MOU Template Companion Guide

Introduction

The objective of this MOU is to establish an understanding between the U.S. Department of State and partner countries that will advance U.S. interests, save lives, and help countries build resilient and durable health systems. Each country will be allocated a multi-year budget and timeline for U.S. foreign assistance support for health programs. The MOU will outline the expected U.S. Government and partner government commitments over the course of this multi-year MOU, subject to the availability of funds.

Completed draft templates should reflect the health country team's best recommendations for the United States' starting point for negotiations as well as identify any relevant potential pitfalls, considerations, or contextual factors for negotiators' awareness. Where applicable, please indicate either in the draft text or in comments in the Word document potential alternative conditions, scenarios, or terms that may be acceptable alternatives to the health country team's starting point.

In each section of the MOU, consider:

- Are there asks that need to be made to further American interests (e.g., regulatory harmonization)?
- What are the investments most valued by the partner government?
- What are the investments most necessary for saving lives?
- Are the investments leading to the country being able to take significantly more, and in many cases, full ownership of its health programs included in this MOU by the end of the term of the MOU while maintaining or improving outcomes?

Section 1: Objectives

Review the metrics proposed in Sections 1.1, 1.2, and 1.3. Please flag if there are any indicators that you believe should be removed and/or are not collected in your country. Please flag whether you recommend including any additional indicators. Please populate the information in this section using the most recent information for each indicator as a baseline. For all selected indicators, identify ambitious yet realistic targets for each year of the MOU. In no instance may targets be below baseline performance without signoff from the GHSD Front Office.

1.1 Outcome Metrics

The three HIV outcome metrics should be replaced with "the percent of people living with HIV who are virally surprised" in countries where the 95-95-95 targets have been met. MOUs should only include outcome metrics on infectious diseases and health programs for which the U.S. Government is providing funding in the MOU. All countries should include outcome metrics for maternal mortality rate and children under 5 mortality rate as overall health systems indicators.

1.2 Process Metrics

MOUs should only include process metrics on infectious diseases and health programs for which the U.S. Government is providing funding in the MOU.

1.3 Infectious Disease Outbreak Response Metrics

Section 2: Areas of Cooperation

2.1 Surveillance & Outbreak Response

2.1.1 Vision

To keep America safe from infectious disease threats, all countries should generally have the same vision: a surveillance and outbreak response system capable of achieving 7-1-7. Please flag if there are any reasons that you do not think the 7-1-7 vision or timeline is appropriate in your country and, if you do so, please propose an alternative vision or timeline. Alternative visions or timelines require signoff from the GHSD Front Office.

2.1.2 Implementation Plan

For the implementation plan, you must include:

- The number of field epidemiologists the partner government will employ by year
- The number of field epidemiologists the U.S. Government will train annually
- A commitment to sign a specimen sharing agreement
- A commitment to establish a specific funding mechanism for surge outbreak assistance

For the implementation plan, you may include details on plans for:

- Completing and addressing gaps identified by a surveillance system assessment
- Surveillance capabilities including early-warning surveillance systems to detect outbreaks
- Ensuring readiness for point of entry and border health measures aligned with International Health Regulations (IHR)
- Other items as deemed important by the health country team

2.1.3 Budget

Budget numbers for this section will be provided by GHSD. Health country teams should work with partner governments to determine how best to invest these resources. Health country teams should review and contact GHSD if there are strong concerns about the total budget number. These budgets do not include global health security resources appropriated to the U.S. Centers for Disease Control & Prevention (CDC). We strongly recommend country health teams ensure the deployment of these U.S. Department of State resources are coordinated with the deployment of CDC resources. Please note any investments in lab workers or lab commodities should be included in Section 2.2.3 and any investments in data systems should be included in Section 2.5.3. Technical assistance related to disease surveillance and outbreak response that was previously funded by U.S. Department of State Global Health Security grants (rather than PEPFAR, TB, or malaria funding) may be included in this section rather than in Section 2.6.3. See additional budget guidance in Appendix I.

