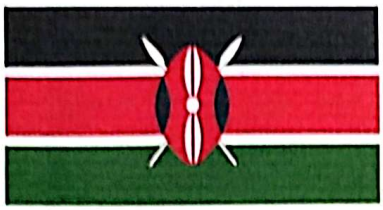

COOPERATION FRAMEWORK

BETWEEN

THE GOVERNMENT OF THE REPUBLIC OF KENYA

AND

THE GOVERNMENT OF THE UNITED STATES OF AMERICA

ON HEALTH

PREAMBLE

This Cooperation Framework (hereinafter referred to as the "Framework") is made between the Government of the United States of America (hereinafter referred to as "U.S. Government") and the Government of the Republic of Kenya (hereinafter referred to as the "Government of Kenya"), hereinafter jointly referred to as the "Participants" and individually as the "Participant."

CONSIDERING that the Government of Kenya 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 Government of Kenya and prevent the spread of emerging and existing infectious disease threats globally;

RECOGNIZING that U.S. Government global health investments made over the past 25 years have saved millions of lives and substantially and meaningfully strengthened Kenya's health system;

RECOGNIZING that Kenya has made substantial progress in advancing its domestic health system over the past 25 years;

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

DESIRING to state their shared objectives and intentions for cooperation as follows:

LIST OF ACRONYMS

ADAM	All Disease Outbreak Module
AI	Artificial Intelligence
ANC	Antenatal Care
ART	Antiretroviral Therapy / Treatment
ARV	Antiretroviral
BSC	Biosafety Cabinet
BSL	Biosafety Level
cVDPV	Circulating Vaccine-Derived Poliovirus
DHA	Digital Health Agency
DNO	Diagnostic Network Optimization
EID	Early Infant Diagnosis
EMR	Electronic Medical Records
eCHIS	Electronic Community Health Information System
EOC	Emergency Operations Center
e-POD	Electronic Proof of Delivery
FDA	Food and Drug Administration (United States)
FBO	Faith-Based Organization
FTE	Full-Time Equivalent
GHS	Global Health Security
GS1	Global Standards 1 (Global traceability standard)
HIV	Human Immunodeficiency Virus
HMIS	Hospital Management Information System
HPT	Health Products and Technologies
HRH	Human Resources for Health
HTA	Health Technology Assessment
ILMIS	Integrated Logistics Management Information System (KEMSA)
IPV	Inactivated Polio Vaccine
ISRS	Integrated Specimen Referral System
ISO	International Organization for Standardization
KEMSA	Kenya Medical Supplies Authority
KEMSA-QA	KEMSA Quality Assurance Laboratory
KEMRI	Kenya Medical Research Institute
KNEQAS	Kenya External Quality Assessment Scheme
LEN	Lenacapavir
LIMS	Laboratory Information Management System
LLIN	Long-Lasting Insecticide-Treated Net
MCH	Maternal and Child Health
MNCH	Maternal, Newborn, and Child Health
MoH	Ministry of Health

ML4	Maturity Level 4 (Regulatory)
NASCOP	National AIDS & STI Control Programme
NLMIS	National Logistics Management Information System
NPHI	National Public Health Institute
NPHIIS	National Public Health Intelligence Information System
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PT	Proficiency Testing
QA/QC	Quality Assurance / Quality Control
QMS	Quality Management System
RTCQI	Rapid Testing Continuous Quality Improvement
SHA	Social Health Authority
STI	Sexually Transmitted Infections
TB	Tuberculosis
UHC	Universal Health Coverage
USG	United States Government
WPV	Wild Poliovirus

LIST OF APPENDICES

Appendix 1: Government of Kenya Co-Funding Summary

Appendix 2: 2026 Planned U.S. Commodity Funding

Appendix 3: Frontline Laboratory and Healthcare Worker Funding

PARAGRAPH 1
OBJECTIVES

1.1 The objective of this Framework is to guide the collaboration of the Participants in the elimination of HIV, malaria, TB and other emerging infectious diseases, strengthen the Kenyan health system so that it can become more self-reliant, and promote U.S. interests abroad, including strengthening the partnership between the U.S. Government and the Government of Kenya.

PARAGRAPH 2
AREAS OF COOPERATION

The Participants intend to collaborate in the following areas:

2.1 SURVEILLANCE & OUTBREAK RESPONSE

2.1.1 Kenya envisions a country-level national surveillance and outbreak response system led by the Kenya National Public Health Institute (KNPHI) with functional capabilities in place to detect infectious disease outbreaks with epidemic or pandemic potential within 7 (seven) days of emergence, notify relevant authorities including critical parties in the national public health system and the U.S. Government within 1 (one) day of an infectious disease outbreak being detected; and complete relevant initial response actions to respond effectively within 7 (seven) days to infectious disease outbreaks in Kenya.

2.1.2 Implementation Plan

2.1.2.1 The U.S. Government intends to support a multi-sectoral assessment of Kenya's early warning, outbreak surveillance and response systems to include disease surveillance, border and migration health and safety procedures for pathogen sample collection, transport, storage, testing, and disposal.

2.1.2.2 This assessment should take into account the priorities outlined in the Kenya Integrated Surveillance Strategy, ensuring alignment with Kenya's national roadmap for integrated and multi-pathogen surveillance across HIV, STI, and viral hepatitis, as well as other epidemic-prone diseases.

2.1.2.3 The Government of Kenya intends to work with the U.S. Government to address any prioritized gaps identified by the aforementioned assessment.

2.1.2.4 The U.S. Government intends to support an integrated approach to strengthening the Government of Kenya's surveillance capacity through comprehensive training across One Health sectors and programs, including empowering academic institutions to deliver in-person and virtual training for current and future surveillance officers within an integrated surveillance framework.

2.1.2.5 The Government of Kenya intends to provide salaries and benefits for the following during the Field Epidemiology and Laboratory and Training Program:

Salaries and Benefits for:	2026	2027	2028	2029	2030
Field Epidemiologists	30	40	50	60	70
Other Positions*	371	405	443	227	155

**Includes public health emergency responders, logisticians, data scientists, laboratorians etc.*

2.1.2.6 The U.S. Government intends to support training of at least two hundred and fifty (250) staff focused on detection, notification, and response processes (e.g., field epidemiologist) each year during the term of this Framework.

2.1.2.7 The Government of Kenya intends to allow the United States Food and Drug Administration's (FDA) approval or Emergency Use Authorization of medical countermeasures to be a sufficient basis to use the medical countermeasures to respond to an outbreak in the country in accordance with applicable legislation in Kenya.

2.1.2.8 The U.S. Government, in coordination with the Government of Kenya, intends to establish a funding mechanism to surge additional personnel, supplies, equipment and other necessary materials needed to respond to detected infectious disease threats with epidemic potential to ensure that it is immediately accessible in line with the 7-1-7 (seven-one-seven) metric and implemented according to applicable laws and regulations of the Republic of Kenya.

2.1.2.9 The U.S. Government, in coordination with the Government of Kenya, intends to support the operationalization of the KNPHI; and the establishment and operationalization of 10 KNPHI Regional hubs and 20 County Emergency Operation Centers, and facilitate the training and capacity development of their personnel to enhance surveillance, national preparedness and response capabilities, within the 7-1-7 (seven-one-seven) metric.

2.1.2.10 The U.S Government, in coordination with the Government of Kenya, plans to institutionalize multi-sectoral collaboration and coordination, multi-sectoral data quality audits, enhance data security protocols, and promote evidence-driven decision-making and accountability at all levels.

