MEMORANDUM OF UNDERSTANDING

BETWEEN

THE GOVERNMENT OF THE UNITED STATES OF AMERICA

AND

THE GOVERNMENT OF THE KINGDOM OF ESWATINI

Preamble

This Memorandum of Understanding (hereinafter referred to as the "MOU") is made between the Government of the United States of America (hereinafter referred to as "U.S. Government") and the Government of the Kingdom of Eswatini (hereinafter referred to as "GOKE", hereinafter jointly referred to as the "Participants" and individually as the "Participant."

CONSIDERING that the GOKE aims to develop a durable and resilient health system that prevents disease, maintains the health of its population, and enables its economy to thrive;

FURTHER CONSIDERING that the U.S. Government seeks to advance its bilateral relationship with the GOKE and prevent the spread of emerging and existing infectious disease threats globally;

RECOGNIZING that United States global health investments made over the past 20 years have saved nearly 150,000 lives and prevented over 38,800 babies from becoming HIV infected in Eswatini alone and substantially and meaningfully strengthened Eswatini's health system;

RECOGNIZING that the GOKE has made substantial progress in advancing its domestic health system over the past 20 years; and

FURTHER RECOGNIZING the benefits of ongoing collaboration between the GOKE and the U.S. Government to detect, prevent, and respond to emerging and existing infectious disease threats affecting the countries of Eswatini and the United States;

Have reached the following understandings:

SECTION 1
Objectives

1.1 **Outcome Metrics:** The Participants aim to work together to achieve the following outcomes metrics by the end of each of the specified years:

	Baseline	2026	2027	2028	2029	2030
% People (15+ years) With HIV Who Know Their Status*	98%	99%	99%	99%	99%	99%
% People (15+ years) Who Know Their HIV Status on Treatment*	98.5%	99%	99%	99%	99%	99%
% People (15+ years) On Antiretroviral Treatment (ART) Who Are Virally Suppressed*	98%	99%	99%	99%	99%	99%
# Malaria Deaths in Children Under 5	0	0	0	0	0	0
# TB Deaths (per 100,000)^	79	49	41	35	20	10
Maternal Mortality Rate (per 100,000)**	118	110	95	80	75	70
Institutional Maternal Mortality Ratio (per 100,000 live births)**	90	85	80	75	70	60
Children Under 5 Mortality Rate (per 1000) †	41	33	30	25	20	20

*2024 Baseline from: *UNAIDS Spectrum; ^Global TB report 2024; **World Bank estimates 2023; †MICS 2024. Subsequent years from National Multisectoral HIV Strategic Framework 2024-2028 and government projections.*

1.2 Process Metrics: The Participants aim to work together to achieve the following process metrics by the end of each of the specified years:

	Baseline	2026	2027	2028	2029	2030
# people on ART[1,2]	214,884	216,496	218,119	219,755	220,854	221,958
# new HIV diagnoses among infants (0-18 months)*[3]	75	65	55	45	40	35
# new HIV diagnoses among children and adults (age 24 months or older)[4]	3,956	3,800	3,600	3,350	3,200	3,000
% pregnant and breastfeeding women living with HIV who receive ART *[3]	97%	100%	100%	100%	100%	100%
# patients with TB notified (i.e., bacteriologically confirmed + clinically diagnosed)*[5]	2,374	2,964	3,168	2,851	2,566	2,309
% patients with TB notified who completed treatment *[5]	83%	90%	90%	>90%	>90%	>90%
% surviving infants who received at least one dose of inactivated polio vaccine[6]	70%	74%	79%	80%	85%	≥90%
% of children aged 12–23 months who received one dose of measles-containing vaccine[6]	85%	87%	89%	≥90%	≥90%	≥90%
ANC coverage[3]	97%	97%	97%	97%	99%	99%

% accuracy of data fields assessed during the annual data audit	95%	95%	95%	95%	95%	95%

Data sources: [1]QSCR 2025; [2]HIV Annual Report 2024; [3]SRH annual report 2024; [4]UNAIDS Spectrum; [5]Global TB Report 2024; [6]WHO and UNICEF estimates of national infant immunization coverage; [7]World Malaria Report.

1.3 Infectious Disease Outbreak Response Metrics: To ensure infectious disease threats are quickly identified and responded to, the Participants also aim to achieve the following metrics throughout the term of this MOU:

I. The GOKE detects suspected infectious disease outbreaks with epidemic potential in Eswatini within 7 days of disease emergence;
II. The GOKE notifies the U.S. Government within 1 day of detection of an infectious disease outbreak in Eswatini and engages in meaningful coordination and consultation with the U.S. Government; and
III. The GOKE completes relevant initial response actions to respond effectively to infectious disease outbreaks in Eswatini within 7 days of notification, including engaging in meaningful consultation with the U.S. Government on the GOKE's response.

SECTION 2
Areas of Cooperation

The Participants plan to collaborate in the following areas (each an "Area of Cooperation"):

2.1 Surveillance & Outbreak Response

2.1.1 2030 Vision: The GOKE envisions a country-level national surveillance and outbreak response system led by national public health institutions with functional capabilities in place to detect infectious disease outbreaks with epidemic or pandemic potential within 7 days of emergence, notify relevant authorities including critical parties in the national public health system and the U.S. Government within 1 day of an infectious disease outbreak being detected; and, complete relevant initial response actions to respond effectively within 7 days to infectious disease outbreaks in Eswatini.

2.1.2 Implementation Plan:

I. The GOKE commits to work with the U.S. Government to address prioritized gaps identified by the 2024 Joint External Evaluation.
II. The GOKE commits to continue providing salaries and benefits to fund 2 epidemiologists and 4 regional surveillance officers. The GOKE further commits to providing salaries and benefits for 4 additional epidemiologists and 12 additional regional surveillance officers in 2029 and beyond.
III. U.S Government commits to providing salaries and benefits to fund 20 epidemiologists and surveillance officers in 2026, 2027, and 2028, and 0 additional epidemiologist and surveillance officers in 2029 and beyond.
IV. The U.S. Government commits to support workforce development, with transition to the GOKE over the course of the MOU, including:

a. Training of at least 45 frontline health workers in field epidemiology each year of this MOU;
b. Strengthening skills in integrated disease surveillance and response (IDSR) and related public health surveillance systems;
c. Advanced data analytics for health intelligence including modelling, machine learning, and geographic information system (GIS).

V. The U.S. Government commits to support strengthening of points of entry surveillance and response capacity.

VI. The United States and the GOKE commit to negotiate a specimen sharing arrangement for the purpose of providing a percentage of physical specimens for further testing and quality assurance and related data, including genetic sequence data, of detected pathogens with epidemic potential to the United States within ten (10) days of detection. Both Participants intend this specimen sharing arrangement to continue for ten (10) years.