2.2 Laboratory Systems

2.2.1 Vision

Please articulate a vision for the nation's laboratory system. The vision should be concise, along the lines of the draft in the MOU template, and align with what you believe the partner government's vision to be.

2.2.2 Implementation Plan

For the implementation plan, you must include:

- The rates at which the U.S. Government and partner government will fund lab commodity purchases and frontline lab worker positions, including how those rates will change over the course of the agreement
- A commitment to ensure that all Biosafety Level 2 and 3 and (if applicable) Level 4 labs have biosafety and biosecurity management programs and quality assurance in place aligned with ISO 35001 and ISO 15189 standards
- The entity that will oversee the country's integrated national sample transport system

For the implementation plan, you may include details on plans for:

- Lab network capacity capabilities, including sequencing, bacterial culture, and antimicrobial sensitivity capabilities and the ability to test for all endemic and priority diseases
- Implementing lab quality improvement programs
- Accrediting national, regional, or other laboratories
- Other items as deemed important by the health country team

2.2.3 Budget

Complete laboratory commodity budget table with:

- Estimated State Department funding for future laboratory commodity procurements by year. 2026 funding levels should generally be the same or higher than 2024 levels, unless an exception is granted by the GHSD Front Office. Annual State Department funding should decline over time at an ambitious yet feasible rate.
- Estimated partner government budget levels, including an estimate of the country's current laboratory commodity funding, and new funding that will be devoted to laboratory commodities. The funding level should increase over time to replace State Department funding. This should only include funding from domestic sources and should exclude funding from other donor countries or multilateral institutions.
- The total amount of laboratory commodity funding between the State Department and partner government funding should not decline over time unless there is a good reason to do so (which must be reviewed and approved by the GHSD Front Office).
- For both State Department and partner country funding, the MOU should lay out the mechanism(s) through which each government will purchase lab commodities and how, if at all, that mechanism will change over the course of the agreement. The MOU should also lay out the mechanisms by which each government will distribute lab commodities including how, if at all, those mechanisms will change over the course of the MOU. Mechanisms should not include specific contractors but rather select from options like "the national ministry of health," "regional governments," "the private sector," or "U.S. implementing partners."
- For purposes of this agreement, 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 respectively.

Complete frontline lab worker budget table with:

- Number of frontline lab worker FTEs the State Department will fund by year. The number of 2026 FTEs should generally be the same or higher than 2024 levels, unless there is a good reason for them to be lower. Annual State Department funded FTEs should decline over time at an ambitious yet feasible rate.
- Estimated current number of FTEs the partner government funds.
- Estimated number of new (or absorbed from State Department) FTEs the partner government will fund. The number of FTEs should increase over time to replace State Department funded positions. This should only include positions funded by domestic sources and should exclude positions funded by other donor countries or multilateral institutions.
- The total aggregate number of frontline lab workers funded by the State Department and partner government should not decline over time unless there is a good reason to do so (which must be reviewed and approved by the GHSD Front Office).
- For State Department funded positions, the MOU should lay out the mechanism(s) through which the State Department will fund the positions and how, if at all, that mechanism will change over the course of the MOU. Mechanisms should not include specific contractors but rather select from options like "the national ministry of health," "regional governments," "the private sector," or "U.S. implementing partners."
- For purposes of the MOU, funding will cover the salary and benefits for frontline lab workers. This funding does not include any costs related to data systems or technical assistance for lab workers, which are covered in Sections 2.5.3 and 2.6.3 respectively.

The above budgets should not include global health security resources appropriated to the U.S. Centers for Disease Control & Prevention (CDC). We strongly recommend country health teams ensure the deployment of these U.S. Department of State resources are coordinated with the deployment of CDC resources. See additional budget guidance in Appendix I.

