UNITED REPUBLIC OF TANZANIA

Prime Minister's Office

Tanzania Commission for AIDS (TACAIDS)

GUIDELINES FOR SOCIAL CONTRACTING IN TANZANIA

Strengthening Partnerships for Integrated and Sustainable, Community-Led Health Service Delivery

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Preface

The development of these Guidelines for Social Contracting in Tanzania marks an important milestone in the country's journey toward sustainable, inclusive, and community-centered health systems. For many years, Civil Society Organizations (CSOs) and Community-Led Organizations (CLOs) have played a vital role in extending the reach of public health services—especially among populations that are hardest to reach or most affected by stigma, poverty, and social exclusion. Their partnership with the Government has been instrumental in accelerating progress in the national response to HIV, tuberculosis, malaria, and other public health priorities.

As Tanzania moves toward more domestic funding and ownership of its health programs, social contracting gives the government a clear and organized way to work with and pay civil society organizations (CSOs) to provide important services on behalf of the state. This method not only enhances accountability and value for money, but it also ensures that communities remain at the center of our national response. We reaffirm our shared commitment to not leaving anyone behind through social contracting.

The country's current legal and policy framework, including the Public Procurement Act, the Public Finance Act, and the establishment of the AIDS Trust Fund (ATF), will be utilized to implement this framework. It also fits with the Global Fund's Sustainability, Transition, and Co-Financing (STC) Policy, UNAIDS' call for community-led responses, and the Sustainable Development Goals (SDGs). Because of this, these Guidelines lay out the steps that need to be taken to make social contracting a permanent part of Tanzania's health financing system.

I would like to thank everyone who contributed to the development of this document on behalf of TACAIDS and our partners in government, civil society, and development cooperation. Let us use this framework to foster trust, collaboration, and shared responsibility between the Government and communities. This will make sure that all Tanzanians have equal access to quality, people-centered health services.

Together, we can sustain the gains achieved and secure the future of our national response through shared responsibility and partnership.

[Name]
Chairperson
Tanzania Commission for AIDS (TACAIDS)

Foreword

The Guidelines for Social Contracting in Tanzania represent a significant step forward in strengthening the country's health financing and service delivery systems by fostering structured partnerships between the government and civil society organizations (CSOs). They embody Tanzania’s commitment to advancing Universal Health Coverage (UHC) and ensuring that every citizen—especially those most vulnerable and underserved—has access to quality, equitable, and people-centred health services.

CSOs and Community-Led Organizations (CLOs) have been important partners in the national health response for many years. Because they are close to communities, flexible, and understand different cultures, they have been able to reach people that public systems often struggle to serve. The Government formalizes and expands this partnership through social contracting. This provides a clear way to allocate public funds to qualified non-state actors while maintaining strong accountability, quality assurance, and alignment with national health priorities.

This method is critical as Tanzania moves toward long-term domestic financing. The creation of the AIDS Trust Fund (ATF) and the inclusion of social contracting in national budget frameworks demonstrate that the government is committed to gradually reducing its reliance on external funding while continuing to provide life-saving care for HIV, tuberculosis, malaria, reproductive and child health, and emerging public health issues. Furthermore, the country is also developing a HIV Sustainability Roadmap, which has prioritized social contracting as a cornerstone strategy to enhance domestic resource mobilization, institutionalize community-led service delivery, and ensure long-term sustainability of the national HIV response.

These guidelines establish the policy, legal, and operational framework for implementing social contracting. They explain the rules, steps, and organizational structures necessary to ensure that planning, buying, contracting, monitoring, and verification all work effectively. This framework enhances the efficiency of health programs, fosters accountability, and empowers communities to take ownership of health initiatives by bringing together the Ministry of Health, TACAIDS, PO-RALG, development partners, and civil society.

I would like to thank all the organizations and partners that helped develop these Guidelines. Not only are they a technical achievement, but they also demonstrate our collective commitment to making Tanzania's health system more sustainable, resilient, and accessible to everyone.

Let's work together to put this framework into action with honesty and dedication. This way, every resource used will have a measurable impact, and every citizen will benefit from a health system that is fair, open, and responsive to the community's needs.