VII. The U.S. Government, in coordination with the GOKE, commits to establish a funding mechanism to surge additional personnel and equipment to respond to detected infectious disease threats with epidemic potential if needed.

2.1.3 Funding Plan:

The Participants intend to provide the following support for surveillance and outbreak response activities in each of the specified years, subject to the availability of funds:

Year	U.S. Government Surveillance & Outbreak Response Funding	GOKE Surveillance & Outbreak and Response Funding
2026	$2,452,862	$ 1,540,990
2027	$2,772,862	$ 1,540,990
2028	$6,253,154	$ 1,540,990
2029	$4,924,779	$ 2,154,011
2030	$2,614,555	$ 2,154,011

U.S. Government surveillance and outbreak response funding is expected to fund activities outlined in Section 2.1.2 of this MOU. The U.S. Government plans to provide funding through mechanisms it identifies, with advice and input from the GOKE.

2.2 Laboratory Systems

2.2.1 2030 Vision: The GOKE envisions a connected network of 22 public health and 10 private laboratories that have the capabilities to conduct routine clinical diagnostics/monitoring. These labs, plus two regional satellite public health labs, also support the identification, characterization, and surveillance of pathogens of outbreak, epidemic, or pandemic potential. The labs link to one national public health laboratory (NPHL) for more complex investigations including antimicrobial resistance, immunology, and molecular virology testing. Under a multisectoral approach, the NPHL collaborates with agriculture, environmental and water services to detect and manage high consequence agents and toxins (HCAT) to address human and zoonotic diseases.

2.2.2 Implementation Plan:

I. For the purposes of this section, the U.S. Government has funded approximately $4,677,892 of laboratory commodities annually and 85 frontline lab worker full-time equivalents (FTEs) in Eswatini in 2024.

II. The U.S. Government commits to fund 100% of the aforementioned lab commodities in 2026, subject to the availability of funds, and thereafter the U.S. Government's funding for these commodities is expected to decline gradually with the GOKE funding 100% of these commodities by the end of this MOU as outlined in Section 2.2.3 of this MOU.

III. The U.S. Government commits to fund frontline lab workers as outlined in Section 2.2.3 of this MOU. This includes laboratory technologists, laboratory technicians and laboratory assistants/phlebotomists.

IV. The GOKE commits to add 20 frontline lab workers onto government payrolls in 2028, 20 additional frontline lab workers onto government payrolls in 2029, and 39 additional frontline lab workers onto government payrolls in 2030 for a total of 79 frontline lab workers over the duration of the MOU.

V. The GOKE commits to ensure all biosafety Level 2 and biosafety Level 3 labs and enhanced P4 laboratories in Eswatini have biosafety and biosecurity management programs and quality assurance in place aligned with the national laboratory quality assurance policy and any relevant international accreditation standards (e.g. ISO 35001-2019, ISO 15189-22, ISO 15190, ISO 17043, ISO 22367-2020 and ISO 20658-2023) by the end of 2028.

VI. Any sample transport support provided by the U.S. Government is expected to be transitioned to the GOKE by the end of 2027. All specimen transport systems are expected to meet established global biosafety and biosecurity standards by the end of 2027.

VII. Any diagnostic network optimization support provided by the U.S. Government is expected to be transitioned to the GOKE by 2030.

VIII. Any lab quality improvement accreditation support provided by the U.S. Government is expected to be transitioned to the GOKE by the end of 2027.

IX. Specialized bioinformatics equipment and human resources are expected to be necessary to enhance the diagnostic capacity of the NPHL and are intended to be supported by the U.S. Government until it is transitioned to the GOKE by 2030.

2.2.3 Funding Plan:

The Participants intend to provide the following support for lab commodities in each of the specific years, subject to the availability of funds:

Year	U.S. Government Funding	New GOKE Funding	Existing GOKE Funding	Total Funding
Baseline	$4,677,892	$0	$1,980,593	$6,658,485
2026	$4,677,892	$0	$1,980,593	$6,658,485
2027	$3,508,419	$1,169,473	$1,980,593	$6,658,485
2028	$2,338,946	$2,338,946	$1,980,593	$6,658,485

2029	$1,169,473	$3,508,419	$1,980,593	$6,658,485
2030	$0	$4,677,892	$1,980,593	$6,658,485
TOTAL GOKE commitment over 5 years		**$11,694,730**		

The breakdown of the U.S. Government's planned 2026 laboratory commodity procurement spending is in Appendix 2. The U.S. Government plans to purchase its lab commodities through the central laboratory commodities implementing mechanism in decreasing quantities after 2027 as the GOKE increases its funding proportionately to ensure that there are no funding gaps. The U.S. Government plans to distribute its laboratory commodities through Eswatini Central Medical Stores. The GOKE plans to purchase its laboratory commodities through platforms approved by the Eswatini Public Procurement Authority and distribute its laboratory commodities through Eswatini Central Medical Stores. The GOKE commits to assuring the security and quality of any laboratory commodity inventory both (a) paid for by the U.S. Government and (b) distributed through GOKE-owned supply chains. For purposes of this MOU, lab commodities include the actual cost of the commodities as well as related commodity distribution costs, except for warehousing, shipping, and trucking. These costs also do not include any costs of data systems or technical assistance to support commodity procurement or supply chain distribution, which are covered in Sections 2.5.3 and 2.6.3 of this MOU respectively. Funding provided by the GOKE in the table above is to only include funding provided directly by the GOKE and is not to include funding from other donors or multilateral organizations.

The U.S. Government currently funds 86 frontline laboratory workers. The GOKE commits to fund the 79 frontline laboratory worker positions in GOKE facilities, which include 53 phlebotomist posts and 26 laboratory technologist posts. The Participants intend to fund the following number of frontline lab workers in each of the specified years, subject to the availability of funds:

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	86	0	54	140
2027	86	0	54	140
2028	66	20	54	140
2029	46	40	54	140
2030	0	79	54	133*

**7 lab workers are expected to be transitioned to their respective non-governmental facilities.*

The breakdown of FTEs by type of frontline laboratory workers is in Appendix 3. The U.S. Government commits to provide funding for frontline lab workers through government-to-government (G2G) mechanisms through 2029. For purposes of this MOU, funding is expected to cover the salary and benefits for frontline lab workers. To the extent it has not already done so, the U.S. Government intends to ensure pay rates for frontline lab workers

are commensurate to pay rates for such workers employed directly by the GOKE. This funding does not include any costs related to data systems or technical assistance for frontline lab workers, which are covered in Sections 2.5.3 and 2.6.3 of this MOU, respectively. Positions funded by the GOKE in the table above are expected to only include positions funded directly by the GOKE and are not expected to include positions funded by other donors or multilateral organizations.