2.1.3 Funding plan

2.1.3.1 The U.S. Government intends to provide the following support for surveillance and outbreak response activities in each of the specified years:

Year	U.S. Government Surveillance & Outbreak Response Funding (USD)
2026	$4,506,360
2027	$4,506,360
2028	$4,506,360
2029	$4,506,360
2030	$4,506,360

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

2.2 LABORATORY SYSTEMS

2.2.1 Kenya envisions a strategically coordinated tiered laboratory network that is fully equipped to detect, identify, and characterize pathogens with outbreak, epidemic, or pandemic potential whilst ensuring blood safety. Central to this vision is the establishment of a resilient and tiered laboratory system that ensures equitable and sustained access to diagnostic services across all regions. This integrated approach is critical to strengthening national health security, enabling timely public health responses, and supporting evidence-based decision-making at all levels of government.

2.2.2 The tiered network should consist of the labs below:

Level	Lab Category	No. of labs in Kenya
National	Public health surveillance	12
	Research	4
	Animal Health	2
	Level 6 referral	4
	National Quality Control Lab	1
	KEMSA Quality Assurance Lab	1
	National Blood safety reference laboratory	1
Regional	Public health surveillance	35
	Animal Health	5
	Regional Blood Safety Laboratories	6
County	County labs	4,542

2.2.3 Implementation Plan

2.2.3.1 For the purposes of this section, the U.S. Government currently funds approximately $14,961,000 of laboratory commodities and approximately 515 frontline laboratory workers in Kenya.

2.2.3.2 The U.S. Government plans to fund 100% of the aforementioned lab commodities in 2026, subject to the availability of funds. Thereafter, the U.S. Government's funding for these commodities is expected to decline gradually, with Kenya funding 100% of these commodities by the end of this Framework, as outlined in Paragraph 2.2.4.

2.2.3.3 The U.S. Government plans to fund frontline lab workers as outlined in Paragraph 2.2.4. This includes laboratory technicians and laboratory quality assurance officers.

2.2.3.4 The Government of Kenya plans to add onto the government payroll 515 frontline lab workers in 2028.

2.2.3.5 The Government of Kenya plans to ensure 90% of Level 2 and eight (8) Level 3 biosafety labs in Kenya 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 and ISO 15189) by the end of 2030.

2.2.3.6 The Government of Kenya plans to ensure that one (1) Level 4 biosafety lab in Kenya has biosafety and biosecurity management programs and quality assurance in place aligned with all relevant international accreditation standards (e.g. ISO 35001 and ISO 15189) by the end of 2030.

2.2.3.7 Any sample transport support provided by the U.S. Government is expected to be transitioned to Kenya by 2029. All specimen transport systems are expected to meet established global biosafety and biosecurity standards by the end of 2030.

2.2.3.8 Any diagnostic network optimization support provided by the U.S. Government is expected to be transitioned to Kenya by 2027.

2.2.3.9 Any laboratory quality improvement accreditation support provided by the U.S. Government is expected to be transitioned to Kenya by 2030.

2.2.3.10 The U.S. Government intends to support 3,500 county laboratories in 2026 for an estimated $3,313,024. The support includes integrated specimen referral, multi-disease testing, quality assurance, laboratory commodity management, biosafety/biosecurity, and laboratory decentralization. This is expected to decline gradually, with the Government of Kenya funding 100% of these laboratories and related services by 2030.

2.2.4 Funding Plan

2.2.4.1 The Participants intend to provide the following support for laboratory commodities in each of the specific years:

Year	U.S. Government Funding	New Government of Kenya Funding	Existing Government of Kenya Funding	Total Funding
2026	$14,960,974	-	$2,116,279	$17,077,253
2027	$10,472,682	$4,488,292	$2,116,279	$17,077,253
2028	$5,236,341	$9,724,633	$2,116,279	$17,077,253
2029	-	$14 960 974	$2,116,279	$17,077,253
2030	-	$14 960 974	$2,116,279	$17,077,253

2.2.4.2 The breakdown of the U.S. Government's planned 2026 lab commodity procurement spending is in Appendix 2.

2.2.4.3 The U.S. Government intends to transition the procurement, warehousing, and distribution of its lab commodities to the Kenya Medical Supplies Authority (KEMSA) by 31st December 2026.

2.2.4.4 The Government of Kenya intends to insure any lab commodity inventory both (a) paid for by the U.S. Government and (b) distributed through Kenya government-owned supply chains.

2.2.4.5 For the purposes of this Framework, lab commodities include the actual cost of the commodities as well as related commodity distribution costs, including warehousing, shipping, and trucking. These costs do not include any costs of data systems or technical assistance to support commodity procurement or supply chain distribution, which are covered in Paragraphs 2.5.9 and 2.6.3, respectively.

2.2.4.6 Funding provided by the Government of Kenya in the table above is to only include funding provided directly by the Government of Kenya and does not include grant funding from other donors or multilateral organizations.

2.2.4.7 The Participants intend to fund the following number of frontline laboratory workers in each of the specified years:

Year	U.S. Government # FTEs Funded	Government of Kenya New # FTEs Funded
2026	515	0
2027	515	0
2028	0	515
2029	0	515
2030	0	515

2.2.4.8 The breakdown of full-time equivalents (FTEs) by type of frontline lab workers is in Appendix 3. For purposes of this Framework, 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 with pay rates for such workers employed directly by the Government of Kenya. Positions funded by the Government of Kenya in the table above are expected to only include positions funded directly by the Government of Kenya and are expected not to include positions funded by other donors or multilateral organizations. This funding does not include any costs related to data systems or technical assistance for frontline lab workers, which are covered in Paragraphs 2.5.9 and 2.6.3, respectively.

2.3 COMMODITIES

2.3.1 Kenya envisions an integrated health care commodity supply chain system that uses KEMSA as a national pooled procurement, warehousing and distribution vehicle to public, faith-based, and private health facilities.

2.3.2 Implementation Plan

2.3.2.1 For the purposes of this section, the U.S. Government currently funds an estimated $74,782,231 of commodities annually, including HIV treatment, HIV rapid tests, HIV opportunistic infection treatment, tuberculosis preventive therapy, malaria rapid tests, malaria treatment, insecticide-treated nets, and limited commodities related to the management of maternal, newborn, and child health.

2.3.2.2 The U.S. Government intends to fund 100% of the aforementioned commodities in 2026 in the amount specified in Paragraph 2.3.3. Thereafter, the U.S. Government's funding for these commodities is expected to decline gradually with an increase in Kenyan domestic resources, funding to 100% of these commodities by the end of this Framework as outlined in Paragraph 2.3.3.

2.3.2.3 The Government of Kenya intends to fully implement a system based on Global Standards 1 (GS1) for tracing commodities funded by the U.S. Government under this Framework and distributed through KEMSA.

2.3.2.4 The Government of Kenya intends to strengthen national systems for the timely detection, investigation of cases of loss or diversion and falsification of health commodities. This includes enhancing KEMSA's internal safeguards comprising its existing and dedicated Security Department, real-time geo-fenced e-locks, e-POD systems, and oversight by the distribution Monitoring and Evaluation unit. This is in addition to reinforcing the Pharmacy and Poisons Board's (PPB) role in identifying and addressing falsified health products.

2.3.2.5 The Government of Kenya intends to notify the U.S. Government within seven (7) days when there are cases of loss or diversion of U.S. Government funded commodities.

2.3.2.6 The Participants intend to adopt a vendor-managed inventory system through KEMSA for selected, jointly decided-upon commodities to enhance the availability and efficient distribution of essential health products and technologies (HPT).

2.3.3 Funding Plan

2.3.3.1 The Participants intend to provide the following amount of support for commodities in each of the specified years:

Year	U.S. Government Funding	New Government of Kenya Funding	Existing Government of Kenya Funding	Total Funding
2026	$94,782,231	$0	$105,928,166	$200,710,397
2027	$44,869,339	$29,912,892	$105,928,166	$180,710,397
2028	$44,869,339	$29,912,892	$105,928,166	$180,710,397
2029	$29,912,892	$44,869,339	$105,928,166	$180,710,397
2030	$14,956,446	$59,825,785	$105,928,166	$180,710,397
2031	-	$74,782,231	$105,928,166	$180,710,397

2.3.3.2 The breakdown of the U.S. Government's planned 2026 commodity procurement funding is in Appendix 2, and the 2026 funding includes an additional one-time strategic investment in buffer stock for HIV treatment to support the implementation of six-month dispensing for stable patients and HIV prevention to support the elimination of mother-to-child transmission.