[Name]

Permanent Secretary
Prime Ministers’ - Office
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Acknowledgements

The Tanzania Commission for AIDS extends its sincere appreciation to all individuals and institutions that contributed to the development of these Guidelines for Social Contracting in Tanzania. This document reflects a truly collaborative effort aimed at strengthening partnerships between the Government and Civil Society Organizations (CSOs) in advancing equitable, community-led health service delivery.

Special recognition is given to the National Social Contracting Task Force (SCTF), whose leadership and technical expertise guided the conceptualization, review, and validation of the framework. The Task Force brought together representatives from the Tanzania Commission for AIDS (TACAIDS), Ministry of Health, President's Office – Regional Administration and Local Government (PO-RALG), Ministry of Community Development, Gender, Women and Special Groups (MOCDGWSG) and key national CSO networks. Their combined insights ensured that the Guidelines are both technically sound and operationally feasible within the national health architecture.

The Ministry further acknowledges the invaluable technical and financial support provided by UNAIDS, whose partnership was instrumental throughout the drafting, stakeholder consultations, and finalization process. UNAIDS' commitment to strengthening community systems and advancing sustainability within Tanzania's health response is deeply appreciated.

We also wish to commend the National Council of People Living with HIV (NACOPHA) for its dedicated efforts in gathering community perspectives, facilitating dialogues, and developing key inputs that informed the development of these Guidelines. NACOPHA's leadership ensured that the voices and experiences of communities most affected by HIV and other public health challenges are meaningfully reflected throughout the framework.

Finally, appreciation is extended to all development partners, civil society organizations, and technical experts who provided input during consultations and validation sessions. Their collective contributions have enriched the quality and relevance of this document.

We hope that these Guidelines will serve as a practical tool for fostering stronger, more accountable partnerships between the Government and communities, ensuring that Tanzania's health response remains sustainable, inclusive, and responsive to the needs of all.

Executive Director
Tanzania Commission for AIDS (TACAIDS)

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List of Abbreviations

AGYW	Adolescent Girls and Young Women
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ATF	AIDS Trust Fund
ABYM	Adolescent Boys and Young Men
BCC	Behaviour Change Communication
CAG	Controller and Auditor General
CBO	Community-Based Organization
CHAC	Council HIV and AIDS Coordinator
CHMT	Council Health Management Team
CHW	Community Health Worker
CLM	Community-Led Monitoring
CLO	Community-Led Organization
CRRAF	Common Results, Resources, and Accountability Framework
CSO	Civil Society Organization
DHIS2	District Health Information System, version 2
FBO	Faith-Based Organization
GBV	Gender-Based Violence
GoT	Government of Tanzania
HBF	Health Basket Fund
HFGC	Health Facility Governing Committee
HIV	Human Immunodeficiency Virus
HSHSP	Health Sector HIV and AIDS Strategic Plan
HMIS	Health Management Information System
IEC	Independent Evaluation Committee
KVP	Key and Vulnerable Populations
LGA	Local Government Authority
MEL	Monitoring, Evaluation, and Learning
MoCDGWSG	Ministry of Community Development, Gender, Women, and Special Groups
MoF	Ministry of Finance
MoH	Ministry of Health
MSM	Men who have Sex with Men
MTEF	Medium-Term Expenditure Framework
NACOPHA	National Council of People Living with HIV and AIDS
NASHCoP	National AIDS, STIs, and Hepatitis Control Programme
NCD	Non-Communicable Disease
NeST	National e-Procurement System of Tanzania
NGO	Non-Governmental Organization
NMSF	National Multisectoral Strategic Framework
NTLP	National Tuberculosis and Leprosy Programme
OCAG	Office of the Controller and Auditor General
PAA	Pre-Award Assessment
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President’s Emergency Plan for AIDS Relief

PLHIV	People Living with HIV
PMI	President's Malaria Initiative
PO-RALG	President's Office – Regional Administration and Local Government
PPP	Public–Private Partnership
PPRA	Public Procurement Regulatory Authority
PrEP	Pre-Exposure Prophylaxis
PSEA	Prevention of Sexual Exploitation and Abuse
RBF	Results-Based Financing
RHMT	Regional Health Management Team
RMNCAH	Reproductive, Maternal, Newborn, Child, and Adolescent Health
SBC	Social and Behaviour Change
SCFTF	Social Contracting Financing Task Force
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
STC	Sustainability, Transition, and Co-Financing
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TPT	Tuberculosis Preventive Therapy
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
URT	United Republic of Tanzania
UHC	Universal Health Coverage
WHO	World Health Organization