2.3 Commodities

2.3.1 2030 Vision: The GOKE envisions an integrated health care commodity supply chain system that uses regional and international pooled procurement vehicles (such as the Global Fund Wambo platform and Southern African Development Community Pooled Procurement Platform, etc.) and the Eswatini Central Medical Stores for warehousing and distribution to public and private health facilities.

The GOKE is in the process of policy and legal reforms to transform the Eswatini Central Medical Stores (CMS) into a parastatal entity likely to be named the Eswatini Medical Supply Agency or "EMSA." Accordingly, for the purposes of this MOU, all references to "CMS" are intended to apply to its successor organization or agency.

2.3.2 Implementation Plan:

I. For the purposes of this section, the U.S. Government currently funds $5,547,226 of commodities annually including pediatric HIV treatment; long-acting HIV prevention; viral load, early infant diagnosis, and HIV drug resistance testing; HIV testing commodities; and advanced HIV disease diagnostics.

II. The U.S. Government plans to fund 100% of the aforementioned commodities in 2026 in the amount specified in Section 2.3.3 of this MOU, subject to the availability of funds, and thereafter the U.S. Government's funding for these commodities is expected to decline gradually with the GOKE funding 100% of these commodities by the end of this MOU as outlined in Section 2.3.3 of this MOU.

III. The GOKE plans to fully implement a system for tracing commodities procured by the U.S. Government under this MOU. CMS currently uses an inventory management system (NAVISION) and LMIS to track commodities from warehousing to facility level. The GOKE commits to upgrading and fully implementing an integrated commodity tracking system that provides full end-to-end visibility of health commodities by 2030.

IV. The GOKE commits to ensuring that its government owned, managed, or run warehouses storing commodities funded by the U.S. government under this MOU meet International Guidelines on Good Storage Practices (as contained in the Good Storage Practices for Central Medical Stores and Health Facilities documents) and plans to review them to ensure that they reflect updated best-practices by 2027 and maintain such standards through the end of the MOU period.

V. The GOKE plans to notify the U.S. Government as soon as there is suspicion of theft or diversion of U.S. Government funded commodities.

2.3.3. Funding Plan:
The Participants intend to provide the following amount of support for commodities in each of the specified years, subject to the availability of funds:

ARVs

Year	U.S. Government Funding	New GOKE Funding	Existing GOKE Funding	Total Funding
Baseline	$869,334	$0	$15,657,143	$16,526,477
2026	$652,001	$217,334	$15,657,143	$16,526,477
2027	$434,667	$434,667	$15,657,143	$16,526,477
2028	$0	$869,334	$15,657,143	$16,526,477
2029	$0	$869,334	$15,657,143	$16,526,477
2030	$0	$869,334	$15,657,143	$16,526,477
TOTAL new GOKE commitment over 5 years		$3,260,003		

The breakdown of the U.S. Government's planned 2026 commodity procurement funding is in Appendix 2. The U.S. Government plans to purchase its commodities through the central health commodities implementing mechanism in decreasing quantities after 2027 as the GOKE increases its funding proportionately to ensure that there are no funding gaps. The U.S. Government plans to distribute its commodities to government and non-government health facilities through Eswatini Central Medical Stores.

The GOKE plans to purchase its commodities through the pooled platform approved by the Ministry of Finance and Eswatini Public Procurement Authority and store and distribute its commodities to public and private health facilities through the Eswatini Central Medical Stores. For purposes of this MOU, commodity funding includes the actual cost of the commodities as well as commodity distribution costs including warehousing, shipping, and trucking. Commodity costs do not include any costs of data systems or technical assistance related to commodity procurement and supply chain distribution, which are covered in Sections 2.5.3 and 2.6.3 of this MOU respectively. Funding provided by the GOKE in the table above is expected to only include funding provided directly by the GOKE and is expected not to include funding from other donors or multilateral organizations.

2.4 Frontline Healthcare Workers

2.4.1 2030 Vision: The GOKE envisions integrating 489 positions (33 nurses, 444 community health workers, 7 clinical social workers, and 5 medical officers) currently funded by the U.S. Government into its permanent healthcare workforce.

2.4.2 Implementation Plan:

I. The U.S. Government plans to fund 694 frontline healthcare workers as outlined in Section 2.4.3 of this MOU. This includes 18 medical officers, 67 nurses, 3 pharmacy staff, 15 clinical social workers, and 591 community health workers.
II. The GOKE plans to transition only the 45 U.S. Government funded frontline health

worker positions posted in GOKE facilities to GOKE-funded positions. These positions include: 5 of the 18 medical officers, 33 of the 67 nurses, 0 of the pharmacy staff, and 7 of the clinical social workers.

III. The GOKE plans to add 5 nurses onto government payrolls in 2027; 2 medical officers, 10 additional nurses, and 3 clinical social workers onto government payrolls in 2028; 3 additional medical officers, 15 additional nurses, and 4 additional clinical social workers onto government payrolls in 2029; and 3 additional nurses onto government payrolls in 2030.

IV. The GOKE also plans to transition the functions of community health worker cadres posted in GOKE facilities to existing cadres within the GOKE establishment, including nurses. To absorb these functions, the GOKE plans to hire additional nurses equivalent to the amount of U.S. Government funding currently supporting the 444 U.S. Government-funded community health workers who currently work in GOKE facilities (approximately $1.3M).

V. Transition arrangements for the 181 frontline health workers posted in non-governmental facilities are expected to be determined through consultations between the U.S. Government, the GOKE, and the respective non-governmental entity benefitting from the current frontline healthcare worker placement.

2.4.3 Funding Plan:

The Participants intend to fund the following number of frontline healthcare workers in each of the specified years, subject to the availability of funds:

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	694	0	754	1448
2027	644	50	754	1448
2028	544	150	754	1448
2029	394	300	754	1448
2030	0	513	754	1267

As per section 2.4.2 of this MOU, the GOKE plans to transition the 45 U.S government funded frontline health worker positions posted in GOKE facilities plus additional nurses to take on the functions of the community health workers and nurse mentors currently supporting GOKE facilities.

The breakdown by type of frontline healthcare worker is in Appendix 3. The U.S. Government plans to provide funding through G2G mechanisms. For purposes of this MOU, this funding includes the salary and benefit for frontline healthcare workers. To the extent it has not already done so, the U.S. Government intends to ensure pay rates for frontline healthcare workers are commensurate to pay rates for such workers employed directly by the GOKE. This funding does not include any costs related to data systems or technical assistance to support frontline healthcare workers, which are covered in Sections 2.5.3 and 2.6.3 of this MOU, respectively. Positions funded by the GOKE in the table above are expected only to include positions funded directly by the GOKE and are expected not to include positions funded by other donors or multilateral organizations.