2.3.3.3 In support of Kenya's Vision 2030 agenda and the shared commitment to sustainable, resilient health systems, the U.S. Government intends to continue procuring and distributing its health commodities through a U.S. Government–designated implementing partner as an interim measure until 31st March 2026. Any further engagement of implementing partners in the procuring and distributing of health commodities is to be subject to the provisions of Paragraph 7 of this Framework on "Implementing Partners."

2.3.3.4 In alignment with 2.3.3.3 of this Framework, the U.S. Government intends to provide clear visibility on the quantities of commodities to be procured during the transition phase.

2.3.3.5 The U.S. Government intends to fully transition the procurement, warehousing, and distribution of its commodities to KEMSA by 31st December 2026.

2.3.3.6 Within ninety (90) days of signing this Framework, the Participants intend to develop a transition framework and KEMSA institutional readiness assessment, to structure the transition of commodities and inventory from U.S. Government implementing partners to KEMSA.

2.3.3.7 Concurrently, the Government of Kenya intends to continue to procure, warehouse, and distribute its commodities through KEMSA thereby advancing an integrated, efficient, and transparent national commodity management system that optimizes resources, strengthens accountability, and reinforces long-term supply-chain sustainability.

2.3.3.8 Funding provided by the Government of Kenya in the table above is expected to only include funding provided directly by the Government of Kenya and is expected not to include grant funding from other donors or multilateral organizations.

2.3.3.9 For purposes of this Framework, 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 Paragraphs 2.5.9 and 2.6.3 respectively.

2.4 HEALTHCARE WORKERS

2.4.1 The Government of Kenya aims to integrate healthcare workers funded by the U.S. Government, as set out in Appendix 3, into its healthcare workforce. Participants intend to enhance the services provided by other healthcare providers through capacity building for existing personnel, reverse task shifting, and the active engagement of community health promoters within the primary health care (PHC) model.

2.4.2 Implementation Plan

2.4.2.1 The U.S. Government intends to fund healthcare workers as outlined in Paragraph 2.4.3. This includes nurses, clinical officers, laboratory workers, pharmacy workers, and HIV testing and counseling service providers.

2.4.2.2 The Government of Kenya intends to absorb healthcare workers, as provided under Appendix 3 to this Framework, by 30th June 2028.

2.4.2.3 Further, the Government of Kenya intends to integrate and/or task-shift essential services currently provided by lay cadres not within the Government of Kenya schemes of service (including mentor mothers, seasonal frontline workers (malaria program), community health workers and other frontline clinical providers) to appropriate Government of Kenya cadres to ensure continuity.

2.4.3 Funding Plan

2.4.3.1 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	Government of Kenya New # FTEs Funded
2026	28,668	0
2027	21,407	0
2028	0	13,293
2029	0	13,293
2030	0	13,293

2.4.3.2 The breakdown by type of frontline healthcare worker is in Appendix 3. The U.S. Government intends to provide funding through a transition mechanism and then through

the Government of Kenya from 2027 to the end of this Framework. For purposes of this Framework, this funding is expected to include the salary and benefits 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 that are commensurate with pay rates for such workers employed directly by the Government of Kenya. Positions funded by the Government of Kenya in the table above are expected to only include positions funded directly by the Government of Kenya and are expected not to include positions funded by other donors or multilateral organizations. This funding does not include any costs related to data systems or technical assistance to support frontline healthcare workers, which are covered in Paragraphs 2.5.9 and 2.6.3, respectively.

2.5 DATA SYSTEMS

2.5.1 Participants intend to accelerate the ongoing digital health transformation reforms for delivery of universal health coverage as provided in the Government of Kenya Bottom-up Economic Transformation Agenda.

2.5.2 The Government of Kenya is implementing digital transformation of the health ecosystem as the backbone towards meeting universal health coverage. This involves operationalization of the comprehensive integrated health information management system as provided in the Digital Health Act, 2023. A core component of this system is health facility digitalization using a comprehensive hospital management information system (HMIS) that includes comprehensive clinical management, laboratory, pharmacy, and billing modules.

2.5.3 The Government of Kenya has already deployed TaifaCare HMIS, the flagship solution for health facilities, in 1,500 public health facilities. In addition, the Government of Kenya intends to deploy other complementary digital solutions to support surveillance and outbreak response such as National Public Health Intelligence Information System (NPHIIS), all disease outbreak module (ADAM), and ports of entry surveillance module. Additionally, the Government of Kenya is currently implementing the electronic community health information system (eCHIS), which is part of the digital health ecosystem and integrated with the Health Information Exchange, to monitor health at the community level with referrals to the facility.

2.5.4 The Government of Kenya is also in the process of implementing the National Logistics Management Integrated System (NLMIS) which includes order management, commodity availability, health products & technology (HPT) analytics and forecasting, track and trace, warehousing and order processing, distribution of HPTs, route optimization, and delivery tracking. NLMIS is expected to be integrated with other logistics systems.

2.5.5 The system also has digitalization of health care financing under Social Health Authority and Human Resources for Health.

2.5.6 These systems are interconnected through an operational health information exchange.

2.5.7 All data from health facilities and community information systems should be warehoused in the national data bank and county-based data banks as provided in the Digital Health Act, 2023.

2.5.8 Implementation Plan

2.5.8.1 The Government of Kenya intends to use TaifaCare HMIS and deploy and maintain it in 2,000 (public + faith-based organizations [FBOs]) health facilities by 2026, 4,000 (public + FBOs) health facilities by 2027 and 8,000 (public + FBOs) health facilities by 2028.

2.5.8.2 The Participants intend to support the following improvements to TaifaCare HMIS for provision of comprehensive health care: integration with laboratory and commodity management systems, Blood System - DAMUKe, requisite One Health related systems, mature standalone systems such as TIBU, Quality Management System (QMS), Community Reporting System, surveillance functionalities (including use of AI), machine learning based clinical decision support, Automated Indicator Reporting, and integration with Health Information Exchange over the term of this Framework consistent with Paragraph 2.5.9.

2.5.8.3 Further, the Participants intend to support innovative digital health infrastructure during the digitalization of health facilities such as efficient data connectivity, data banks, creation of data lake for advanced analytics, and AI-functionalities for surveillance and clinical care.

2.5.8.4 Before 1st April 2026, the Participants intend to develop a transition plan of Kenya EMR and other data systems currently supported by the U.S. Government to the Digital Health Agency.

2.5.8.5 The Participants intend to expand national- and county-level information platforms to support integrated, real-time, and multi-disease data for service delivery and coordination.

2.5.8.6 The Participants intend to build data architecture that integrates all health data systems including disease and emergency response outbreak systems.

2.5.8.7 The Government of Kenya intends to ensure greater than fifty percent (50%) of clinical encounters that are loaded in the Electronic Health Record within 1 (one) year of rollout in a facility and ninety percent (90%) of encounters loaded in the Electronic Health Record within two years of rollout in a facility.

2.5.8.8 The Government of Kenya intends to use a certified laboratory information management system in the regional and national public health laboratories. This system should serve regional and national laboratories which can integrate with the health facility HMIS, process samples, integrate with test analyzers, store samples, and release results back to the client or facility. This system should serve the needs of clinical care, surveillance, outbreak detection and response, including One Health, to be deployed by the end of 2028.

2.5.8.9 The U.S. Government intends to support the following improvements to the TaifaCare HMIS laboratory modules: two-way communication between laboratory, facility, and community systems for all samples requisition and return of results, the capability to track

sample transport as part of the integrated specimen referral system (ISRS), and the development of laboratory information systems to serve the regional and national public health laboratories over the term of this Framework consistent with Paragraph 2.5.9.

