ighter model) begins in **Uganda** to support the PHFOC	May	
Launch of the **Budget Advocacy Toolkit for Epidemic Preparedness**: Facilitator's Guide	December	
	2024	
	January	Federal health security budget up 1/3 since 2021 NCDC budget reaches N4.1B tripled since 2019) Lagos EPR budget increases to US$3.5M Kano CDC established with US$1.1M budget
	May	**Uganda** approves US$15.4M dedicated to COVID-19 response and EPR
CSO Budget Advocacy Academy begins with 14 participants from 7 countries	May	
	2025	
	January	Kalu Woreda, Ethiopia increases EPR funding $4K (from $0), the result of a **CSO academy** capstone project.
	March	**CSO Academy** capstones conclude, having estaol shed local EPR budget lines, accountability tools, and planning documents.

Nigeria Senegal Ghana Budget advocacy toolkit/framework Uganda CSO budget advocacy

Testing the waters

Nigeria, Senegal and Ghana

Nigeria

In early 2018, advocacy work started in Nigeria**,** a large, federated state confronting significant epidemic risks that presented unique advocacy challenges and opportunities. The Nigeria Centre for Disease Control (NCDC), established in 2011was operating without clear legal authority or a regular budget allocation; instead, it relied on ad hoc support from the Ministry of Health. RTSL began supporting the NCDC shortly after the country's first Joint External Evaluation (JEE) in 2017. RSTL had a strong technical presence supporting the inaugural Director General of the NCDC, while GHAI had a track record of success using a CSO-led advocacy model in Nigeria under the Campaign for Tobacco Free Kids. This combination of need and assets, in addition to the country's strong public health leadership and vibrant civil society space, made Nigeria an ideal testing ground for a CSO-led advocacy approach.

Each member of the coalition — the RTSL teams, GHAI in-country coordinators, and CSO partners — BudgIT, which focuses on budget analysis and transparency; Nigeria Health Watch , with expertise in media engagement; and later LISDEL, focused on legislative advocacy — brought complementary expertise. While GHAI had a tested multi-year and multi-prong advocacy model on other issues, this type of epidemic preparedness funding advocacy was new; the group developed and refined the model over time.

Together, the coalition engaged a range of stakeholders — including traditional and social media, local and federal elected officials, federal ministries and both houses of the Nigerian National Assembly, and others — to push for dedicated funding for epidemic preparedness and elevate the importance of epidemic preparedness to the attention of the public (including by linking the issue to ongoing outbreaks). To the coalitions benefit, the NCDC Act passed as the campaign began,paving the way for the NCDC budget to become formalized. NCDC was a true cornerstone of this work, advising on needs and working hand-in-hand on developing plans and capabilities. The advocates kept the issue on the front burner in a busy landscape, supporting media through trainings and awards to encourage better-informed reporting on issues of epidemic preparedness. By 2024, advocates had succeeded in nearly tripling the NCDC budget, all while other elements of epidemic preparedness budgets also increased due to improvement in the quality of budget requests.

Funding for NCDC has been stable because of advocacy early on.

One of the things we did was a budget process mapping to understand the various steps involved in the budget cycle and also to identify the various sticky points where there were likely to be bottlenecks or bureaucratic issues due to competition for the same pot of funds.

– Prof. Emmanuel Alhassan, Nigeria Coordinator, Prevent Epidemics, Global Health Advocacy Incubator

Kano/Lagos

With RSTL developing a focus on strengthening capacities at the subnational level, the application of budget advocacy methods to Kano and Lagos States began in 2020. BudgIT, LISDEL, and Nigeria Health Watch joined the state-level work, supported in Kano State by GHAI's in-state coordinator. In 2024, Kano State established the Kano CDC , the first state-level public health institute in Africa. Advocates in both states secured tremendous increases in epidemic preparedness budgets; in Kano, each local government also established a preparedness budget line.

But advocates knew from the beginning that increases in funding alone would not be sufficient. Once money is allocated, the funding needs to be released by the government. The Ministries, Departments, and Agencies (MDAs) to which funding is allocated need well-prioritized plans to spend the money, and capacity to absorb it. Spending needs to be tracked in a transparent manner to ensure that the proposed activities are implemented, and to identify glitches and gaps to advocate for improved utilization. In some cases, there are also stringent requirements that agencies such as the NCDC and states must meet to receive federal funds. Finally, effective budgeting is a dynamic process that requires ongoing vigilance and accountability to ensure allocations are sustained over time.