2.5 Data Systems

2.5.1 2030 Vision: The GOKE envisions an integrated health information exchange (HIE) tying to together robust health data systems that includes the Client Management Information System (or "CMIS") as its electronic medical records (EMR), Disa*Lab Laboratory Information System (LIS) as its lab management system, open Electronic Logistics Management System (or "eLMIS") and CMIS as its pharmacy management systems, IDSR, Event-Based Surveillance (EBS), HIV Case-Based Surveillance (HIV CBS), HIVDR, Community-Based Health Information System (CBHIS), Master Data System (MDS), POE and Immediate Disease Notification System (IDNS) as its surveillance and outbreak response data systems, CMS Enterprise Resource Planning system (which includes the health commodity inventory management system). The Eswatini Data Repository is the national health data warehouse and District Health Information Software 2 (DHIS 2) is used as the data reporting and analytics platform. The GOKE, with the support of the U.S. Government, intends to routinely review and update data system platforms to ensure they are cost-effective and best suited to drive service delivery efficiencies, giving consideration to U.S. technologies and companies for investments supported by U.S. Foreign Assistance.

2.5.2 Implementation Plan:

I. The GOKE plans to use CMIS as its Electronic Medical Record system (EMR) in government-supported facilities. The EMR is currently at 246 facilities. The U.S. Government plans to support its rollout to an additional 28 facilities to reach total of 274 public facilities by 2030.

II. The U.S. Government plans to support the following improvements to CMIS EMRs over the term of this MOU consistent with Section 2.5.3 of this MOU:
   a. Software upgrades to address evolving public health requirements and program adaptation
   b. Capacity building for advanced data analytics and visualization
   c. System integration, interoperability, and maintenance
   d. Facilitating data review platforms to provide access for use at all levels
   e. Connectivity enhancements to mitigate network downtime

III. The GOKE plans to use LIS as its laboratory management system. LIS is expected to be rolled out across all national and regional labs by the end of 2026. The U.S. Government plans to support the following improvements to LIS over the term of this MOU consistent with Section 2.5.3 of this MOU:
   a. Capacity building within MOH for LIS support and system maintenance
   b. Enhanced interoperability with CMIS and the national data repository
   c. Automation of lab result transmission and quality control tracking
   d. Data analytics tools for lab performance monitoring

IV. The GOKE plans to implement eLMIS as its pharmacy management system. eLMIS is expected to be rolled out across 60% of pharmacies by the end of 2026, 85% of pharmacies by the end of 2027, and 100% of pharmacies by the end of 2028.

V. The U.S. Government plans to provide technical support to the implementation of the eLMIS pharmacy management system over the term of this MOU consistent with Section 2.5.3 of this MOU.
   a. Integration with CMIS for synchronized dispensing and stock data

b. Connectivity enhancement for pharmacy sites
c. Software improvement for real-time commodity tracking and forecasting
d. Capacity building for pharmacy data users and logisticians

VI. The GOKE commits to use CBHIS as the national community-level data system, linking Community Health Workers (CHWs) to the national digital health infrastructure. Areas of support are expected to include the following:
a. Supportive supervision and mentorship for CHWs using digital data tools
b. Integration with CMIS and DHIS2 for community-to-facility data flow
c. Strengthening coordination and performance monitoring at community level
d. Capacity building for CHWs and supervisors on data quality and use

VII. The GOKE plans to use IDSR, EBS, HIV CBS, HIVDR, and IDNS as its disease outbreak surveillance systems. IDSR, EBS, HIV CBS, HIVDR, and IDNS are expected to be rolled out across all applicable sites by the end of 2026

VIII. The U.S. Government plans to support the following improvements to IDSR, EBS, HIV CBS, HIVDR, and IDNS disease outbreak surveillance system over the term of this MOU, consistent with Section 2.5.3 of this MOU:
a. Integration and data exchange with CMIS and DHIS2
b. Real-time alerting and early warning mechanisms
c. Capacity building for surveillance officers and data teams
d. Continuous technical maintenance and cybersecurity compliance

IX. The GOKE plans to use Open ERP Microsoft 365 as its health commodity inventory management system. The Microsoft 365 (Warehouse Management System (WMS) and eLMIS are expected to be rolled out across all components of the government-run health commodity supply chain by the end of 2026

X. The U.S. Government plans to fund the following improvements to The Microsoft 365 WMS and eLMIS health commodity inventory management system over the term of this MOU, consistent with Section 2.5.3 of this MOU:
a. Integration of WMS with CMS ERP and eLMIS for unified supply chain data
b. Capacity building for stock management and reporting
c. Automation of forecasting and order management processes
d. Connectivity enhancements at warehouse locations

XI. The GOKE plans to use the national data repository as its national health data warehouse and analytics platform. The U.S. Government plans to support the following improvements to the national health data warehouse over the term of this MOU consistent with Section 2.5.3 of this MOU:
a. Strengthening integration with all upstream systems
b. Developing advanced analytics and real-time dashboards
c. Supporting data governance, metadata standards, and data quality frameworks
d. Building capacity for data analytics, visualization, and data use for decision-making

XII. The GOKE intends to strengthen its Monitoring and Evaluation (M&E) Framework to ensure data is used proactively to trigger timely interventions to program implementation and management

XIII. The U.S. Government plans to support the following improvements to the Monitoring and Evaluation (M&E) Framework over the term of this MOU consistent with Section 2.5.3 of this MOU:

a. Develop real-time monitoring tools and evaluation dashboards
b. Digitize supervisory tools to track operational performance in real time
c. Build capacity for M&E officers at central, regional, and community levels
d. Establish mechanisms for continuous learning and adaptive program management

XIV. The GOKE plans to establish a Health Intelligence Centre (HIC) under the Ministry of Health as a central hub for integrated data analysis, insight generation, and policy intelligence. The HIC is expected to serve the following Objectives:
a. Consolidate data from all national health systems (CMIS, LIS, eLMIS, DHIS2, CBHIS, surveillance systems)
b. Generate health intelligence to inform strategic planning, policy, and resource allocation
c. Provide real-time dashboards for ministry leadership and national officials
d. Enable remote access for decision-makers to view critical national dashboards
e. Serve as a "smart centre" driving data-driven decision-making and innovation

XV. Both the U.S. Government and the GOKE intend to maximize integration and interoperability between the aforementioned systems, to strengthen data governance, and to ensure that appropriate cybersecurity and data security is in place for all the aforementioned systems.

XVI. The national health data warehouse and/or other data systems are expected to be able to collect and report on all data described in Section 1 of this MOU.