2.5.8.10 The Government of Kenya intends to use TaifaCare HMIS which has an in-built pharmacy management system and is expected to be rolled out in 50% of all public and Faith-Based Organizations (FBOs) facilities by end of 2027 and 100% of all public and FBO facilities by end of 2028.

2.5.8.11 The U.S. Government intends to support the improvements to TaifaCare HMIS pharmacy module over the term of this Framework consistent with Paragraph 2.5.9.

2.5.8.12 The Government of Kenya intends to use the National Public Health Intelligence Information System and All Disease Outbreak Module as its active surveillance systems. These systems are expected to be rolled out across all applicable sites by the end of 2027.

2.5.8.13 The U.S. Government plans to support the following improvements (system integration, module enhancement, and reporting) to disease outbreak surveillance system including the digitization of emergency operations centers (EOCs) for surveillance and outbreak detection and response from acute outbreaks and other public health priorities such as monitoring Lenacapavir (LEN) uptake and performance, mother-to-child transmission, and malaria infections over the term of this Framework, consistent with Paragraph 2.5.9.

2.5.8.14 The Government of Kenya intends to use the National Logistic Management Information System (NLMIS) as its health commodity inventory management system and associated functions. KEMSA logistics management information system, which should be integrated with the NLMIS, is expected to be in use across all components of the government-run health commodity supply chain by the end of 2027.

2.5.8.15 The U.S. Government intends to fund the following improvements to NLMIS and KEMSA iLMIS health commodity inventory management system over the term of this Framework: analytics and forecasting, including use of artificial intelligence (AI) in forecasting, enhancement of route optimization, track and trace, integration with complementary logistics systems, and HMIS improvements plus associated infrastructure, consistent with Paragraph 2.5.9.

2.5.8.16 The Government of Kenya intends to use the national health cloud.

2.5.8.17 The U.S. Government intends to support identified improvements to the national health cloud and operationalize sub-national unit health data banks over the term of this Framework consistent with Paragraph 2.5.9.

2.5.8.18 Both the U.S. Government and the Government of Kenya intend to maximize integration and interoperability between the aforementioned systems and to ensure that appropriate cybersecurity and data security are in place.

2.5.8.19 The national health cloud and/or other data systems are expected to be able to collect and report on all data described in Paragraph 3 of this Framework.

2.5.8.20 The U.S. Government and the Government of Kenya intend to negotiate a data sharing agreement in line with Paragraph 15 on 'Separate Agreements' for the purpose of implementation of this Framework.

2.5.9 Funding Plan

2.5.9.1 The U.S. Government intends to provide $175,000,000 over the course of the Framework to support data systems. The Government of Kenya intends to continue investing in the Digital Superhighway.

2.5.9.2 In 2026, the U.S. Government intends to provide funding for the following specific data systems: Kenya's Taifa Care HMIS enhancement, including laboratory and pharmacy integration and scale-up, and onboarding standalone systems to Taifa Care; for Kenya's National Logistics Management System (NLMIS); and Kenya's surveillance systems including EOC digitization.

2.5.9.3 Over the course of this Framework, the U.S. Government plans to fund Kenya's Taifa Care HMIS enhancements and maintenance including Kenya Electronic Medical Records systems; to develop one comprehensive Laboratory Information Management systems (LIMS); Kenya's surveillance systems including EOC digitization surveillance and outbreak response data system; Kenya's National Logistics Management System (NLMS) including pharmacy module, track and trace, health commodity inventory management system; and KEMSA iLMIS and GS1 implementation Kenya's National and county data banks as its national and county health data warehouse.

2.5.9.4 For purposes of this Framework, the amount in 2.5.9.1 includes 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.

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

2.6 STRATEGIC INTERVENTIONS

2.6.1 The Government of Kenya envisions being able to provide all of its own strategic assistance without U.S. Government support except for surveillance and outbreak response; and strategic assistance to support the rollout of new innovative diagnostics, vaccines, drugs, and other interventions.

2.6.2 Implementation Plan

To achieve the goal of full transition of U.S. Government-supported activities within five years, the following potential strategic interventions are listed:

2.6.2.1 **Save lives by decreasing deaths from HIV, TB, malaria, GHS (emerging threats), MCH, and polio.**

2.6.2.1.1 Quality HIV, TB, and malaria services integrated into national health insurance:

2.6.2.1.1.1 Participants may seek to update the Social Health Authority (SHA) benefits package to include HIV, TB, and other donor-funded services in standardized reimbursement rates for public, faith-based, and private providers.

2.6.2.1.1.2 Participants may explore the development and implementation of a national health-sector financing transition framework to guide Kenya toward increased fiscal ownership of HIV, TB, malaria, and essential health services.

2.6.2.1.1.3 Participants may support, as appropriate, SHA integration with DHA and eCHIS, including digital claims processing, biometric-linked verification, and provider-payment workflows.

2.6.2.1.1.4 Participants may encourage integration of prevention of mother to child transmission (PMTCT) into the MNCH platform to improve maternal care, ART continuity, HIV testing, early infant diagnosis (EID), and comprehensive newborn care.

2.6.2.1.1.5 Participants plan to work towards developing innovative models for the rollout of the new innovative diagnostics, drugs and vaccines.

2.6.2.1.2 Strengthen laboratory systems for diagnosis and surveillance:

2.6.2.1.2.1 Participants intend to operationalize the Integrated Specimen Referral System and Diagnostic Network Optimization (DNO) in all 47 counties to facilitate timely referral and relay of results for quality care.

2.6.2.1.2.2 Participants intend to institutionalize DNO to optimize diagnostic platforms for efficient, integrated testing services.

2.6.2.1.2.3 Participants intend to operationalize additional laboratory hubs and refurbish mobile labs to enhance internal laboratory infrastructure and reduce reliance on external labs.

2.6.2.1.2.4 Participants intend to establish a national biobanking system and laboratory cold chain storage to support independent handling of global health security tasks.

2.6.2.1.2.5 Participants plan to ensure that a significant proportion of biosafety level (BSL)-2 clinical, public health, and blood safety laboratories have biosafety cabinets (BSC) certifications, bio-risk management, will undergo refurbishment, and sustain their accreditations.

2.6.2.1.2.6 Participants aim to support the development of biosafety and biosecurity management standards and legislation to foster a self-reliant biosecurity framework.

2.6.2.1.2.7 Participants plan to jointly establish a BSL-4 lab and upgrade BSL-3 labs to support public health surveillance and emergency outbreak response and maintain their certification status.

2.6.2.1.2.8 Participants plan to implement quality assurance activities to meet national laboratory quality assurance standards and relevant international accreditation standards, while supporting laboratory capacity for disease outbreak detection at multiple sites.

2.6.2.1.2.9 Participants seek to build capacity for the Kenya External Quality Assessment Scheme (KNEQAS) to produce proficiency testing (PT) panels for multiple pathogens, thus reducing reliance on external sources.

2.6.2.1.2.10 Participants plan to support implementation of the Rapid Testing Continuous Quality Improvement (RTCQI) initiative for multiple pathogens of public health concern to facilitate rapid diagnosis of disease outbreaks.

2.6.2.1.2.11 Participants plan to implement and strengthen laboratory waste management systems through the installation of a high-capacity incinerator and a glass crushing system.

2.6.2.1.2.12 Participants seek to modernize the KEMSA quality assurance lab to enhance its capacity to detect substandard products as part of internal quality control.

2.6.2.1.2.13 Participants plan to modernize the National Quality Control Lab to achieve maturity level 4.

2.6.2.1.2.14 The Government of Kenya plans to ensure that 100% of blood samples are tested for transfusion transmissible infections.