The teams in Nigeria addressed these issues together with the MDAs that were allocated funding, ensuring memos needed to release allocated funds were issued at the national and state level. They supported both the NCDC and states to meet the requirements to access federal funding. They worked with MDAs that needed funding to draft annual budget requests backed up by effective implementation plans. Advocates participated in national-and state-level JEEs to understand gaps in preparedness and in the drafting of costed National Action Plans for Health Security (NAPHS) and advocated for spending accordingly.

To further bolster budget accountability, LISDEL created the Health Security Accountability Framework, validated in June 2022. The framework has been used to track allocations and spending and informs campaign planning by helping to identify bottlenecks. LISDEL, working with BudgIT, initially managed the Framework at the federal level and in Kano State; Kano State now has an platform to review the Framework with a coalition of CSOs who populate the framework, and it is becoming a key tool. (For more information, see page 15 Scaling the Model: the CSO Budget Advocacy Academy.)

Though domestic preparedness funding advocacy has created important change across Nigeria since 2018, increasing its ability to prevent outbreaks through technical support and increased investments in preparedness, advocates faced some setbacks. In some years budget lines were decreased — in some cases due to shifting political priorities — which took redoubling of efforts to

In the past, health reporting was often sensational and lacked depth.

Throughout the project, we consistently worked to change this by training journalists through masterclasses, fellowships, and other tools that introduced the concepts behind health security... This helped advance the agenda of preventing infectious disease outbreaks in the country.

– Ibukun Oguntola,
Program Manager,
Nigeria Health Watch

restore. Nonetheless, over more than seven years, the Nigeria advocates continued to engage with the public, communities, parliamentarians, government officials from the executive, and the media to keep epidemic preparedness funding at the front of the policy agenda, changing the discussion on and landscape for epidemic preparedness funding.

Work in Senegal launched in June 2018.

The government of Senegal was planning to increase tobacco levies, with the potential for additional resources to be channeled to health. This effort was supported by a GHAI in-country consultant who worked in collaboration with ONG 3D, a CSO focused on improving public health, development, and human rights.

The advocacy model in Senegal was similar to Nigeria's. The team identified budget lines that could support the Centre des Opérations d'Urgence Sanitaire (COUS), Senegal's Public Health Emergency Operations Center — then heavily dependent on US funding — as well as other components of epidemic preparedness. To advance this goal, ONG 3D brought together like-minded CSOs to create a civil society alliance–Coalition des Organisations de la Société civile pour la Prévention des Épidémies et la gestion des Catastrophes (COSPEC).

This passionate team of advocates met regularly with COUS and other public health officials to understand gaps in preparedness and to strategize about how to support increased allocations. They met with parliamentarians to educate them about the need for support for epidemic preparedness and held trainings for journalists covering related issues. ONG 3D raised awareness about epidemic preparedness and created further momentum for change with a series of video reports for the public shown on national television program "Focus.". The head of ONG 3D made the case in person with Senegal's president, Macky Sall — an effort that was well received. Advocates went further by creating an evidence-based proposal "Project to Support the Management of Health Crises and Emergencies in Senegal" or PAPCCUSS, that created an expansive vision of what domestic preparedness funding could do in the country. PAPCCUSS proposed a five-year investment of US$10.5M (5.87B CFA) and it was included in the Ministry of Health's Public Investment Program for 2021-2023.

In 2020, the COUS and other MDAs supporting epidemic preparedness in Senegal received increased funding — for the first time since the COUS' creation in 2014 — thanks in part to COSPEC's strategic campaigning, which primed leaders to recognize both the importance of this well targeted investment and its relevance to their constituents. However, the new funding fell short of the PAPCCUSS

ONG 3D recognized the power of engaging elected politicians through their constituencies to build genuine political buy-in for epidemic preparedness

By connecting the issue directly to the needs and concerns of the people they represent, the campaign translated awareness into concrete support — demonstrating how grassroots engagement can shape policy and drive change.