Definition of Key Terms

Term	Definition
Adolescent Boys and Young Men (ABYM)	Males aged approximately 10–24 years who are a focus for HIV prevention and health programs due to behavioural and social vulnerability.
Adolescent Girls and Young Women (AGYW)	Females aged approximately 10–24 years are prioritized in HIV and SRH programs because of heightened biological and social risks.
AIDS Trust Fund (ATF)	A national financing mechanism established under the HIV and AIDS (Prevention and Control) Act, 2008, to mobilize and manage domestic resources for Tanzania's HIV response, including through social contracting.
Capacity Development	The process of strengthening the abilities, systems, and resources of institutions and individuals—especially CSOs—to perform effectively, sustainably, and with accountability.
Civil Society Organization (CSO)	A non-state, not-for-profit entity, including NGOs, CBOs, and FBOs, that operates independently of government and delivers social, health, or advocacy services in the public interest.
Community-Based Organization (CBO)	A locally rooted organization operating within a specific community, focused on grassroots mobilization, advocacy, or service delivery.
Community-Led Monitoring (CLM)	A structured, community-driven process in which people affected by health programs collect, analyse, and use data to improve service quality and accountability.
Contract "Tranche"	A portion or instalment of funds is released to an implementing partner upon achievement of agreed performance milestones or deliverables.
Contracting Authority	The legally mandated government entity (e.g., TACAIDS, MoH, PORALG,) responsible for awarding, managing, and monitoring social contracts with CSOs or other non-state implementers.
Council Health Management Team (CHMT)	A district or council-level health management body responsible for planning, coordinating, and supervising all health service delivery, including contracted programs.
Council HIV and AIDS Coordinator (CHAC)	A designated officer within an LGA who coordinates HIV-related activities, supports CSO engagement, and ensures data and program reporting at local level.
Differentiated Service Delivery (DSD)	A client-cantered approach that adapts how, when, and where health services are delivered to meet the diverse needs of different population groups.
Faith-Based Organization (FBO)	A non-governmental organization or association founded on religious principles that provides social or health services aligned with public health objectives.
Gender-Based Violence (GBV)	Any harmful act directed against an individual based on gender differences, including physical, sexual, or psychological harm, is addressed as a cross-cutting issue within social contracting programs.
Grievance Redress Mechanism (GRM)	A formal process through which beneficiaries or stakeholders can lodge complaints, concerns, or feedback regarding program operations, with established procedures for resolution.

Health Basket Fund (HBF)	A pooled funding mechanism supported by government and partners to finance health sector activities under a harmonized framework.
Independent Verification Committees / Agent (IVA)	A third-party organization, such as a university or audit firm, contracted to verify service delivery data and performance before payment disbursements independently.
Key and Vulnerable Populations (KVPs)	Groups disproportionately affected by HIV due to higher-risk behaviours or social marginalization, including sex workers, MSM, people who inject drugs, prisoners, miners, truck drivers, and fisherfolk.
Marginalized Populations	Groups excluded or disadvantaged due to social, economic, or cultural factors, often facing discrimination and limited access to health or social services.
Medium-Term Expenditure Framework (MTEF)	A public finance tool that links multi-year policy priorities to annual budgets, ensuring predictability and fiscal discipline in government spending.
Monitoring, Evaluation, and Learning (MEL)	A system that tracks program performance, evaluates outcomes, and promotes adaptive learning to improve program effectiveness and accountability.
Non-Communicable Diseases (NCDs)	Chronic diseases not transmitted from person to person, such as hypertension, diabetes, cancer, and cardiovascular diseases.
Non-State Actors (NSAs)	Organizations and entities that operate independently of the government, including CSOs, private sector actors, and community groups, which contribute to service delivery and policy dialogue.
People Living with HIV (PLHIV)	Individuals diagnosed with HIV infection who are living with the virus and are central to designing and implementing HIV-related interventions.
Public Procurement Regulatory Authority (PPRA)	A statutory body overseeing compliance with procurement laws and regulations in the use of public funds, including contracting with CSOs.
Result-Based Financing (RBF)	A financing approach in which disbursements are contingent upon the verified achievement of predefined outputs or outcomes.
Safeguarding (including PSEA)	Policies and actions designed to protect beneficiaries, particularly women and children, from abuse, exploitation, and other forms of harm within programs.
Service Packages	Defined sets of services to be delivered by contracted organizations—covering prevention, testing, care, treatment, and community support—based on national program priorities.
Social and Behaviour Change (SBC)	Evidence-based communication and community engagement approaches used to influence positive health-seeking behaviors and reduce stigma or misinformation.
Social Contracting	A structured process through which the government allocates public funds to non-state actors to deliver specified public services, under formal contracts with defined outputs, performance standards, and accountability mechanisms.
Underserved Populations	Groups that have limited or no access to essential health or social services due to geography, poverty, stigma, or other barriers.