2.6.2.1.3 Enhance outbreak detection, prevention, and response:

2.6.2.1.3.1 Participants intend to support the optimal operationalization of the Kenya National Public Health Institute.

2.6.2.1.3.2 Participants may seek to establish a national surveillance and rapid outbreak response network that integrates disease surveillance, genomic sequencing, field response teams, and real-time analytics, alongside a platform with early-warning indicators to enhance capacity for swift outbreak detection and response and proactive public health management.

2.6.2.1.3.3 Participants may encourage catalytic novel innovations and interventions that accelerate and sustain gains for case finding for TB and HIV and prevent outbreaks, such as seasonal malaria chemoprevention, indoor residual spraying (IRS), and new interventions.

2.6.2.1.3.4 Participants may consider establishing rapid-deployment multidisciplinary outbreak response teams capable of responding within 48–72 hours.

2.6.2.1.3.5 Participants may support the introduction of standardized protocols for outbreak verification, reporting, escalation, and post-response monitoring.

2.6.2.2 **Develop local and resilient health systems to decrease reliance on U.S. Government support**

2.6.2.2.1 Transition to domestic financing and integrated health systems:

2.6.2.2.1.1 Participants may seek to strengthen domestic financing to shift from donor-driven vertical programs to an integrated health system through a national transition framework.

2.6.2.2.1.2 Participants may encourage strengthening SHA's actuarial modeling, revenue mobilization, efficient monitoring processes, and separation of strategic purchasing from revenue collection.

2.6.2.2.1.3 Participants may support building SHA institutional capacity through specialized modelers, actuaries, and governance support.

2.6.2.2.1.4 Participants may support the SHA Benefits Package and Tariffs Advisory Panel and encourage institutionalization of Health Technology Assessment (HTA) for evidence-based purchasing.

2.6.2.2.2 Strengthen health workforce and institutional capacity:

2.6.2.2.2.1 Participants may work with counties to build a resilient, multi-competent workforce through structured skills transfer, mentorship, harmonized training, and continuous professional development.

2.6.2.2.2.2 Participants may support the development and implementation of guidelines for post-graduate and in-service training of health workers.

2.6.2.2.2.3 Participants intend to review existing policies and guidelines on training and development to mainstream e-learning.

2.6.2.2.2.4 Participants plan to scale a harmonized community health promoters model and redesign training modules based on health service needs.

2.6.2.2.2.5 Participants seek to support models for integration of services and develop clinical pathways for improvement of the quality of care.

2.6.2.2.3 Modernize supply chain and vendor management:

2.6.2.2.3.1 Participants intend to implement a transparent national supply chain platform integrating forecasting, pooled procurement, warehousing, distribution, and expiry management.

2.6.2.2.3.2 Participants intend to deploy Vendor-Managed Inventory (VMI) for jointly identified products and GS1 for ARVs, TB drugs, long-lasting insecticidal nets (LLINs), rapid diagnostic tests (RDTs), vaccines, and emergency commodities.

2.6.2.2.3.3 Participants plan to support integration of updated HIV, TB, and malaria regimens into national supply planning.

2.6.2.2.3.4 Participants plan to consider costing and provision of essential commodities, including 6MMD (6 month multi-month dispensing), Lenacapavir, heat-stable carbetocin for post-partum hemorrhage (PPH), and caffeine citrate for prematurity.

2.6.2.2.3.5 Participants intend to ensure availability of commodities for emergency preparedness and response.

2.6.2.2.4 Advance digital health transformation:

2.6.2.2.4.1 Participants plan to operationalize a unified national digital health architecture integrating service provision, surveillance and outbreak detection, human resources for health (HRH), HPT, laboratory, and financing data.

2.6.2.2.4.2 Participants plan to migrate USG-operated digital systems to the DHA ecosystem.

2.6.2.2.4.3 Participants plan to support digitization of county-level EOCs.

2.6.2.2.4.4 Participants intend to consider establishing county-level data banks and optimizing the national-level data lake.

2.6.2.2.4.5 Participants plan to institutionalize data-driven decision-making and automated performance management tools.

2.6.2.2.4.6 Participants plan to operationalize the health data governance strategy and Digital Health Regulations and build capacity for predictive analytics and modeling.

2.6.2.2.4.7 Participants intend to institutionalize accountability mechanisms for planning, budgeting, and oversight using integrated digital platforms.

2.6.2.2.4.8 Participants plan to build a national, county, and facility leadership strengthening program linked to digital M&E dashboards, HRH accountability tools, and PHC governance.

2.6.2.2.4.9 Participants intend to establish a joint monitoring and accountability framework for tracking progress and ensuring transparency.

2.6.2.3 **Promote American and Kenyan interests**

2.6.2.3.1 Foster United States of America-Kenya partnerships and innovation:

2.6.2.3.1.1 Participants plan to operationalize a unified national digital health architecture integrating service provision, surveillance and outbreak detection, HRH, HPT, laboratory, and financing data.

2.6.2.3.1.2 Participants plan to explore local manufacturing efforts to encourage partnerships between U.S. companies for diagnostics, vaccines, biologics, and pharmaceuticals.

2.6.2.3.1.3 Participants plan to migrate USG-operated digital systems to the DHA ecosystem.

2.6.2.3.1.4 Participants plan to support digitization of county-level EOCs.

2.6.2.3.1.5 Participants plan to establish county-level data banks and optimize the national-level data lake.

2.6.2.3.1.6 Participants intend to institutionalize data-driven decision-making and automated performance management tools.

2.6.2.3.1.7 Participants intend to support operationalization of Digital Health Regulations and build capacity for predictive analytics and modelling.

2.6.2.3.1.8 Participants plan to institutionalize accountability mechanisms for planning, budgeting, and oversight using integrated digital platforms.

2.6.2.3.1.9 Participants plan to build a national leadership strengthening program linked to digital monitoring and evaluation (M&E) dashboards, HRH accountability tools, and PHC governance.

2.6.2.3.1.10 Participants intend to establish a joint monitoring and accountability framework for tracking progress and ensuring transparency.

2.6.2.3.1.11 Participants intend to support Kenya's progression toward ML4 regulatory maturity and expand domestic vaccine production capacity.

2.6.2.4 **Promote standards and best practices**

2.6.2.4.1 Participants plan to align all partner and donor investments under transparent, MoH-led governance, and consistent with U.S. standards for accountability and oversight.

2.6.2.4.2 Participants plan to adopt global best practices in supply chain management, digital health, and laboratory quality assurance, leveraging American technology and systems.

2.6.2.4.3 Participants intend to support regulatory strengthening, policy and legal frameworks, and market access pathways that facilitate U.S. investment and private sector engagement in Kenya's health sector.

2.6.2.5 **Advance leadership in global health security**

2.6.2.5.1 Participants plan to support Kenya's capacity to detect, prevent, and respond to emerging health threats, protecting both Kenyan and American interests.

2.6.2.5.2 Participants intend to advance sustainable digital health systems and services implemented through U.S. Government funding, embedding American standards for data governance and interoperability.

2.6.3 Funding Plan

2.6.3.1 The U.S. Government intends to provide the following amount of strategic assistance funding in each of the specified years:

Year	U.S. Government Strategic Assistance Funding (USD)
2026	$102,706,246
2027	$127,637,380
2028	$168,814,814
2029	$235,118,267
2030	$113,313,280

2.7 ADDITIONAL RESPONSIBILITIES OF THE PARTICIPANTS

2.7.1 The Participants commit to negotiate tax-exemption mechanisms in separate implementation agreements to give effect to the tax exemption principle for assistance provided under this Framework.

2.7.2 The Government of Kenya intends to apply reliance principles in recognizing U.S. FDA approvals and Emergency Use Authorizations as a basis for authorizing corresponding health products in Kenya, by December 31, 2026, subject to verification of product

sameness and the applicable review processes of the PPB and other applicable regulatory bodies. This commitment extends beyond emergency-use countermeasures to include routine therapeutics, new chemical entities, biologics, vaccines, diagnostics, and other health-related innovations.