2.3 Commodities

2.3.1 Vision

Please articulate a concise vision for commodity procurement and distribution, along the lines of the draft in the MOU template, and aligned with what you believe the partner government's vision to be. This should include outlining what the commodity procurement mechanism will be at the end of the MOU period as well as how commodity distribution will occur to both public hospitals and clinics as well as other hospitals and clinics at the end of the MOU period.

2.3.2 Implementation Plan

For the implementation plan, you must include:

- The amount the U.S. Government and partner government will fund commodity purchases by year, including how those rates will change over the course of the MOU
- The list of commodities that the U.S. Government will fund

For the implementation plan, you may include details on plans for:

- Commodity storage
- Commodity distribution, including last-mile distribution strategies
- Supply chain management, oversight and quality control initiatives
- Coordination with the Global Fund
- Other items as deemed important by the health country team

All commodity or supply chain related data systems investments should be included in Section 2.5 rather than 2.3. All commodity or supply chain related technical assistance investments should be included in Section 2.6 rather than Section 2.3.

2.3.3 Budget

Complete commodity budget table with:

- Estimated U.S. Government funding for future commodity procurements by year. 2026 funding levels should be the same or higher than 2024 levels, unless an exception is granted by the GHSD Front Office. Annual U.S. Government funding should decline over time at an ambitious yet feasible rate.
- Estimated partner government budget levels, including an estimate of the country's current commodity funding, and new funding that will be devoted to commodities. The funding level should increase over time to replace U.S. government funding. This should only include funding from domestic sources and should exclude funding from other donor countries or multilateral institutions.
- The total amount of commodity funding between the U.S. Government and partner government funding should not decline over time unless there is a good reason to do so (which must be reviewed and approved by the GHSD Front Office).
- For both U.S. Government and partner country funding, the MOU should lay out the mechanism(s) through which each government will purchase commodities and how, if at all, that mechanism will change over the course of the MOU. The MOU should also lay out the mechanisms by which each government will distribute commodities including, how if at all, those mechanisms will change over the course of the MOU and how, if at all, those mechanisms will differ between public and other hospitals and clinics. Mechanisms should not include specific contractors but rather select from options like "the national ministry of health," "regional governments," "the private sector," or "U.S. implementing partners."
- If your country's term of the MOU is less than five years, the general expectation is that the partner government will fund 100% of commodities in the first year after the MOU period ends. If your country's term of the MOU is five years, the GHSD team will let you know whether the expectation is that the partner government will fund 100% of commodities in the first year after the MOU period ends or if the U.S. Government plans to continue to provide commodity funding after the end of the MOU. For countries who will pick up 100% of commodity funding in the first year after the MOU, please ensure the amount of commodity funding covered by the U.S. Government in the last year of the MOU is such that it can reasonably be picked up by the partner country in the first year after the MOU.
- 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 respectively.
- See additional budget guidance in Appendix I.

2.4 Frontline Healthcare Workers

2.4.1 Vision

Please articulate a concise vision for how the partner government will integrate and absorb U.S. funded frontline healthcare workers into its current workforce. This vision should be concise, along the lines of the draft in the MOU template, and aligned with what you believe the partner government's vision to be.

2.4.2 Implementation Plan

For the implementation plan, you must include:

- The number and types of frontline healthcare workers that the government will absorb in each year of the MOU
- Please ensure all frontline healthcare workers, including seasonal malaria campaign workers, are included in this section as appropriate

For the implementation plan, you may include details on plans for:

- Integrating the frontline healthcare workforce across disease areas to improve efficiency
- Modifying the role of specific frontline healthcare workers to better integrate them with the partner country's service delivery model
- Helpful policy changes (e.g., the formal recognition of community health workers)
- Training frontline healthcare workers
- Ensuring U.S. Government funded frontline healthcare workers have salaries and roles that can easily be cross-walked to government frontline healthcare worker salaries and roles
- Other items as deemed important by the health country team

All healthcare worker related data systems investments should be included in Section 2.5 rather than 2.4. All healthcare worker technical assistance investments should be included in Section 2.6 rather than Section 2.3.