Universal Health Coverage (UHC)	The principle that all individuals should have access to needed health services—prevention, treatment, and care—without suffering financial hardship.

Executive Summary

The Guidelines for Social Contracting in Tanzania provide a national framework for institutionalizing government–civil society partnerships in financing and delivering HIV and other priority public health services. Rooted in Tanzania's commitment to Universal Health Coverage (UHC), equity, and sustainability, the framework outlines how Government resources—particularly from the AIDS Trust Fund (ATF), Health Basket Fund (HBF), and Local Government budgets—are allocated to Civil Society Organizations (CSOs), Community-Based Organizations (CBOs), and Faith-Based Organizations (FBOs) through transparent, performance-based contracts.

Social contracting marks a significant shift in Tanzania's health financing—from externally driven, donor-dependent models to domestically financed, government-led, and community-delivered systems. It recognizes the comparative advantage of CSOs in reaching key, vulnerable, and underserved populations through culturally sensitive and rights-based approaches. The mechanism formalizes these partnerships within national legal and financial systems, ensuring continuity of essential community programs and promoting shared accountability for health outcomes.

The Guidelines define the policy, legal, and institutional foundations of social contracting, aligned with national laws and strategies including the Public Finance Act, Public Procurement Act, HIV and AIDS (Prevention and Control) Act, ATF Regulations (2022), the National Multisectoral Strategic Framework for HIV and AIDS (NMSF V, 2021–2026), and the Health Sector AIDS, STIs and Hepatitis Strategic Plan (NASHCoP NSP, 2022–2026). Institutional arrangements involve the TACAIDS, MoH, PO-RALG, the Ministry of Finance, and others, coordinated through a multi-stakeholder Social Contracting Task Force (SCTF).

While social contracting is anchored in the HIV response as its central focus, the Tanzania framework's application extends beyond HIV. It encompasses tuberculosis (TB), malaria, reproductive, maternal, newborn, child, and adolescent health (RMNCAH), non-communicable diseases (NCDs), and outbreak preparedness—fostering a multisectoral, resilient, and community-driven health system.

The framework introduces a six-step operational cycle: (1) Planning, (2) Call for Proposals, (3) Proposal Submission and Evaluation, (4) Pre-Award Assessment, (5) Approval and Contracting, and (6) Contract Award and Signing. Implementation is guided by standardized eligibility criteria, service packages, and costing tools, supported by robust monitoring, verification, capacity-building, and safeguarding systems.

To ensure efficiency and accountability, a hybrid results-based financing model is applied—combining base tranches for continuity with tariff-linked payments per verified output and performance bonuses for equity-focused results. Oversight and verification are ensured through Independent Verification teams/agents, audits by the Controller and Auditor General (CAG), and Community-Led Monitoring (CLM).

Implementation of social contracting will:

- **Increase domestic financing** for community-led health services through ATF, HBF, and LGA budgets.
- **Improve service coverage and quality** for HIV, TB, RMNCAH, malaria, and NCDs, especially among key and vulnerable populations.
- **Enhance accountability and transparency** through integrated data systems and independent verification.
- **Institutionalize community partnerships** that strengthen sustainability, ownership, and public trust.