2.7.3 The U.S. Government intends to support capacity-building for regulatory staff through targeted training programs, technical assistance, and workforce development initiatives to sustain advanced regulatory system functionality for health products and to enhance regulatory preparedness and response capacities for public health emergencies.

2.7.4 The Participants intend to enable timely and appropriate information-sharing between the FDA and PPB to support regulatory decision-making, strengthen oversight of health products, and facilitate coordinated regulatory actions, where appropriate.

2.7.5 The Participants intend to strengthen and expand public–private partnerships for supply-chain logistics, diagnostic services, and health technology to enhance coverage, efficiency, and innovation.

2.7.6 The Participants intend to work together to support American companies seeking to establish operations in Kenya in accordance with the laws and regulations of the Republic of Kenya.

2.7.7 The Participants acknowledge the important work of faith-based health facilities and intend to continue working with faith-based health facilities to deliver frontline health services consistent with Paragraph 7 of this Framework.

PARAGRAPH 3
PERFORMANCE INDICATORS

3.1 Outcome Metrics: The Participants aim to work together to achieve the following outcome metrics by the end of each of the specified years:

Outcome Indicators	Baseline 2025	2026	2027	2028	2029	2030
% People With HIV Who Know Their Status	95.0%	95.5%	96.0%	96.5%	97.0%	97.5%
% People Who Know Their HIV Status on Treatment	97.0%	97.2%	97.4%	97.6%	97.8%	98.0%
% People On Antiretroviral Treatment (ART) Who Are Virally Suppressed	94.0%	95.0%	96.0%	97.0%	97.5%	98.0%
# Malaria Deaths in Children Under 5	3,242	2,658	2,180	1,788	1,466	1,202
# of TB deaths (of the notified TB cases)	5,812	4,861	4,629	4,383	4,076	3,791
# Polio Cases (e.g., WPV, cVDPVB)	7	5	3	2	2	2
# Measles Cases	725	594	463	332	201	72

Facility Maternal Mortality Rate (per 100,000)	98	90	88	86	84	82
Facility Neonatal Mortality Rate (per 1,000 live births)	10	9	8	7	7	6

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

Process Indicators	Baseline	2026	2027	2028	2029	2030
# people on ART	1,299,672	1,302,472	1,305,272	1,308,072	1,310,872	1,313,672
# new HIV diagnoses among infants (0-12 months)	2,002	1,802	1,622	1,459	1,314	1,182
# new HIV diagnoses among children and adults (age 18 months or older)	80,700	70,700	60,700	50,700	40,700	30,700
% pregnant and breastfeeding women living with HIV who receive ART	90%	92%	94%	96%	97%	98%
% confirmed malaria cases that receive first-line antimalarial treatment	98.5%	100%	100%	100%	100%	100%
# insecticide-treated nets distributed to populations at risk of malaria	1.4M	1.4M	1.4M	1.4M	1.4M	1.4M
# patients with TB notified (i.e., bacteriologically confirmed + clinically diagnosed)	96,865	97,219	92,585	87,659	81,523	75,816
% patients with TB notified who completed treatment	89%	90%	91%	92%	92%	92%
% surviving infants who received at least one dose of inactivated polio vaccine	79%	82%	85%	88%	90%	93%
% children aged 12–23 months who received one dose of measles-containing vaccine	75%	80%	82%	84%	86%	88%

% pregnant women with 4th ANC visit (%)	51.7%	53%	55%	57%	59%	61%
% accuracy of data fields assessed during the annual data audit	N/A	90%	92.5%	95%	95%	95%

3.3 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 duration of this Framework:

3.3.1 The Government of Kenya detects suspected infectious disease outbreaks with epidemic potential in Kenya within 7 (seven) days of disease emergence.

3.3.2 The Government of Kenya notifies the U.S. Government within 1 (one) day of detection of an infectious disease outbreak through the Director General of the Ministry of Health and Ministry of Foreign & Diaspora Affairs.

3.3.3 The Government of Kenya completes relevant initial response actions to respond effectively to infectious disease outbreaks in Kenya within 7 (seven) days of notification, including engaging in consultation with the U.S. Government on Kenya's response.

PARAGRAPH 4
IMPLEMENTATION

4.1 **Implementation Plan:** Within ninety (90) days of signing this Framework, the Participants intend to develop a detailed implementation plan ("Implementation Plan") that includes the timelines for implementing all areas of this Framework outlined in Paragraph 2 of this Framework.

4.2 The Participants acknowledge ongoing projects funded by the U.S. Government and implemented through the U.S. Government implementing partner contracts and agreements, from 1st October 2025 to 31st March 2026.

4.3 **Steering Committee:** The Participants intend to establish a Joint Health Framework Steering Committee (JHFSC) composed of senior representatives from both governments and other key stakeholders as mutually decided by the Government of Kenya and the U.S. Government. The JHFSC is expected to meet at least quarterly to monitor implementation of this Framework, review progress and propose areas of possible modification.

PARAGRAPH 5
AUDIT

5.1 **Outcomes Metrics Audit:** Both Participants acknowledge the importance of ensuring accurate outcomes data. The Government of Kenya acknowledges that so long as the U.S. Government is providing any funding in support of activities described in this Framework, the U.S. Government has a significant and material interest in ensuring the outcome metrics outlined in Paragraph 3.1 of this Framework are accurately collected, complete, and maintained. To this

end, the U.S. Government intends to fund a survey for up to $10 million in each of 2027 and 2029, to objectively measure the outcomes outlined in Paragraph 1.1 of this Framework. The U.S. Government and the Government of Kenya intend to work together to mutually decide upon the design and execution of the survey.

5.2 **Process Metric Audit:** The Government of Kenya acknowledges that so long as the U.S. Government is providing any funding in support of activities described in this Framework, the U.S. Government has a significant and material interest in ensuring the process metrics outlined in Paragraph 3.2 of this Framework are accurately collected, complete, and maintained. To this end, the Government of Kenya intends to provide the U.S. Government with any information needed to audit the process metrics in Paragraph 1.2 and 1.3 of this Framework in up to five percent (5%) of randomly selected and/or specific health facilities, clinics, labs, or programs identified by both Participants.

5.3 **Supply Chain Audit:** The Government of Kenya acknowledges that so long as the U.S. Government is providing funding for commodities as described in Paragraph 2.2 or 2.3 of this Framework, 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 Government of Kenya intends to provide the U.S. Government with any information needed to audit supply chain leakage as provided under the applicable laws and regulations of Kenya.

5.4 **Co-Investment Audit:** The Government of Kenya acknowledges that so long as the U.S. Government is providing funding for activities described in Paragraph 2.2, 2.3, and/or 2.4 of this Framework, the U.S. Government has a significant and material interest in ensuring the Government of Kenya is making its co-investment. To this end, the Government of Kenya intends to provide the U.S. Government with any information needed to audit any accounts from which or to which co-investment funding is being made, as provided under the applicable laws and regulations of the Government of Kenya.

5.5 **Regulatory Compliance Audit:** The Government of Kenya acknowledges that so long as the U.S. Government is providing funding in support of any activities described in this Framework, the U.S. Government has a significant and material interest in ensuring compliance with all U.S. laws and policies including the Helms Amendment, including those which prohibit 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 Government of Kenya intends to provide the U.S. Government with information needed to monitor compliance with applicable law and legal requirements of Kenya, 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.

5.6 The Government of Kenya acknowledges its commitment to provide the data access or information requested for reporting purposes in order to continue with implementation of this Framework as planned.

5.7 The information shared with the U.S. Government for the purpose of audit is expected to be subject to existing laws and regulations of Kenya and concurrence of the Office of Data Protection Commissioner.