2.4.3 Budget

Complete frontline healthcare worker budget table with:

- Number of frontline healthcare worker FTEs the U.S. Government will fund by year. The number of 2026 FTEs should generally be the same or higher than 2024 levels, unless there is a good reason for them to be lower. Annual U.S. Government funded FTEs should decline over time at an ambitious yet feasible rate.
- Estimated current number of FTEs the partner government funds
- Estimated number of new (or absorbed from U.S. Government) FTEs the partner government will fund. The number of FTEs should increase over time to replace U.S. government funded positions. This should only include positions funded by domestic sources and should exclude positions funded by other donor countries or multilateral institutions.
- The total aggregate number of frontline healthcare workers funded by the U.S. Government and partner government should not decline over time unless there is a good reason to do so (which must be reviewed and approved by the GHSD Front Office).
- By the end of the MOU, the partner government should have absorbed all frontline health workers required to maintain services.

- The MOU should define the specific positions included in frontline healthcare workers which should generally be doctors, clinical officers, nurses, community health workers and other similar frontline positions where the individual is directly serving patients.
- For U.S. Government funded positions, the MOU should lay out the mechanism(s) through which the U.S. Government will fund the positions and how, if at all, that mechanism will change over the course of the MOU. Mechanisms should not include specific contractors but rather select from options like "the national ministry of health," "regional governments," "the private sector," or "U.S. implementing partners."
- For purposes of this MOU, funding will cover the salary and benefits for frontline healthcare workers. This funding does not include any costs related to data systems or technical assistance for lab workers, which are covered in Sections 2.5.3 and 2.6.3 respectively.
- See additional budget guidance in Appendix I.

2.5 Data Systems

2.5.1 Vision

Please articulate a concise vision for the long-term data systems in the country. This vision should be concise, along the lines of the draft in the MOU template, and aligned with what you believe the partner government's vision to be. The vision should in particular identify the specific systems that will be selected and prioritized and for what purpose including:

- Electronic Medical Records (EMR) system(s)
- Laboratory management system(s)
- Pharmacy management system(s)
- Health commodity inventory / logistics management information system
- Health Management Information and Surveillance (DHIS2-type) systems for tracking and reporting health data at the facility level as well as any other integrated disease surveillance systems such as routine suspect disease case notification, or event-based, laboratory-based or sentinel surveillance methods
- National health data warehouse

In general, it is most advantageous if one system is identified for each of the above bullets, although we recognize in some cases it may be more than one system.

2.5.2 Implementation Plan

For the implementation plan, you must include:

- The specific data system being used for each purpose
- The type of investments the U.S. will make in each data system
- The number of facilities at which each data system will be rolled out by year, where applicable

For the implementation plan, you may include details on plans for:

- Data privacy, governance and cybersecurity politics
- Data quality / monitoring initiatives
- Efforts to automate certain data collection tasks so as to reduce data-related personnel, including digitalization and use of new technologies rather than paper-based systems
- The ongoing maintenance cost of each data system

- Energy sources and internet access including reliable power and internet access at health facilities
- Other items as deemed important by the health country team

2.5.3 Budget

Outline the total budget that will be invested annually in data systems. For 2026, estimate the specific amount that will be invested in specific data systems. For the entirety of the MOU period, estimate the specific amount that will be invested in each specific type of data systems (e.g., EMRs vs. laboratory management system vs. national health data warehouse). These amounts should only 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. All technical assistance related to data systems or other personnel related to data systems (such as data clerks) should be included in Section 2.6.

During the term of the MOU, the government must commit to paying all reasonable ongoing costs of software licenses, cloud computing, and servers for all systems discussed in Section 2.5 that are not otherwise paid for by the U.S. Government. See additional budget guidance in Appendix I.