Through this framework, Tanzania reaffirms its vision of a resilient, inclusive, and people-centred health system—where government and communities work together to ensure no one is left behind.

1. Introduction

1.1 Background

Social contracting is a government-led financing mechanism through which public funds are allocated to not-for-profit civil society and community-based organizations for the delivery of defined social and health services—particularly those reaching key and vulnerable populations that remain underserved by mainstream systems. It formalizes collaboration between government and non-state actors through legally binding agreements that outline service packages, performance expectations, payment modalities, and monitoring arrangements. By institutionalizing such partnerships, social contracting enhances accountability, transparency, and sustainability within national public health responses.

Globally, social contracting has emerged as a strategic response to the decline in external funding for HIV, TB, malaria, and other priority programmes. It is recognized under the Global Fund Sustainability, Transition and Co-financing (STC) Policy as a key instrument for sustaining community-led service delivery while reinforcing domestic ownership. Countries such as Thailand, Vietnam, Namibia, and Brazil demonstrate that, when backed by an enabling legal framework and transparent procurement systems, social contracting can expand coverage, enhance efficiency, and deepen community participation. For example, Thailand's per-capita payment model for key populations and Vietnam's national performance-based monitoring system have achieved measurable improvements in service reach and cost-effectiveness.

In Tanzania, civil-society and community-led organizations have long complemented government efforts to extend essential services to marginalized and high-risk populations. Their proximity to communities fosters trust, inclusion, and responsiveness. However, as donor funding declines, the sustainability of these contributions is increasingly at risk.

To safeguard progress, the Government of the United Republic of Tanzania is institutionalizing social contracting as a strategic mechanism to mobilize domestic resources, strengthen partnerships, and ensure the equitable and people-centered delivery of health and social services. This commitment—anchored in the AIDS Trust Fund (ATF), sectoral budget allocations, and broader public-finance reforms—signals a shift toward a sustainable, domestically financed, and community-led model of service delivery, supported by partners such as UNAIDS, PEPFAR, and the Global Fund.

1.2 Social Contracting Context in Tanzania

Tanzania has progressively engaged with Civil Society Organizations (CSOs) and Community-Led Organizations (CLOs) in delivering public services across health, education, social protection, and livelihoods. While the term social contracting is relatively new, many national initiatives already reflect government readiness to finance CSO-led service delivery through formal mechanisms. In the health sector, CSOs have collaborated with the government to implement interventions for HIV, TB, malaria, maternal and child health, COVID-19 vaccination campaigns, and responses to gender-based violence (GBV). These experiences—though largely donor-funded—illustrate the effectiveness of community actors in extending coverage and addressing inequities.

Nevertheless, existing government-CSO partnerships remain largely informal, short-term, and fragmented. The absence of a standardized framework for eligibility, contracting, and performance monitoring limits coordination and long-term sustainability. Institutionalizing social contracting offers an opportunity to address these gaps by embedding transparent, performance-based arrangements within national financing and accountability systems. Building on these foundations, Tanzania can unlock the full potential of CSOs as strategic partners in delivering inclusive, equitable, and sustainable health and HIV services nationwide.

1.3 Financing Landscape in Tanzania

Tanzania's HIV, TB, and malaria response remains heavily dependent on external donor support, with over 80 percent of HIV financing derived from bilateral and multilateral partners. As global priorities evolve and external assistance declines, the country faces a widening resource gap in financing its national health goals. This challenge highlights the importance of institutionalizing sustainable domestic financing mechanisms to protect and sustain prioritized community-led interventions.

In response, the Government of Tanzania has taken critical steps to develop and strengthen domestic financing structures, particularly through the ATF, established in 2015 under the amended TACAIDS Act, No. 22 of 2001. Operational since 2015, the ATF is designed to complement declining donor support by mobilizing domestic resources from both public and private sectors. Allocations have shown a fluctuating trend: 2016/17 (TZS 5.5 billion), 2017/18 (TZS 3.0 billion), 2021/22 (TZS 1.0 billion), 2024/25 (TZS 1.8 billion), and 2025/26 (TZS 5.2 billion)[1]; with disbursement picking from an inconsistently low rate below 30% to an exhaustive at 100% in 2024/25[2]. While the recent uptick is welcome, ATF resources still represent less than 0.3% of the estimated TZS 2 trillion national HIV financing need.