XVII. The United States and the GOKE intend to negotiate a data sharing for the purpose of exchanging data on the long-term performance of this MOU and for accountability to the United States Congress for appropriated funds. Both Participants expect this data sharing arrangement to continue while this MOU is operative.

2.5.3 Funding Plan:

The U.S. Government intends to provide the following amount of funding for data systems in each of the specified years, subject to the availability of funds:

Year	U.S. Government Data System Funding
2026	$10,477,354
2027	$9,464,970
2028	$11,360,778
2029	$9,436,149
2030	$6,525,195

In 2026, the U.S. Government intends to provide $10,477,354 to scale-up, enhance, and strengthen the interoperability of the data systems listed in section 2.5.2. Over the course of the MOU, the U.S. Government plans to fund approximately $47.3M for strengthening the electronic medical record, laboratory management, pharmacy management, surveillance and outbreak response, health commodity inventory management, and national health data warehouse systems and for human resource capacity building to operate, maintain and enhance digital information systems in response to evolving program needs. For purposes of this MOU, these amounts include the cost of developers, product managers, systems engineers and other similar personnel; the cost of cloud computing capacity, software

licenses, and other similar software costs; and the cost of hardware including computers, tablets, servers, and other similar hardware costs.

During the term of this MOU, the GOKE commits to pay all reasonable and ongoing software licensing, cloud computing, hardware maintenance, hardware replacement, and other similar costs for the systems outlined in this Section 2.5 of this MOU that are not specifically paid for by the U.S. Government.

2.6 Strategic Assistance

2.6.1 2030 Vision: The GOKE envisions being able to provide all its own strategic and technical assistance without U.S. Government support with the exception of surveillance and outbreak response technical assistance and technical assistance to support the rollout of new innovative diagnostics, vaccines, drugs, and other interventions. The Participants plan to consider use of U.S. technologies, companies, and public-private partnerships as solutions to addressing strategic health areas under this MOU.

The Participants intend to prioritize the following areas for any strategic and technical assistance:

2.6.2 Strategic Investments:

The following five strategic investments include non-frontline HRH necessary to implement and maintain these activities. The HRH required to maintain the activities have been incorporated into the GOKE's co-investment plan.

I. **Advancing self-reliance through digitization**
   a. The GOKE has developed a broad digital information ecosystem including the electronic medical records (CMIS), laboratory information system and various disease surveillance outbreak and monitoring systems. USG's support to develop and implement these country-led systems has been instrumental in informing clinical management, program planning and prioritization. Yet these health information systems remain siloed, with limited ability to exchange data efficiently, effectively, and consistently, aspects which are necessary for continuous quality improvement, program decision making and policy making. Inadequate power and connectivity infrastructure continues to be a challenge for system uptime and operations, impeding reliable access to these electronic systems. Further, additional innovations and upgrades are needed to incorporate digital and technological advancements necessary to support improved efficiency and functionality of the health system. Addressing these gaps is expected to ensure a reliable, integrated and interoperable digital information ecosystem that can advance sustainable and self-reliant clinical management, program monitoring, reporting, disease surveillance, and outbreak response.
   b. **Minimize health service disruption** by putting in place redundant connectivity options and power back-up (with consideration for U.S. technologies and hardware) to ensure uninterrupted access to electronic data systems. Build

local HRH capacity for data systems upgrades, modifications, maintenance, and troubleshooting through SID/RSTP.

c. **Promote patient/client autonomy and health decision-making** through digital accessibility to individual health data (e.g. a patient portal in CMIS), clinic appointment making (e.g. utilizing Government in Your Hand or similar applications), and accurate and reliable health information via chat-bots.
d. **Cater for evolving public health requirements and programmatic adaptation** by strengthening systems integration, interoperability, and data exchange, facilitating AI based predictive analytics and insights, and improving automated data dashboards and prompts at all levels.
e. **Strengthen governance and security of health information systems and data** by developing national health enterprise architecture, data exchange, health information systems support, and cybersecurity frameworks and procuring and/or developing data security tools.

II. Identifying and containing disease threats

a. The 2024 Joint External Evaluation demonstrated that while Eswatini had made tremendous progress in improving public health preparedness and response, significant gaps remain in disease surveillance systems, epidemiology skills, timely diagnosis, and integrated outbreak response. Addressing these gaps is expected to institutionalize a robust approach to concerning trends in HIV and TB indicators while simultaneously moving Eswatini toward attaining 7-1-7 global benchmarks.
b. **Strengthen digital disease surveillance and response systems** by improving functionality, integration, and interoperability including real time data visualization and use at all levels.
c. **Advance public health intelligence** through expanded staffing and capacity building initiatives focused on epidemiology, advanced data analytics, predictive surveillance/modelling, and geospatial analysis. Develop skills of frontline health workers to detect and respond to concerning disease trends through scaling field epidemiology (FETP), integrated disease surveillance and response (IDSR), and public health emergency management (PHEM) training programs.
d. **Improve outbreak response** by utilizing rapid response teams to conduct HIV/TB epidemic control activities, such as field tracing and testing of HIV and TB contacts, establishing a system for emergency sample transportation, strengthening laboratory capacity for advanced diagnostics, and strengthening point of entry screening and response.

III. Breaking the cycle of HIV transmission – Scaling Lenacapavir

a. Women continue to acquire HIV at a rate over 7 times that of men, while 15% of men remain without treatment and virally unsuppressed. Thirty-four (34) babies continue to be born with HIV annually, often due to new maternal HIV infections during pregnancy and breastfeeding.
b. **Introduce Lenacapavir** (a long-acting pre-exposure prophylaxis injection) at scale as a game-changing prevention intervention targeting women 15-34 by supporting innovative interventions to generate demand (stakeholder-

informed messages, diverse messaging platforms), address myths and misconceptions, expand access (opt-out approach, integration with MNCH services, community distribution, digital tools), and monitor outcomes and impact.

c. **Close remaining gaps in HIV treatment coverage** among men 20-39.

IV. Transform HIV service delivery to sustain 95-95-95

a. Eswatini has successfully achieved the 95-95-95 epidemic control targets. Ingredients responsible for this success include timely, accurate, and contextualized guideline and policy updates; implementation of interventions and innovations with fidelity, robust, data-driven quality management; disease monitoring (e.g. tracking of trends, management of complicated cases, defaulter tracing, intensive adherence counseling) through multidisciplinary teams; and contingency planning with stop-gap implementation for commodity stock-outs and sample transport breakdowns. To date, a surge approach, heavily reliant on human resources and logistics, has been utilized to rapidly address HIV as a public health emergency. A more cost-efficient approach is required for long-term resilience and self-reliance.

b. **Simplify and integrate service delivery tailored to population need** to address clients with complex disease process and circumstances as well as those requiring access after-hours or in alternative settings.

c. **Incorporate continuous learning and quality improvement processes within existing structures** including strengthening and expanding the functions of regional health management teams.

d. **Leverage digital tools and platforms for clients, providers, and program decision makers to improve efficiency and information access.** Solutions include patient portals and chat-bots, artificial intelligence innovations to guide service delivery support (identify service quality gaps, flag potential stock ruptures, flag client services due), establishing a national online training hub, and utilizing virtual platforms like ECHO to support high level care and bedside teaching.

e. **Review, update, and consolidate workforce roles, responsibilities, and skills** by merging functions currently conducted by lay providers into government establishment positions. Filling of posts, differentiation of duties, and streamlined workflow is expected to be critical.