2.6 Technical Assistance

2.6.1 Vision

The vision for all countries related to technical assistance should be fairly consistent across MOUs. In general, the MOUs should aim to wind down all technical assistance except the technical assistance tied to Section 2.1 (surveillance and outbreak response) and rolling out new innovative diagnostics, drugs, and other interventions by the end of the MOU period. If additional types of technical assistance will be needed after the MOU period, they can be added here but all additional types of technical assistance that will be needed after the MOU period must be approved by the GHSD Front Office.

2.6.2 Implementation Plan

For the implementation plan, you must include:

- Areas of technical assistance anticipated to be provided.
- Areas, if any, for continued U.S. Government technical assistance after the term of the MOU. Except for technical assistance related to Section 2.1 (surveillance and outbreak response) and rolling out new innovative diagnostics, drugs, and other interventions, all technical assistance in this Section 2.6.2 that may be continued after the term of the MOU must be approved by the GHSD Front Office.

The areas of technical assistance prioritized should heavily consider input from the partner country government on what types of technical assistance it most values.

For the implementation plan, you may include details on plans for:

- How the partner country government will provide technical assistance at the national or sub national level
- Other items as deemed important by the health country team

2.6.3 Budget

Outline the total budget that will be invested annually in technical assistance. For 2026, estimate the specific amount that will be invested in specific technical assistance efforts. In general, the technical assistance budget should decline over time; however, the downward trajectory should be calibrated to account for countries potentially requiring additional technical assistance as they take on greater responsibility for oversight, management, delivery, and financing of specific capabilities. The amount of technical assistance in the last year of the MOU should generally be small enough that it is reasonable to be picked up entirely by the partner country in the first year after the MOU, unless there are exceptions to continue technical assistance that are laid out in Section 2.6.1.

When developing a budget for the entire MOU, it is recommended that you budget Sections 2.1.3, 2.2.3, 2.3.3, 2.4.3, and 2.5.3 first and then allocate any remaining funding to Section 2.6.3 so as not to reduce funding for surveillance and outbreak response, laboratory systems, commodities, frontline healthcare workers, or data systems to provide more funding for technical assistance. See additional budget guidance in Appendix I.

2.7 Additional Responsibilities

Please propose any additional commitments that you think should be included in the MOU that are not included elsewhere in the MOU.

This could include any additional commitments that would be advantageous for promoting American interests with the partner government. This could include expanding market access for American companies or pushing for regulatory harmonization. In countries with large domestic markets or for which there are other strategic reasons, please include the drafted term requiring that a country recognize the U.S. Food & Drug Administration as meeting the country's regulatory approval requirements. Other countries may delete this term where they do not deem it to be significant or strategically important.

Additional commitments may also include requested policy changes by partner governments related to infectious diseases, expanding partnerships with the private sector or faith-based institutions, or other items as recommended by the health country team.

All additional terms added must be approved by the GHSD Front Office.

Section 3: Implementation

Please flag any concerns, additions, or modifications required or recommended within this section in order to increase the effectiveness of joint management and oversight of the MOU.

Section 4: Audit

Please flag any concerns, additions, or modifications required within this section.

Section 5: Co-Investment & Performance Benchmarks

Please flag any concerns, additions, or modifications required within this section.

Section 6: Additional Terms

The term for the MOU for each country will be provided by GHSD.

The proposed signatory from the country is the Head of State or his or her designee. Potential designees could include the Foreign Minister, Finance Minister, or another individual with authority to make the co-investment commitments on behalf of the partner government.

Additional Budget Guidance

Overview

Per the America First Global Health Strategy, the United States is committed to ensuring funding for 100% of commodities and 100% of frontline healthcare workers currently funded by the U.S. Government throughout the period of the MOU. In addition, the strategy prioritized the importance of surveillance and outbreak response as well as data systems. To that end, all country health teams should prioritize these items in their budgeting process.
Any MOUs that do not ensure continued funding for 100% of commodities and 100% of frontline healthcare workers currently funded by the U.S. Government throughout the MOU period (through a combination of U.S. Government and partner government funding) must be approved by the GHSD Front Office.