– Marine Buissonnière,
Senior Advisor,
Prevent Epidemics,
Resolve to Save Lives

proprosal and came at the start of the COVID-19 outbreak. Competing priorities and political divisions left the work of securing sustained resources for preparedness unfinished.

As the campaign in Senegal finished, work began in Ghana, following a similar model.

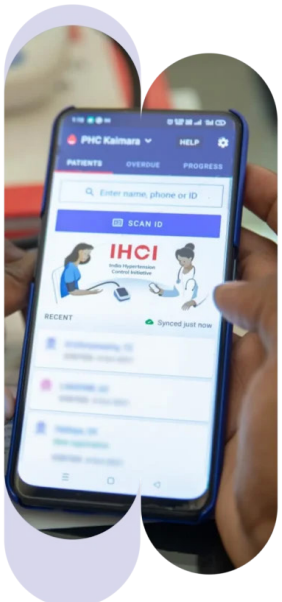
A GHAI in-country coordinator worked with SEND GHANA to lead CSO efforts. In Ghana, the initial landscape analysis informed the decision to seek the creation of a public health emergency fund to support preparedness — a recommendation from the 2017 Joint External Evaluation.[2] Ghana did not have any specific budget line items for preparedness and response; funding was allocated ad hoc only after an outbreak had begun. It also lacked formal mechanisms to access contingency funds when outbreaks did occur, causing delays in response.[3] Proposals for a public health emergency fund — which would repurpose a successful COVID-19 levy — advanced to the highest levels of government and seemed on track for adoption. However, a change in government — and with it, the replacement of all key interlocutors — significantly set the campaign back. As of 2025, advances had been made with the new government, but adoption of a public health emergency fund remains uncertain.

The landscape analysis had also shown that local governments in Ghana were meant to have epidemic preparedness plans and funding sources in place to support response activities but did not. SEND GHANA worked with 15 local governments to encourage epidemic preparedness funding, adopting a newer and more localized approach. Advocates partnered with traditional rulers, religious leaders and NGOs to sensitize local government officials and assembly members about the importance of such funding, and used media — especially radio stations — to sensitize communities. The coalition spurred five localities to allocate preparedness funding;, several others are actively considering funds or establishing preparedness plans.

The awareness built through radio and engaging other media and in-person conversations really brought this to people

that we [the Country] haven't done well and the government has not implemented its commitments. It then gave us leverage for others to join us.

- Harriet Nuamah Agyemang, Country Director, SEND GHANA



2, 3 Personal communication

Integrating learning

Early CSO budget advocacy raised important questions: about return on investment (i.e., the risk that operational costs over several years might exceed the funds ultimately mobilized), replicability and scalability. Though the original model produced results, it relied heavily on resource inputs — grants and staff time — and would prove difficult to scale across new countries or subnational jurisdictions. RTSL and GHAI explored a more **adaptable, sustainable approach that would require fewer resources and less hands-on support:** synthesizing lessons learned to guide others .

1	Campaign Planning: Conduct a political and legal landscape analysis and impact assessment to build the case for increased investments in epidemic preparedness, and plan the political strategy.
2	Campaign Implementation: Working with technical experts, build civil society and academic sector coalitions, engage policymakers and generate media coverage and support for increased funding.
3	Budget Accountability: Track budget allocations and spending of increased resources, identify bottlenecks to spending, assess and build capacity to increase accountability and promote transparent disbursement and effective spending.
4	Budget Sustainability: Conduct program impact evaluation, assess budget needs for the next budget cycle, promote different sources of funding and build demand to sustain and/ or increase the investment to improve health indicators in the medium and long-term.

With RTSL input and support, GHAI program leads and in-country coordinators created the Budget Advocacy Framework for Increased and Sustained Investment in Epidemic Preparedness, launched in September 2021.[4] Informed by the experiences in Nigeria, Senegal, and Ghana, the framework presented a high-

You have to understand the context. That is one of the key strategies that GHAI's advocacy action guide teaches.

You do mapping and analysis to understand what the intricacies are that you have to take on, and work based on what the findings are.

- Abdullahi Hamza Hassan, In-country coordinator for Kano State, Nigeria and coordinator for Kenya, Global Health Advocacy Incubator

4 https://www.advocacyincubator.org/news/2021-09-23-epidemic-preparedness-budget-advocacy-framework-unveiled-at-unga-side-event

level roadmap for political and civil society leaders to increase support for and sustain investments in preparedness.