PARAGRAPH 6
CO-INVESTMENT & PERFORMANCE BENCHMARKS

6.1 Co-Investment

6.1.1 In the event that the Government of Kenya does not fulfill the co-investment commitments outlined in Paragraph 2.2.3, 2.3.3, and/or 2.4.3 of this Framework within the specified calendar year, the U.S. Government may within a period of nine (9) months give notice to reduce or cease providing funding to the Government of Kenya under this Framework in future years. For purposes of this Paragraph and Paragraphs 2.2.3, 2.3.3, and 2.4.3, co-investment by the Government of Kenya may only be calculated based on funds raised directly by the Government of Kenya including loans and may not include grant funding from other donors or multilateral organizations.

6.1.2 In addition, the Government of Kenya plans to increase its domestic government health expenditures by the following amounts in each of the following years:

Year	Increase in Domestic Health Expenditures by the Government of Kenya Relative to 2025 Baseline
Kenya FY 2025/2026	0
Kenya FY 2026/2027	10 billion Kenyan Shillings
Kenya FY 2027/2028	20 billion Kenyan Shillings
Kenya FY 2028/2029	35 billion Kenyan Shillings
Kenya FY 2029/2030	50 billion Kenyan Shillings

6.1.3 A precise definition of domestic government health expenditures should be jointly determined during the implementation period but should include all domestic government health expenditures and may not include grants or other funds from the U.S. Government, other donors, or multilateral organizations. The Participants intend to work together during the implementation period to determine the amount the Government of Kenya is spending on domestic government health expenditures in 2025 and this amount is to be the 2025 baseline.

6.1.4 Both Participants acknowledge that so long as the U.S. Government is providing any funding in support of activities described in this Framework, the U.S. Government has a significant and material interest in ensuring the co-investment outlined in this Paragraph 6.1 occurs. To this end, both Participants acknowledge the U.S. Government plans to

decrease its funding 1:1 under this Framework if the Government of Kenya does not meet the above co-investment.

6.1.5 Participants acknowledge that this Framework is between the Government of the Republic of Kenya and the U.S. Government. Funds from the U.S. Government should be disbursed through Government of Kenya development funding in the spirit of Government-to-Government cooperation to the maximum extent practical.

6.2 Performance Incentives

6.2.1 In the event that the Government of Kenya achieves all the process and outbreak response metrics for 2027 or 2028 outlined in Paragraphs 3.2 and 3.3 of this Framework, the Government of Kenya is expected to be eligible to receive a performance incentive for 2027 or 2028 respectively.

6.2.2 The U.S. Government reserves the discretion to build a composite score of these metrics for the purpose of calculating eligibility for the performance incentive in a manner that avoids decreasing Kenya's eligibility for the performance incentive in consultation with the Government of Kenya. Performance incentives may be used by the Government of Kenya to fund any health-related costs that would be allowed under this Framework.

PARAGRAPH 7
IMPLEMENTING PARTNERS

7.1 Both Participants acknowledge the importance of moving to on-budget, government-to-government funding as quickly as possible and sunsetting all implementing partners that are outside of that government-to-government mechanism in order to maximize the Government of Kenya's ability to deliver on the outcomes in Paragraph 3 of this Framework and develop a resilient and durable health system that does not require future funding from the U.S. Government.

7.2 The U.S. Government intends to provide to the Government of Kenya all contractual documents utilized in the engagement with implementing partners in Kenya, including contracts, sub-contracts, agreements and scopes of work, upon signing of this Framework to the maximum extent practicable and consistent with U.S. laws and regulations.

7.3 Within ninety (90) days of the signing of this Framework, the Participants intend to conduct an in-depth portfolio review of programs funded by the U.S. Government and identify implementing partners for termination/discontinuation, modification, or continuation of their contracts by the U.S. Government.

7.4 Engagement of implementing partners whose contracts are considered for modification or continuation is expected to be through the Government of Kenya mechanisms not later than 31st of March 2026 to the maximum extent practicable under U.S. law and regulations.

7.5 Notwithstanding the above, the Government of Kenya intends to ensure continuity of services in faith-based health facilities currently being supported by the U.S. Government.

7.6 In the event the Participants are not able to decide on a mutually acceptable implementation plan under Paragraph 4 of this Framework, including the details of government-to-government funding, both Participants acknowledge the Participants may revisit Paragraph 3, Paragraph 6.1, and U.S. Government funding levels under this Framework.

PARAGRAPH 8
SPECIMEN TESTING

8.1 The U.S. Government and the Government of Kenya intend to continue specimen testing including genetic sequencing and sharing data on detected pathogens subject to the existing laws and regulations of the Government of Kenya.

PARAGRAPH 9
APPLICABLE LAWS

9.1 This Framework between the Participants is expected to be carried out consistently with applicable law and the relevant rules and regulations of the Government of Kenya and the U.S. Government.

PARAGRAPH 10
FUNDING

10.1 The Participants acknowledge that this Framework is intended to exclusively cover activities funded by the U.S. Department of State and the Government of Kenya. All activities described in and/or pursued by the Participants under this Framework are subject to the availability of funds, personnel, and other resources.

PARAGRAPH 11
CONFIDENTIALITY

11.1 Unless otherwise authorized under this Framework or its appendices, the Participants are expected not to disseminate or otherwise make available any information exchanged under this Framework 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 Framework public.

PARAGRAPH 12
PRIVILEGES, IMMUNITIES, AND FACILITIES

12.1 Nothing in this Framework should be interpreted or construed as a waiver of the privileges, immunities, and facilities which each of the Participants enjoys by virtue of the international agreements and laws applicable to each Participant.

PARAGRAPH 13
NOTICES

10.1 Any notice required under this Framework is expected to be provided to:

For the U.S. Government
Chief of Mission
United Nations Avenue, Gigiri
P.O. Box 606 Village Market
00621 Nairobi, Kenya
cs@health.go.ke

For the Kenyan Government
Cabinet Secretary
Ministry of Health
PO Box 30016 - 00100
Afya House, Cathedral Road

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

PARAGRAPH 14
RESOLUTION OF DIFFERENCES

14.1 The Participants intend to resolve any differences between them arising from or in connection with the interpretation or performance of this Framework amicably through consultations and negotiations through diplomatic channels.

PARAGRAPH 15
SEPARATE AGREEMENTS

15.1 In implementing the Paragraph 1 Areas of Cooperation, the Participants may enter into further subsidiary agreements to give effect to any provisions of this Framework and any other contemplated commitments required of the Participants, including financing agreement(s), data sharing agreement and specimen testing agreement.

PARAGRAPH 16
PARTICIPATION IN SIMILAR ACTIVITIES

16.1 This Framework should be construed so as not to prevent the Participants from engaging in similar activities not otherwise covered by this Framework with other parties or similar agencies.

PARAGRAPH 17
BASIC PRINCIPLE OF IMPLEMENTATION

17.1 The Participants commit to adhere to the internationally accepted principles and values consistent with their applicable domestic laws.

PARAGRAPH 18
INTELLECTUAL PROPERTY

18.1 All intellectual property rights with respect to any research, product and/or services developed jointly by the Participants pursuant to this Framework should be determined on a case-by-case basis in accordance with all applicable laws and relevant international agreements to which either or both Participants are a party.

18.2 Each Participant may use, reproduce, adapt or modify, publish, communicate, license, and transfer such intellectual property upon the written consent of the other Participant.

18.3 Where either Participant intends to use the intellectual property rights developed in sub paragraph 18.2 above, for purposes other than envisaged by this Framework, the Participants plan to resolve any matter in relation to such use, in a separate agreement.

PARAGRAPH 19
LEGAL STATUS

19.1 This Framework is not an international agreement and does not give rise to rights or obligations under international or domestic law.

PARAGRAPH 20
COMMENCEMENT AND DURATION

20.1 The activities under this Framework are intended to commence upon signature by both Participants.

20.2 The Framework is intended to continue for a period of five (5) years, after which the Participants plan to review implementation of the activities under this Framework and may extend the duration by mutual decision.

PARAGRAPH 21
MODIFICATION

21.1 This Framework may be modified by the mutual decision of the Participants in writing. Such modifications are to become operative on the date mutually determined by the Participants.