The HIV Sustainability Roadmap (Part A) identifies social contracting as a cornerstone of domestic-financing sustainability—enhancing resource targeting, improving service quality, and institutionalizing community leadership. Existing legislation, including the Public Finance Act, Public Procurement Act, and ATF Regulations, already permits government-to-CSO financing; however, operational systems for identifying eligible CSOs, structuring contracts, and verifying results remain underdeveloped. Institutionalizing social contracting will therefore provide a practical platform to channel ATF and other domestic resources to capable implementers, closing service-delivery gaps and ensuring value for money across priority programmes.

1.4 Rationale for Social Contracting

As Tanzania advances toward a sustainable and resilient health system, the formal integration of civil society and community-led organizations through social contracting offers a strategic solution to persistent equity and efficiency challenges.

(i) Bridging the Financing Gap

Tanzania's annual HIV response requires more than USD 800 million, yet available resources average about USD 500 million, with over 90 percent from external partners. By channeling ATF and other domestic resources through structured contracts, the Government can leverage local capacity, ensure predictable financing, and accelerate the transition toward domestic ownership.

(ii) Leveraging Community Expertise

CSOs and CLOs possess deep community reach, cultural competence, and adaptability—qualities that often surpass formal systems. Institutionalized contracting enables the Government to leverage this comparative advantage, sustain proven community initiatives, and align them with national priorities within a unified accountability framework.

(iii) Advancing Accountability and Equity

Social contracting operationalizes Tanzania's NMSF V (2021-2026) and the HIV Sustainability Roadmap (2024), aligning with the global transition policies. The introduction of performance-based financing and transparent eligibility criteria strengthens mutual accountability between government and citizens, enhances equity, and supports the country's pursuit of Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

[1] Government Budget Books, Volume IV, 2016/17 - 2025/26
[2] ATF Annual Report, 2023

1.5 Objectives of the Guideline

Overall Objective
To institutionalize an inclusive, equitable, and sustainable government-to-CSO financing mechanism for community-based delivery of HIV and other priority public-health services.

Specific Objectives

(i) Strengthen structured partnerships and engagement between the Government and CSOs in national and sub-national health responses.
(ii) Improve access to quality, people-centred services through innovative, community-driven delivery models.
(iii) Sustain national health gains through efficient, transparent, and performance-based use of domestic financing under social-contracting mechanisms.

1.6 Guiding Principles for Social Contracting

Implementation of social contracting shall be guided by the following principles, which align with Tanzania's legal framework, national HIV strategies, and global commitments to people-centred, rights-based, and results-driven health systems:

- **Equity** – Ensure fair and inclusive access to services for all, particularly underserved and high-burden populations, through differentiated and gender-responsive delivery models.
- **Community Ownership** – Empower communities, including PLHIV and key and vulnerable populations and marginalized populations, to co-design, deliver, and monitor services to enhance relevance and trust.
- **Transparency** – Guarantee openness in eligibility, proposal evaluation, fund disbursement, and performance reporting through publicly available procedures and results.
- **Accountability** – Establish robust mechanisms for both Government and CSOs to report, verify, and account for financial and programmatic performance.
- **Integrity** – Uphold ethical standards and compliance with national laws and procurement regulations to prevent misuse of public resources.
- **Sustainability** – Integrate social contracting within national financing systems such as the ATF, council budgets, and sector plans to ensure continuity beyond donor funding.
- **Commitment** – Foster sustained political, institutional, and partner support through adequate resourcing, policy coherence, and shared responsibility for results.

1.7 Target Audience

This guideline is intended for all actors involved in the planning, financing, implementation, and oversight of social contracting in Tanzania, including:

- **Government Institutions:** Tanzania Commission for AIDS (TACAIDS), Ministry of Health (MoH), President's Office – Regional Administration and Local Government (PORALG), Ministry of Finance (MoF), and Public Procurement Regulatory Authority (PPRA).
- **Sub-national Authorities:** Regional and Council Health Management Teams (RHMTs and CHMTs) and Local Government Authorities (LGAs).
- **Non-State Actors:** Civil-Society, Community-Based, and Faith-Based Organizations (CSOs, CBOs, FBOs) and other not-for-profit entities in health and community development.
- **Development and Technical Partners:** Bilateral and multilateral agencies, academic and research institutions, independent verification agents, and community-led monitoring coalitions supporting implementation, oversight, and learning.