The framework breaks the approach into four phases–campaign planning, campaign implementation, budget accountability, and budget sustainability–and lays out concrete steps and key activities advocates can take in each phase to create a successful campaign.

With support from RTSL, GHAI created additional materials related to the framework, developing the Budget Advocacy Toolkit for Epidemic Preparedness. RSTL field-tested the toolkit with its country teams working on infection prevention and control, providing feedback on how to refine the toolkit and enhance its usefulness for future users. The toolkit, completed in June 2022, details key actions at each step of the campaign process. For instance, it gives guidance on where to find information on the status of epidemic preparedness in the country needed to complete the landscape analysis . It includes worksheets to support political analysis, budget process mapping, and understanding the legal context. It also provides resources on engaging decision-makers and creating a media advocacy engagement plan. Once new funding is won, it includes budget and expenditures tracking worksheets, recommendations on where to gather budget information, and guidance to inform ongoing campaigning for sustainable funding. In December 2023,[5] GHAI brought all these tools together, and launched the Budget Advocacy Toolkit for Epidemic Preparedness: Facilitator's Guide. The guide trains facilitators in how to prepare advocates to use the Toolkit to plan campaigns through 11 modules.[6]

WIth these tools, GHAI and RTSL aimed to lower the barriers to running epidemic preparedness funding campaigns while enabling a larger audience, including those not affiliated with either organization, to benefit from the learnings and implement their own advocacy efforts with fewer resources. To further field test the new tools and identify potential CSO partners in new geographies, GHAI organized a capacity building workshop in Tanzania in July 2023, with CSOs from Ethiopia, Kenya, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe (all countries in which RTSL works). The workshop leveraged the experience of key actors from earlier campaigns, including GHAI and RSTL staff and CSO partners like Nigeria Health Watch, and LISDEL as faculty. It also modelled a peer learning approach to create a sustained network of relationships that could support campaigners as they worked in their countries.

In the budget committee of parliament there was a recognition of this need for increased spending on epidemic preparedness.

And they didn't want impacts on trade and tourism. At the same time we approached the office of the president. So going through all of those avenues we were able to move those levers. Our first level of ambition was to cover the EOC and it was commendable for the government to recognize that we need to focus on the bigger picture toward health security.

– Justinian Kateera, In-Country Coordinator for Uganda, Global Health Advocacy Incubator

5 https://www.advocacyincubator.org/news/2023-12-13-raising-community-voices-for-prioritizing-domestic-resource-mobilization-for-health-security-ghais-impactful-event-at-cphia-2023

6 https://www.advocacyincubator.org/news/2024-01-08-ghai-launches-the-budget-advocacy-toolkit-for-epidemic-preparedness-toolkit-facilitators-guide

A lighter model

Uganda, Kenya and Zambia

While earlier campaigns operated with larger budgets — between $200,000 and $300,000 — these amounts were not sustainable for the long-term. Accordingly, new efforts in Uganda, Kenya and Zambia were organized to operate in a leaner way and structured as “incubation grants” — between $50,000 and $70,000 — testing the assumption that, with a clear plan built on a proven model, meaningful impact could be achieved with fewer resources.

Uganda

Advocacy in Uganda launched in 2023, benefiting from learnings from previous efforts in Nigeria, Senegal, and Ghana. With the Uganda National Health Consumer Organization (UNHCO) identified as CSO partner, Uganda presented an opportunity to pilot the Budget Advocacy Toolkit for Epidemic Preparedness. Experienced campaigners from Nigeria, where domestic funding advocacy was entering its sixth year, provided capacity building, including =support with media strategy from Nigeria Health Watch. The GHAI in-country coordinator and the team developed a focused campaign plan using the Toolkit and established the Health Security Coalition, a group of CSOs who would support campaign efforts. They took advantage of early opportunities to connect with national health leadership by participating in the RTSL-supported Joint External Evaluation and supporting development of the National Action Plan for Health Security (NAPHS).