Funding levels will be provided by GHSD for each year and health program area (e.g., HIV, TB, malaria, maternal and child health, and global health security). During the implementation planning phase, country health teams will need to ensure that in aggregate the MOU can cross-walk at a high-level to those health area toplines. It is highly encouraged that country health teams take this into consideration during the MOU negotiation process.

While each country health team will have flexibility within this guidance to develop the details of the MOU budget, a suggested approach for budgeting is below.

Potential Budgeting Approach

Begin with the total MOU period funding amount provided by GHSD.

First, fund Section 2.1.3 surveillance and outbreak response at the budget levels provided by GHSD for global health security.

Second, fund 2026 in Sections 2.2.3, 2.3.3, and 2.4.3 at current spending levels.

Third, fund the last year of the MOU in Sections 2.2.3, 2.3.3, and 2.4.3 at a level that is appropriate based on what the level of funding will be in the first year after the MOU is completed.

For Section 2.2.3 frontline lab workers, any positions funded after the first year of the MOU should be able to be funded out of GHSD Global Health Security funding in Section 2.1.3 (assuming it stays flat from the last year of the MOU to the first year after the MOU).
For Section 2.2.3 lab commodities and Section 2.3.3, if your country's term of the MOU is less than five years, the general expectation is that the partner government will fund 100% of commodities in the first year after the MOU period ends. If your country's term of the MOU is five years, the GHSD team will let you know whether the expectation is that the partner government will fund 100% of commodities in the first year after the MOU period ends or if the U.S. Government plans to continue to provide commodity funding after the end of the MOU. For countries who will pick up 100% of commodity funding in the first year after the MOU, please ensure the amount of commodity funding covered by the U.S. Government in the last year of the MOU is such that it can reasonably be picked up by the partner country in the first year after the MOU.

For section 2.4, the partner government should have absorbed all frontline health workers required to maintain services by the end of the MOU (if not before).

Fourth, ramp down the spending from 2026 to the last year of the MOU for Sections 2.2.3, 2.3.3, and 2.4.3 at a pace that you believe is ambitious yet reasonable for the country.

Fifth, calculate the remaining funds each year after accounting for all spending in Sections 2.1.3, 2.2.3, 2.3.3, and 2.4.3. Based on this remaining total, determine the amount of funds to invest each year in data systems in Section 2.5.3.

Sixth, include any remaining funds for a given year in Section 2.6.3.

Potential Negotiation Approach

Overview

The Chief of Mission in each country will be the ultimate signer of the MOU and, as such, should ultimately decide how best to approach the negotiation. For eighteen countries, there will also be a senior GHSD official from Washington DC co-leading the negotiation. Each post should determine a negotiating strategy that works best for them. One potential strategy is outlined below.

Potential Negotiation Approach

First, the U.S. Government country health team completes the MOU on its own to the best of its ability to help understand what the U.S. Government might see as an ideal outcome from the negotiation.

Second, the U.S. Government country health team meets with the partner country's technical team to talk through each section of the MOU in detail. This could potentially be a half to full day meeting depending on the size of the MOU budget. No documents would have to be exchanged during this meeting.

Third, the U.S. Government country health team drafts the MOU based on input from the two steps above and provides a draft of this MOU to the partner country technical team. This would ensure: (1) the U.S. Government has the pen on the first draft of the MOU and (2) the first draft of the MOU included feedback from the partner government.

Fourth, the U.S. Government country health team and partner government technical team exchange drafts of the agreement and meet as necessary to discuss specific issues.
Fifth, where applicable, during the trips of senior GHSD officials from Washington DC to the country, meetings occur with the Chief of Mission and partner country government to discuss any key issues that are arising from the technical level MOU discussions.