2. Social Contracting Legal and Policy Framework

2.1 Introduction

The implementation of social contracting in Tanzania's HIV response is aligned with the existing legal, regulatory, and policy environment. This ensures compliance with national laws, promotes institutional accountability, and facilitates integration into public financial management systems. The following laws, policies, and frameworks provide a legal basis and strategic direction for the adoption and operationalization of social contracting: Table (1)

Table 1: Legal and Policy Framework for Social Contracting in Tanzania

Legal / Policy Instrument	Key Provisions	Implications for Social Contracting
Non-Governmental Organisations (NGO) Act, 2002 (as amended)	• Provides for registration, regulation, and coordination of NGOs under the Registrar and the NGO Coordination Board. • Requires annual reporting, audited financial statements, and adherence to good-governance standards. • Empowers the Government to suspend or cancel registration for non-compliance. • Mandates periodic renewal and public disclosure of NGO reports.	• Establishes a formal legal identity and legitimacy for CSOs, a prerequisite for contracting. • Creates an accountability framework through audits and public reporting, building trust in CSO partners. • Enables Government oversight to reduce misuse of funds. • Strengthens transparency and public confidence in CSO operations.
Public Procurement Act, 2011 (Revised 2016, amended 2023)	• Defines principles of procurement: transparency, competition, fairness, and value for money. • Permits Government agencies to procure services from non-state actors under specific conditions. • 2023 amendments extend the application to non-government entities when public funds are utilized.	• Provides the legal basis for engaging CSOs through transparent and competitive procurement. • Ensures that all social contracting processes adhere to national procurement standards. • Minimizes favoritism and arbitrary contract awards, enhancing legitimacy.
Public Finance Act, 2001 (Revised 2020)	• Governs the management, accounting, and reporting of public funds. • Establishes financial oversight, audit, and internal-control procedures for public expenditures.	• Guarantees fiscal discipline and integrity in the use of public funds. • Ensures that contracts with CSOs comply with national financial control and audit standards. • Builds donor and public confidence in Government-to-CSO financing.
HIV and AIDS (Prevention and Control) Act, 2008	• Establishes the AIDS Trust Fund (ATF) as a national financing vehicle for HIV programmes. • Authorizes the Fund to support prevention, treatment, and care	• Provides a legally mandated domestic funding source for HIV interventions.

	services through parliamentary allocations, grants, and donations.	• Enables channeling of ATF resources to CSOs for service delivery. • Expands the scope of HIV financing beyond planning to direct implementation.
Tanzania Commission for AIDS (TACAIDS) Act, 2001 (Revised 2015)	• Establishes TACAIDS as the national coordinating body for the HIV and AIDS response. • The 2015 amendment introduced the ATF as a key financing mechanism under TACAIDS oversight.	• Confers institutional authority on TACAIDS to manage and coordinate social contracting. • Aligns coordination and financing functions under one legal framework.
AIDS Trust Fund (ATF) Regulations, 2022	• Operationalizes the ATF by defining procedures for resource collection, allocation, and disbursement. • Explicitly allows funding of non-state actors through grants and subventions under accountable contracting modalities.	• Provides procedural clarity and legal certainty for contracting CSOs using ATF funds. • Standardizes disbursement and reporting procedures, reducing financial and operational risks.
National HIV Prevention Roadmap (2024–2027)	• Emphasizes institutionalization of community-led and CSO-led service delivery. • Outlines milestones on capacity building, financing frameworks, and adoption of social-contracting mechanisms.	• Demonstrates clear policy commitment to social contracting. • Provides a roadmap for the Government and partners with measurable milestones for CSO engagement.
National Multisectoral Strategic Framework for HIV and AIDS (NMSF V, 2021-2026)	• Prioritizes community engagement, multisector collaboration, and institutionalization of CSO roles. • Promotes community-led monitoring, advocacy, and service delivery.	• Embeds social contracting within national HIV planning and budgeting. • Positions CSOs as co-implementers in the multisectoral HIV response.
HIV Response Sustainability Roadmap – Part A (2024)	• Identifies social contracting as a key innovation for sustainability and transition from donor to domestic financing. • Emphasizes institutionalization of contracting mechanisms with capable NGOs and CSOs.	• Reinforces social contracting as a core long-term financing strategy, not an ad hoc measure. • Encourages alignment with PPP and private-sector delivery models.
NASHCoP Strategic Plan (2022-2026)	• Promotes partnerships with CSOs and community-led groups in HIV service expansion. • Calls for strengthening health-system mechanisms, including contracting and verification modalities.	• Integrates social contracting within the broader health-sector architecture. • Promotes decentralized, inclusive, and sustainable models of community service delivery.