The 2023 JEE scores had not moved significantly compared to 2017, highlighting the need for well-targeted and prioritized funding. The Health Security Coalition developed a campaign goal of securing an additional $600,000 to the Ministry of Health for epidemic preparedness and response — to replace donor funding for the Public Health Emergency Operation Center (PHEOC), which was slated for reduction and eventual phase-out, with domestic funding. Advocates vetted the ask with the PHEOC and soon presented their case to Parliament. One important obstacle: the in recent years, the Ministry of Health had not budgeted for many preparedness activities, instead relying on off-budget, bi-lateral funding, primarily from the United States, for many activitiese.

In 2024, a snowballing of enthusiasm following this advocacy led the Parliament to allocate US$15.4M for COVID-19 response and emergency preparedness. A major win that was received with great enthusiasm, it also raised major questions: could the allocation be backed up by actual tax revenue? Would the Ministry of Health be able to absorb such a large sum over a short timeframe? What were the priorities for spending the funds? The costed NAPHS had not been finalized;priorities were still being developed based on the

As much as we push, there are reasons that can delay and therefore timelines like 6 months maybe a little bit too short.

There are certain things that need to be looked at over a year. When looking at a dedicated budget can do a lot of prep work, but the government only looks at the budget once in a year.

-Chilufya Mwaba Phiri,
CEO, Zambia Health Education and Communications Trust

updated JEE assessment. Completion of the costed NAPHS was a precondition for release of the preparedness funds.

Kenya and Zambia marked a further evolution of the advocacy model.

Instead of a local in-country coordinator, these countries were supported remotely and via visits from the coordinators from Kano State and of Ghana, respectively.

In Kenya, the National Organization of Peer Educators (NOPE), which focuses on empowering communities in the realms of health, climate change, and governance was identified as the CSO partner. As in Nigeria and Ghana, work was aimed at multiple levels of government: the central government as well as Kericho and Narok Counties, both selected in consultation with government officials due to their large population influxes (Kericho is on the border with Uganda and Narok is home to Masai Mara, a major tourist destination).

At the national level, NOPE participated in the JEE and based campaign goals on the resulting recommendations: a budget line for epidemic preparedness (which won support of some government officials), and two budget lines for health security, Public Health Epidemic Preparedness and Response and One Health (which were successfully added). Though the creation of budget lines was an important step — creating a placeholder for funding in future years — the lines remain unfunded and could be the focus of future advocacy efforts. (One complicating factor is that in Kenya, to allocate money to a budget line, a funding source must be already identified.) Advocates also contributed to strengthening the Kenya Public Health Institute, including by supporting the National Strategic Plan for Epidemic Preparedness and Response and budget, which was submitted to the national government.

NOPE was deeply affected by US cuts to global health programs in early 2025 and has had to lay off much of its staff, hobbling its efforts to advocate for funding for the budget lines.

In Kericho County, advocates successfully pushed for an epidemic preparedness budget line; unfortunately, it too remained unfunded as of late 2025. Local context proved critical: in Narok County, there was less political support — higher-level politicians regularly refused meetings — and the campaign there did not result in the creation of a budget line. A political crisis and protests about taxation, paired with a short timeline of campaigning, also hampered opportunities to build relationships and public support that could create deeper engagement from political leaders.

We didn't want this to be another program where they join a webinar and go. We want them to learn by doing – they are putting learning into practice.

-Tayo Ajayi,
Associate Director,
Global Health
Advocacy Incubator

In Zambia, the Zambia Health Education and Communications Trust (ZHECT) created a CSO coalition to push for the creation of a budget line and increased funding for the Zambian National Public Health Institute (ZNPHI), where administrative costs alone consumed 80% of the existing budget. ZHECT's landscape analysis yielded a promising direction: advocates realized that the 2020 act of Parliament that set up the ZNPHI included a public health emergency fund that had never been operationalized.[7] To present the public health emergency fund to Parliament for budget approval, ZNPHI would need to first develop a statutory instrument — a difficult task given the institute's many other priorities.

While new funding for a budget line was proposed, it was never allocated by Parliament. To keep pushing work forward, ZHECT and another CSO have supported a series of meetings with officials to finalize the statutory instrument to operationalize the public health emergency fund. This work is nearing completion and ZHECT has indicated it would be able to follow this through to completion, even as funding for its epidemic preparedness program has ended.