V. Enhancing financial stewardship and resource mobilization

a. As the U.S. Government plans to shift its funding support through G2G mechanisms, enhanced financial management mechanisms are expected to be critical to ensuring stewardship of U.S. Government funds. Furthermore, supporting the GOKE's resource mobilization efforts is expected to be crucial to advancing a self-reliant response.

b. **Financial management and governance** support is expected to establish robust internal controls, financial risk-management frameworks, and compliance systems to ensure strong stewardship of U.S. Government funds. These structures are also expected to enhance transparency and visibility of the use of U.S. Government funds to the GOKE.

c. **Leveraging financial and expenditure data for planning and policy formulation** Ministry of Economic Planning and Development (MEPD) and the Ministry of Health (MOH) is expected to be supported to design and operationalize domestic resource mobilization strategies, evidence-based budgeting processes, advocacy platforms, and innovative health financing mechanisms.

d. **Identification and development of a national PPP framework** is expected to enable sustainable last-mile delivery models necessary for the long-term financial sustainability of Eswatini's health sector. The framework is expected to include codifying governance structures, defining risk-sharing arrangements, and establishing standardized procedures for contracting, performance monitoring, and accountability that is expected to facilitate the GOKE to systematically engage private providers, logistics partners, and community-based service platforms to expand coverage, improve service quality, and strengthen resilience within the health system. The national PPP framework is expected to provide opportunities to identify and formalize transformative PPP opportunities as the U.S. Government phases out financial support.

e. The GOKE is **exploring the establishment of a National Health Insurance (NHI) system** that is expected to help ensure long-term sustainability to its national health system. The U.S. Government plans to provide support for NHI situational assessment, policy development, and implementation roadmap. The initiative is also expected to operationalize the Social Insurance Policy requirements issued by the Ministry of Labour, positioning NHI as a central mechanism for sustainable health financing.

2.6.3 Funding Plan:

The U.S. Government intends to provide the following amount of strategic investment funding in each of the specified years, subject to the availability of funds:

Year	U.S. Government Strategic Investment Funding
2026	$19,527,456
2027	$21,821,914
2028	$19,195,324
2029	$14,379,082
2030	$11,659,854

In 2026, the specific strategic investments the U.S. government plans to fund include $19,527,456 as articulated in 2.6.2. The U.S. Government intends to provide its funding through contract or cooperative agreement mechanisms it identifies, with advice and input from the GOKE. For purposes of this MOU, this strategic investment funding includes all costs not specified in Section 2.1.3, 2.2.3, 2.3.3, 2.4.3, and 2.5.3 of this MOU.

2.7 Additional Responsibilities

The GOKE plans to exempt from taxation in Eswatini any U.S. Government funds used to implement any element of this MOU, including U.S. Government funds deployed through a

cooperative agreement, contractor or sub-contractor, consistent with the most favorable terms included in this MOU or other U.S. Government assistance agreements with the GOKE. At a minimum, this should include being exempt from: (a) customs duties, import duties, taxes or fiscal charges of equal effect levied or otherwise imposed on items imported into Eswatini and (b) the value-added tax levied or otherwise imposed on the purchases of goods and services in Eswatini.

SECTION 3
Implementation

3.1 Implementation Plan: Within 90 days of signing this MOU, the Participants expect to develop a detailed implementation plan ("Implementation Plan") that includes the precise timing and mechanisms for implementing all Areas of Cooperation outlined in Section 2 of this MOU as well as for collecting all the data elements outlined in Section 1 of this MOU.

3.2 Steering Committee: The Participants plan to establish a Joint Health Cooperation Steering Committee (JHCSC) composed of senior representatives from both governments and other key stakeholders as mutually decided by the GOKE and the U.S. Government. The JHCSC is expected to meet at least quarterly to monitor progress toward, at a minimum, the goals outlined in Section 1 of this MOU and to meet at least annually to review this MOU and the associated Implementation Plan and recommend modifications to either document as needed.

SECTION 4
Audit

4.1 Outcomes Survey: Both Participants acknowledge the importance of ensuring accurate outcomes data. To this end, the U.S. Government plans to fund a survey for up to $10 million between 2027 and 2029, subject to the availability of funds, to objectively measure the outcomes outlined in Section 1.1 of this MOU. The U.S. Government and the GOKE intend to work together to mutually decide upon the design and execution of the survey.

4.2 Process Metric Audit: The GOKE acknowledges that so long as the U.S. Government is providing any funding in support of activities described in this MOU, the U.S. Government has a significant and material interest in ensuring the process metrics outlined in Section 1.2 and 1.3 of this MOU are accurately collected, complete and maintained. To this end, subject to applicable laws, the GOKE commits to provide the U.S. Government with any relevant data access, on-site access, or other information needed to audit the process metrics in Sections 1.2 and 1.3 of this MOU in up to five percent (5%) of randomly selected and/or specific health facilities, clinics, labs, or programs identified by the U.S. Government.

4.3 Supply Chain Audit: The GOKE acknowledges that so long as the U.S. Government is providing funding for commodities as described in Sections 2.2 or 2.3 of this MOU, the U.S. Government has a significant and material interest in ensuring there is minimal waste and no fraud in the supply chain. To this end, the GOKE commits to provide the U.S. Government with any data access or information needed to audit supply chain leakage.

4.4 Co-Investment Audit: The GOKE acknowledges that so long as the U.S. Government is providing funding for activities described in Section 2.2, 2.3, and/or 2.4 of this MOU, the U.S. Government has a significant and material interest in ensuring the GOKE is making its committed co-investment. To this end, the GOKE commits to provide the U.S. Government with any data access or information needed to audit any accounts from which or to which co-investment funding is being provided.

4.5 Regulatory Compliance Audit: The GOKE acknowledges that so long as the U.S. Government is providing funding in support of any activities described in this MOU, the U.S. Government has a significant and material interest in ensuring compliance with all U.S. laws and policies including the Helms Amendment, which prohibits certain U.S. Government assistance from being used for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions. To this end, the GOKE plans to provide the U.S. Government with any data access or information needed to monitor compliance with applicable legal requirements, including to confirm no U.S. Government funding is being used for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.