PARAGRAPH 22
DISCONTINUATION

22.1 Either Participant may discontinue participating under this Framework by giving the other Participant six (6) months prior written notice through diplomatic channels.

SIGNED at Washington, DC on this FOURTH day of DECEMBER, 2025, in duplicate, in the English language.

FOR THE GOVERNMENT OF THE THE REPUBLIC OF KENYA:

H.E (DR.) MUSALIA MUDAVADI, EGH
PRIME CABINET SECRETARY &
CABINET SECRETARY FOR FOREIGN &
DIASPORA AFFAIRS

FOR THE GOVERNMENT OF UNITED STATES OF AMERICA:

MARCO RUBIO
SECRETARY OF STATE

APPENDICES

Appendix 1: Government of Kenya Co-Funding Summary

In the following tables and throughout the Framework, years designated as 2026 for the U.S. Government is fiscal year 2026 (October 1st, 2025 through September 30th, 2026) and for the Government of Kenya is fiscal year 2025/2026 (July 1st, 2025 through June 30th, 2026) and respectively following for 2027, 2028, 2029, and 2030.

The below represents the total planned financial support by both the U.S. Government and the Government of Kenya during the term of the Framework:

Year	U.S. Government $	Increase in Domestic Government Health Expenditures by Government of Kenya Relative to 2025 Baseline
2026	414,294,000	0
2027	388,294,000	10 billion Kenyan Shillings
2028	341,194,000	20 billion Kenyan Shillings
2029	326,194,000	35 billion Kenyan Shillings
2030	161,494,000	50 billion Kenyan Shillings

**Includes U.S. Government cost of doing business and funding for audits.*

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

Year	2026	2027	2028	2029	2030
Surveillance & Outbreak Response ($)	4,506,350	4,506,350	4,506,350	4,506,350	4,506,350
Lab Commodities ($)	14,960,974	10,472,682	5,236,341	0	0
Frontline Lab Workers (# FTEs)	515	515	0	0	0
Frontline Lab Workers ($)	6,462,293	4,308,195	2,154,098	0	0
Other Commodities($)	94,782,231	44,869,339	44,869,339	29,912,892	14,956,446
Frontline Healthcare Workers (# FTEs)	28,668	21,407	0	0	0
Frontline Healthcare Workers ($)	45,735,429	30,490,286	0	0	0
Data Systems ($)	30,000,000	75,000,000	50,000,000	10,000,000	10,000,000

Strategic Interventions ($)	102,706,246	127,637,380	168,814,814	235,118,267	113,313,280
Program Management ($)	90,282,837	67,712,128	45,141,418	27,084,851	9,028,234
Total	**389,436,360**	**364,996,360**	**320,722,360**	**306,622,360**	**151,804,360**

The below represents the total new planned financial support described in this Framework by the Government of Kenya during the term of the Framework:

Year	2026	2027	2028	2029	2030	2031
Lab Commodities ($)	0	4,488,292	9,724,633	14,960,974	14,960,974	14,960,974
Frontline Lab Workers (# FTEs)	0	0	6,462,293	6,462,293	6,462,293	6,462,293
Other Commodities ($)	0	29,912,892	29,912,892	44,869,339	59,825,785	74,782,231
Frontline Healthcare Workers (# FTEs)	0	0	45,735,429	45,735,429	45,735,429	45,735,429
Total	**0**	**34,401,184**	**91,835,247**	**112,028,035**	**126,984,481**	**141,940,927**

Appendix 2: 2026 Planned U.S. Commodity Funding

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

Laboratory Commodities

Lab Commodity	Amount
HIV	$14,218,608
TB	$194,173
Malaria	$0
Polio	$48,193
MCH	$0
GHS	$500,000
Total	**$14,960,974**

Other Commodities

Commodity	Amount
HIV	$57,239,945
TB	$172,051
Malaria	$16,866,693
Polio	$0
MCH	$503,541
GHS	$0
Sub-Total	$74,782,231
Buffer for 6MMD for ART +Len PrEP- HIV	$20,000,000
Total	**$94,782,231**

Appendix 3: Frontline Laboratory Healthcare Worker Funding

The Government of Kenya intends to absorb 1,244 nurses, 1,428 clinical officers, 348 pharmacy workers, 515 laboratory workers by 30th June 2028 on July 1, 2028, including 2,591 HIV testing and counseling service providers.

The U.S. Government and the Government of Kenya intend to provide the following funding for frontline lab and healthcare workers:

Frontline Healthcare Worker Type #1: Laboratory Workers

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$ 3,618,414	$0	$0	$ 3,618,414
2027	$ 3,618,414	$ 0	$0	$ 3,618,414
2028	$ 0	$ 3,618,414	$0	$ 3,618,414
2029	$ 0	$ 3,618,414	$ 0	$ 3,618,414
2030	$ 0	$ 3,618,414	$0	$ 3,618,414

Frontline Healthcare Worker Type #2: Clinical Officers

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya] Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$ 9,359,968	0	0	$ 9,359,968
2027	$ 9,359,968	$ 0	0	$ 9,359,968
2028	$ 0	$ 9,359,968	$ 0	$ 9,359,968
2029	$ 0	$ 9,359,968	$ 0	$ 9,359,968
2030	$ 0	$ 9,359,968	$ 0	$ 9,359,968

Frontline Healthcare Worker Type #3: Pharmacy Workers

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$ 2,086,233	0	0	$ 2,086,233
2027	$ 2,086,233	$ 0	0	$ 2,086,233
2028	$ 0	$ 2,086,233	$ 0	$ 2,086,233
2029	$ 0	$ 2,086,233	$ 0	$ 2,086,233
2030	$ 0	$ 2,086,233	$ 0	$ 2,086,233

Frontline Healthcare Worker Type #4: Nurses

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$ 7,208,644	0	0	$ 7,208,644
2027	$ 7,208,644	$ 0	0	$ 7,208,644
2028	$ 0	$ 7,208,644	$ 0	$ 7,208,644
2029	$ 0	$ 7,208,644	$ 0	$ 7,208,644
2030	$ 0	$ 7,208,644	$0	$ 7,208,644

Frontline Healthcare Worker Type #5: Testing and Counseling Providers

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$ 8,196,029	0	0	$ 8,196,029
2027	$ 8,196,029	0	0	$ 8,196,029
2028	$ 0	$ 8,196,029	0	$ 8,196,029
2029	$ 0	$ 8,196,029	$ 0	$ 8,196,029
2030	$ 0	$ 8,196,029	$ 0	$ 8,196,029

Frontline Healthcare Worker Type #6: Doctors

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$ 301,349	0	0	$ 301,349
2027	$ 301,349	0	0	$ 301,349
2028	0	$ 301,349	0	$ 301,349
2029	0	$ 301,349	$ 0	$ 301,349
2030	0	$ 301,349	$ 0	$ 301,349

Frontline Healthcare Worker Type #7: Epidemiologists

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$180,173	0	0	$180,173
2027	$180,173	0	0	$180,173
2028	0	$180,173	0	$180,173
2029	0	$180,173	$0	$180,173

2030	0	$180,173	$0	$180,173

Frontline Healthcare Worker Type #8: Clinical Social Worker

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$577,681	0	0	$577,681
2027	$577,681	0	0	$577,681
2028	0	$577,681	0	$577,681
2029	0	$577,681	$0	$577,681
2030	0	$577,681	$0	$577,681

Frontline Healthcare Worker Type #9: Radiographer

Year	U.S. Government # FTEs Funded	Kenya New # FTEs Funded	Kenya Existing # FTEs Funded	Kenya Total # FTEs Funded
2026	$101,544	0	0	$101,544
2027	$101,544	0	0	$101,544
2028	0	$101,544	0	$101,544
2029	0	$101,544	$0	$101,544
2030	0	$101,544	$0	$101,544