We are good at advocacy. But as an organization, this academy brought us to a new frontier.

We have had a bit of work on health security, but the health security financing education is not something we could have gotten if we had not done this for a long time.

-Tessy Nongo Maina, Communications Specialist, Network for Health Equity and Development

7 ZHECT interview

Scaling the model

The CSO Budget Advocacy Academy

2024 brought a new phase to the initiative with the launch of the CSO Budget Advocacy Academy (CSO Academy), which aimed to scale efforts by supporting a wider range of African CSOs to develop their epidemic preparedness budget advocacy skills. After a competitive selection process, representatives from seven organizations (from over 140 applicants) from countries where RTSL had ongoing technical work, enrolled in the first CSO Academy, attending several months of online trainings and one in-person workshop. Two staff members from each organization participated — each with the approval and support by leadership — so that learnings from the Academy would not be held solely by one person.

CSO Academy sessions were led by experts in their fields. RSTL contributed course content on the epidemic preparedness landscape including health security, legal aspects, and health financing; GHAI led sessions on the mechanics of budget advocacy, mirroring the road map identified in the Toolkit. In July 2024, after two months of webinars, an in-person workshop in Nairobi, Kenya brought participants together to build relationships, delve more deeply into key topics and kick-off the process of planning capstone projects.

The capstones were a key part of the methodology of the Academy, which sought to move beyond hypothetical learning: each CSO received a $10,000 grant for six-month project informed by their national context and learnings from the Academy. Projects focused on distinct outcomes that were achievable within the timeframe. As support, each organization was assigned two mentors from the continent with experience advocating for epidemic preparedness budget who accompanied them, fielding questions in real time, holding regular check-ins and offering advice as the short-term campaigns continued. The tailored model of accompaniment was instrumental in allowing CSOs to accomplish a great deal in a short timeframe.

Each of the organizations made significant strides on their capstones. One achieved a new epidemic preparedness budget line for a locality in Ethiopia; several others achieved adoption of guidelines or frameworks. Given the ambitious timeline — and the vicissitudes of advocacy — some organizations did not reach their goals, but all made progress and remain committed to seeing their projects through.

In two cases, CSO Academy participants supported legacy campaigns. In Kano State, the Network for Health Equity and Development helped take the final steps for Kano to integrate the

There are a few CSOs globally, not just in Africa, who know the As, Bs, and Cs of budget advocacy and that's what I find unique for RSTL and GHAI.

That is what got me interested to see how I could bring my experience to bear and my background with SEND GHANA to help CSOs become good budget advocates. I really find it's very unique and I'm very proud to see the successes.

– **Emmanuel Ayifah**, Regional Advisor, Health Security Budget Advocacy Academy, Global Heatlh Advocacy Incubator

Health Security Accountability Framework into its regular work in partnership with a CSO coalition. In Uganda, Samasha Medical Foundation initially intended to track the spending of the US$15.4M allocated by the government, but had to charge course as the costed NAPHS, a precondition for spending the money, remained uncompleted. They pivoted to supporting the government to complete the NAPHS, which was launched in December 2024.

Participants reported both great satisfaction with what they learned and an increased capacity to plan and carry out a successful campaign. A WhatsApp group, quarterly check in calls and ongoing access to former mentors for advice and guidance supports this community of practice amongst CSO Academy participants and sustains ongoing peer learning and encouragement now that the Academy has ended.

CSO Budget Academy Capstone Project Outcomes		
Ethiopia	Professional Alliance for Development	New EP funding line in Kalu Woreda (local district)
Kenya	Kenya Red Cross	Adoption of a One Health strategic plan in Tharaka Nithi County
Nigeria	Network for Health Equity and Development	Incorporation by Kano State of the Health Security Accountability Framework into its work in partnership with CSO coalition
South Africa	Lady of Peace Community Foundation	Work toward an EP budget line in Gauteng Province was not achieved but LOPECO continues work toward goal
Tanzania	Benjamin William Mkapa Foundation	National Multisectoral Workforce Surge Guideline for public health emergencies moving through process but not yet adopted
Uganda	Samasha Medical Foundation	Updated National Action Plan for Health Security and annual operating plan adopted
Zambia	Centre for Reproductive Health and Education	Lusaka District EP budget line not accepted

I see what's really unique is the combination of legal and financing technical assistance paired with grassroots advocacy

to make things that could take years or decades to happen in a much shorter time frame.