4.6 Effect of Failure to Provide Data: The GOKE acknowledges that failure to provide the data access or information requested under Sections 4.2, 4.3, 4.4, or 4.5 of this MOU could result in changes in the planned assistance contemplated under this MOU and/or discontinuation of this MOU by the U.S. Government.

4.7 Effect of Failure to Fulfill Specimen and Data Sharing Commitments: The GOKE acknowledges that so long as the U.S. Government is providing any foreign assistance funding for activities contemplated under this MOU, the U.S. Government has a significant and material interest in ensuring that the GOKE fulfills all commitments in the specimen sharing and data sharing arrangements referenced in Sections 2.1.2 and 2.5.2 of this MOU respectively and that failure to fulfill any commitments in these arrangements could result in changes in the planned assistance contemplated under this MOU and/or discontinuation of this MOU by the U.S. Government.

5ECTION 5
Co-Investment & Performance Benchmarks

5.1 Co-Investment Requirements: In the event that the GOKE does not make the required co-investment outlined in Sections 2.2.3, 2.3.3, and/or 2.4.3 of this MOU, within the specified calendar year, the U.S. Government may, after discussions in good faith, unilaterally reduce or cease providing funding to the GOKE under this MOU in future years. For purposes of this Section and Sections 2.2.3, 2.3.3, and 2.4.3 of this MOU, co-investment by the GOKE may only be calculated based on funds raised directly by the GOKE and may not include funds from other donors or multilateral organizations.

5.2 Performance: In the event the GOKE does not maintain the baselines outlined in Sections 1.1 and 1.2 of this MOU or does not achieve the metrics outlined in Section 1.3 of this MOU, both Participants may enter into discussion in good faith, and note that the U.S. Government may substantially decrease or eliminate funding for one or more Area of Cooperation in future years.

5.3 Performance Incentives: In the event the GOKE achieves all the process and outbreak response metrics for 2027 or 2028 outlined in Sections 1.2 and 1.3 of this MOU, the GOKE is expected to be eligible to receive a performance incentive for 2027 or 2028 respectively, subject to the availability of funds. The U.S. Government reserves the right to build a composite score of these metrics for the purpose of calculating eligibility for the performance incentive if doing so in no way decreases the GOKE's eligibility for the performance incentive. In each year, the size of the performance incentive is expected to equal the population in Eswatini divided by the population of all countries who are eligible for the performance incentive, times the size of the performance pool. In no event would the GOKE's performance incentive for a given year be greater than $10 per person per year. For the purposes of this calculation, Eswatini's population is considered to be 1,260,542. Performance incentives may be used by the GOKE to fund any health-related costs that would be allowed under this MOU.

SECTION 6
Additional Terms

6.1 Duration: The activities under this MOU are intended to commence on April 1, 2026, and to continue through December 31, 2030.

6.2 Modification: This MOU may be modified by a mutual decision of the Participants in writing.

6.3 Discontinuation: Either Participant may discontinue cooperation under this MOU at any time but is expected to make best efforts to give 180 days' advance notice to the other Participant.

6.4 Confidentiality: Unless otherwise authorized under this MOU or its appendices, Participants are expected not to disseminate or otherwise make available any information exchanged under this MOU to any third party (with the exception of the Participants' contractor support personnel) or use the information for purposes other than those for which it was provided, without the prior written consent of the Participant that provided the information, unless otherwise required by applicable law and regulations; however, for the avoidance of doubt, either Participant may make this MOU itself public.

6.5 Notices: Any notice required under this MOU is expected to be provided to:

For the U.S. Government	**For Government of the Kingdom of Eswatini**
CHARGÉ D'AFFAIRES	MINISTER OF ECONOMIC PLANNING AND DEVELOPMENT
United States Embassy Eswatini Corner MR103 and Cultural Centre Drive Ezulwini	Ministry of Economic Planning and Development Mbabane, Eswatini

Either Participant may, by notice in writing to the other Participant, designate additional representatives or substitute other representatives for those designated in this Section. The Participants intend any notice, request or other communication under this MOU to be in writing and delivered to the address specified in this MOU or such other address as either Participant may provide to the other Participant.

6.6 Compliance with Applicable Laws: The cooperation between the Participants is expected to be carried out consistent with applicable law and the relevant rules and regulations of Eswatini and the United States.

6.7 Privileges, Immunities and Facilities of Both Participants: Nothing in this MOU should be interpreted or construed as a waiver of the privileges, immunities and facilities which the Participants enjoy by virtue of the international agreements and laws applicable to the Participants.

6.8 Subject to Funding Availability: Participants acknowledge that this MOU is intended to exclusively cover activities funded by the U.S. Government and the GOKE. All activities described in and/or pursued by the Participants under this MOU are subject to the availability of funds, personnel, and other resources.

6.9 Legal Status: This MOU is not an international agreement and does not give rise to legal rights and obligations under international or domestic law. Nothing in this MOU is intended to override or invalidate any existing agreements between the U.S. Government and the GOKE.

6.10 Resolution of Differences: The Participants intend to resolve any differences between them arising from or in connection with the interpretation or performance of this MOU through consultations between themselves.

SIGNED at Mbabane on December 12, 2025, in duplicate, in the English language.

FOR THE GOVERNMENT OF THE THE UNITED STATES OF AMERICA:

(b)(6)

Marc Weinstock

CHARGÉ D'AFFAIRES

FOR THE GOVERNMENT OF THE KINGDOM OF ESWATINI:

(b)(6)

Hon. E.T. Gina (Dr)

MINISTER OF ECONOMIC PLANNING AND DEVELOPMENT

Appendix 1: Co-Funding Summary

The below represents the total planned financial support by both the U.S. Government and the GOKE during the term of the MOU. The GOKE funding is in addition to baseline expenditure of $ 212,360,300 as shown by the National Health Accounts survey of 2025.