– **Catherine Cantelmo**, Senior Technical Advisor, Domestic Financing, Resolve to Save Lives

Lessons learned

The evolution of the model over time brought to light several important lessons.

1 **Advocacy is context specific.**
Rooting it in local partners and knowledge is critical. The partnerships and coalitions created to advance epidemic preparedness succeeded because they had long histories of success and relationship building in their respective countries — assets that are not quickly acquired or replicated.

2 **Finding the right model for advocacy success is an iterative process.**
The campaign in Nigeria, which achieved notable wins over its eight years, benefited from a long runway, consistent support, and a strong in-country presence by GHAI and RTSL. While countries like Kenya and Zambia faced greater challenges, their experiences highlight the possibility to tailor strategies to the resources and timelines available. Rather than suggesting that large-scale investment over many years is the only viable path, emerging models — such as the CSO Academy — demonstrate that targeted, strategic investments combined with sustained relationship-building can offer a more resource-efficient approach, pointing toward an adaptive and sustainable path to scale.

3 **Advocacy is fickle.**
Ghana had time and resources and momentum, but when an election changed all the key players who had been supporting the operationalization of the public health emergency fund, advocates had to start over. Uganda, by contrast, had a much shorter campaign timeframe with fewer resources, but enthusiasm from a few influential players leveraged excellent, strategic campaign work into a major win. In this case, the campaign benefited from a timely window of opportunity — when political appetite and institutional receptiveness aligned. The massive amount of new funding, however, came before other building blocks such as the costed NAPHS was in place, creating a major impediment to actually spending the funds. This underscored once more that funding alone is not enough; it must be sequenced with strategic planning and foundational systems to translate resources into impact.

It is important to realize that we have built relationships.

No one does advocacy by stepping into the space, saying two words, and stepping out. We have built relationships. We cannot abandon it.

– Tessy Nongo Maina, Communications Specialist, Network for Health Equity and Development

4 **Creating an ecosystem of players with the knowledge and dedication to carry out epidemic preparedness funding campaigns can have long-lasting effects.**
Many of the CSOs, despite facing the end of formal programming, plan to continue advocating for preparedness funding. Graduates of the CSO academy will continue to learn from one another's experiences via a community of practice and have expressed enthusiasm to complete their capstone projects and add domestic funding advocacy to their organizations' portfolios.

5 **Global context has tremendous impacts on this work.**
When campaigns were launched in Nigeria and Senegal, the world was near the height of focus and support for global health in general. The emergence of COVID-19 increased the focus on health security and related funding, while also further increasing debt burden. In many countries, key public health functions were primarily donor-funded, and therefore susceptible to changes in donor priorities. African countries face high levels of debt and many pressing priorities competing for limited public resources alongside debt service. It is thus not unexpected that areas funded by donors would have received less domestic attention.

The rapid and deep funding cuts to US global health programs in early 2025, including USAID, PEPFAR, the Global Fund, and WHO, along with ODA decline from other traditional donors, have created significant challenges for national health budgets in LMICs. These disruptions have also led to major losses of funding for some of the CSO partners. In Tanzania and Kenya, CSO academy participants have been directly impacted by US cuts and have had to lay off staff and cut programs. How the new bilateral MoUs between the USG and countries will unfold remain to be seen, along with the impact that the co-financing requirements will have on national health budget, including health security.In this new reality, mobilizing domestic resources will be critical, making strategic budget advocacy more essential than ever. Growing the CSO epidemic preparedness funding advocacy ecosystem, which did not previously exist, continues to be an unchartered path as there is no natural constituency like those for people living with HIV or maternal and child health. Still, growing and backing the advocates in this space is a strategic investment as they will play a vital role in the years to come in supporting governments to make choices and championing smart, domestically-funded investments in epidemic preparedness.

When the USAID cuts came it just enhanced such conversations.

Of course, we are part of that conversation and telling the government that apart from the Abuja Declaration where 15% of the national budget should be allocated to health, we are telling them, you see health is losing every day.

-Peter Njunguna Karanja,
Program Manager and Epidemic Preparedness Project Director, National Organization of Peer Educators