Year	U.S. Government	GOKE New Funding
2026	$ 47,000,000	$ 242,719
2027	$ 47,000,000	$ 1,943,843
2028	$ 44,179,999	$ 6,755,448
2029	$ 32,900,001	$ 11,254,892
2030	$ 21,620,000	$ 16,592,789
Total	**$ 192,700,000**	**$ 36,789,691**

The below represents the total planned financial support by the U.S. Government during the term of the MOU:

Year	2026	2027	2028	2029	2030
Surveillance & Outbreak Response ($)	$2,452,862	$2,722,862	$6,253,155	$4,924,779	$2,614,555
Frontline Epidemiology Workers (# FTEs)	20	20	20	0	0
Laboratory Systems	$1,812,480	$1,934,414	$827,177	$875,340	$820,396
Lab Commodities ($)	$4,677,892	$3,508,419	$2,338,946	$1,169,473	$0
Frontline Lab Workers (# FTEs)	86	86	66	46	0
Other Commodities – including logistics ($)	$1,297,232	$902,697	$489,521	$257,629	$0
Frontline Healthcare Workers (# FTEs)	694	644	544	394	0
Frontline Healthcare Workers – including laboratory and epidemiologists ($)	$6,754,724	$6,644,724	$3,715,098	$1,857,549	$0
Data Systems ($)	$10,477,354	$9,464,970	$11,360,778	$9,436,149	$6,525,195
Strategic Investments ($)	$19,527,456	$21,821,914	$19,195,324	$14,379,082	$11,659,854
Total	**$47,000,000**	**$47,000,000**	**$44,179,999**	**$32,900,001**	**$21,620,000**

The below represents the total new planned financial support described in this MOU by the GOKE during the term of the MOU:

Year	2026	2027	2028	2029	2030
Surveillance & Outbreak Response ($)	$0	$0	$0	$713,021	$713,021
Frontline Epidemiology Workers (# FTEs)	0	0	0	20	20
Laboratory Systems	$3,651	$79,289	$291,484	$788,112	$925,168
Lab Commodities ($)	$0	$1,169,473	$2,338,946	$3,508,419	$4,677,892
Frontline Lab Workers (# FTEs)	0	0	20	40	79
Other Commodities – including logistics ($)	$239,068	$595,081	$1,190,062	$1,307,109	$1,424,057
Frontline Healthcare Workers (# FTEs)	0	50	150	300	513*
Frontline Healthcare Workers – including laboratory and epidemiologists ($)	$0	$100,000	$1,614,621	$2,421,932	$3,229,242
Data Systems ($)	$0	$0	$0	$0	$2,611,042
Strategic Investments ($)	$0	$0	$1,320,236	$2,516,299	$3,002,367
Total	**$242,719**	**$1,943,843**	**$6,755,349**	**$11,254,892**	**$16,582,789**

** The GOKE plans to transition those U.S. Government funded frontline health workers currently posted in GOKE facilities. Transition arrangements for frontline health workers posted in non-governmental facilities are expected to be determined thraugh consultations between the U.S. Government, the GOKE, and the respective non-governmental entity benefitting from the current frantline healthcare worker placement.*

Appendix 2: 2026 Planned U.S. Commodity Funding

The U.S. Government intends to provide the following frontline funding in 2026:

Lab Commodities

Lab Commodity	USG Baseline (2026) cost	GOKE Baseline (2026) contribution*
Viral Load (VL)	$3,772,818	$641,195
Early Infant Diagnosis (EID)		$688,817
HIV Rapid Diagnostic Test Kits (HIV RTK)	$770,391	$650,581
VISTECT (CD4)	$80,683	$0
HIV Drug Resistance for2nd line failure	$54,000	$0
TOTAL	**$4,677,892**	**$1,980,593**

**Based on August 2025 supply plan and procurement plan*

Year	U.S. Government Funding	New GOKE Funding	Existing GOKE Funding	Total Funding
Baseline	$4,677,892	$0	$1,980,593	$6,658,485
2026	$4,677,892	$0	$1,980,593	$6,658,485
2027	$3,508,419	$1,169,473	$1,980,593	$6,658,485
2028	$2,338,946	$2,338,946	$1,980,593	$6,658,485
2029	$1,169,473	$3,508,419	$1,980,593	$6,658,485
2030	$0	$4,677,892	$1,980,593	$6,658,485
TOTAL GOKE commitment over 5 years		**$11,694,730**		

Other Commodities

Commodity	Total Cost
Pediatric ARVs	$869,334
Total	**$869,334**

Appendix 3: Frontline Lab & Healthcare Worker Funding

The GOKE plans to transition those U.S. Government funded frontline health workers currently posted in GOKE facilities. Transition arrangements for frontline health workers posted in non-governmental facilities are expected to be determined through consultations between the U.S. Government, the GOKE, and the respective non-governmental entity benefitting from the current frontline healthcare worker placement. The U.S. Government and the GOKE intend to provide the following funding for frontline lab, epidemiology, and healthcare workers:

Frontline Lab Worker: Laboratory Assistants/Phlebotomists and Laboratory Technologists

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	86	0	54	140
2027	86	0	54	140
2028	66	20	54	140
2029	46	40	54	140
2030	0	79	54	133

**7 lab workers are expected to be transitioned to their respective non-governmental facilities.*

Frontline Worker: Epidemiologists

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	20	0	6	26
2027	20	0	6	26
2028	20	0	6	26
2029	0	20	6	26
2030	0	20	6	26

Frontline Healthcare Worker: Doctors

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	18	0	169	187
2027	18	0	169	187
2028	16	2	169	187
2029	13	5	169	187
2030	0	5	169	174

**13 doctors are expected to be transitioned to their respective non-governmental facilities.*

Frontline Healthcare Worker: Nurses

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	67	0	483	550
2027	62	5	483	550
2028	52	15	483	550
2029	37	30	483	550
2030	0	3	483	516*

**34 nurses ore expected to be tronsitioned to their respective non-governmental facilities or their functions absorbed by existing positions.*

Frontline Healthcare Worker: Clinical Social Workers

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	15	0	4	19
2027	15	0	4	19
2028	12	3	4	19
2029	8	7	4	19
2030	0	7	4	11*

**8 clinical social workers ore expected to be transitioned to their respective non-governmental facilities.*

Frontline Healthcare Worker: Community Health Workers

"Community health workers" refers to lay counselors, peer navigators/educators, linkage navigators, mentor mothers, expert clients, and HIV testing counselors.

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	591	0	0	591
2027	541	50	0	591
2028	441	150	0	591
2029	291	300	0	591
2030	0	444	0	444*

**The GOKE plans to transition the functions of community health worker cadres posted in GOKE facilities to existing cadres within the GOKE establishment, including nurses. To absorb these functions, the GOKE plans to hire additional nurses equivalent to the amount of U.S. Government funding currently supporting the 444 U.S. Government-funded community health workers who currently work in GOKE facilities (approximately $1.3M). The remaining 147 community health workers are expected to be transitioned to their respective non-government institutions.*

Frontline Healthcare Worker: Pharmacy Technicians and Pharmacists

Year	U.S. Government # FTEs Funded	GOKE New # FTEs Funded	GOKE Existing # FTEs Funded	Total # FTEs Funded
2026	0	45	53	98
2027	0	0	98	98
2028	0	0	98	98
2029	0	0	98	98
2030	0	0	98	98