2.2 Social Contracting Mechanism in Tanzania

2.2.1 Overview

Tanzania's national HIV social contracting mechanism provides a structured, government-led approach for engaging Civil Society Organizations (CSOs) and other non-state actors in the delivery of HIV and related community health services. The mechanism formalizes partnerships between the Government and CSOs through legally binding contracts that define service packages, performance expectations, and accountability requirements, ensuring that public resources are used efficiently and equitably.

At the policy level, overall oversight and strategic direction are provided under the leadership of the Prime Minister's Office, with TACAIDS serving as the coordinating authority. TACAIDS ensures that priorities, financing decisions, and accountability measures remain aligned with national HIV strategies and multisectoral frameworks. Relevant ministries—including the MoH, PO-RALG, and the MoCDGWSG—provide technical input, policy coherence, and sectoral guidance to ensure that social contracting complements national health system goals.

Funding for social contracting is drawn from multiple sources—primarily domestic resources such as the AIDS Trust Fund (ATF), complemented by external contributions from development partners—but all transactions occur through established government budgeting and financial management systems. Both central and local government levels (ministries, agencies, and LGAs) may independently implement social contracting with CSOs under the national HIV Social Contracting Grants Management Framework.

At each level, funds are pooled and managed through a Social Contracting Grants Management Unit (GMU), which is responsible for issuing contracts, managing grants, monitoring implementation, and coordinating independent evaluations. The GMU establishes standardized agreements that outline deliverables, reporting timelines, verification mechanisms, and safeguarding requirements. Once contracted, CSOs implement HIV-related interventions covering prevention, testing, treatment, care, and community support—particularly targeting underserved and key populations.

This mechanism ensures that public resources are utilized transparently and effectively while leveraging the comparative advantage of CSOs in reaching communities with trusted, people-centered, and inclusive services. Through regular monitoring, joint reviews, and community feedback, social contracting reinforces accountability, strengthens decentralization, and enhances sustainability—contributing to Tanzania's broader goals of resilient health systems, civil society engagement, and improved population health outcomes.

2.2.2 Eligibility of CSOs

Civil Society Organizations (CSOs) and Community-Led Organizations (CLOs) may participate in Tanzania's national social contracting mechanism upon demonstrating compliance with minimum eligibility requirements set by the contracting authority. The eligibility verification process ensures that public resources are allocated to capable, accountable, and community-rooted organizations that can deliver high-quality HIV and related health services responsibly and efficiently.

Eligibility assessments are conducted as part of the proposal review and contracting process, and certification remains valid for the duration of the contractual period unless otherwise revoked due to non-compliance. Only organizations that meet the established standards of technical competence, governance, and financial integrity will be eligible to receive funding under government-managed social contracting arrangements.

2.2.3 Minimum Eligibility Criteria

To qualify for participation in government-funded social contracting mechanisms, CSOs and CLOs must meet the following minimum requirements: (*Annex 1*)

Legal and Regulatory Compliance:
Must be legally registered and compliant with Tanzanian laws and regulations, possessing valid certificates, good governance structures, and internal controls.

Technical Capacity and Thematic Relevance:
Must demonstrate proven experience in HIV and related public health services, with qualified staff and alignment to national priorities and target populations.

Community Presence and Engagement:
Must have an active presence and trusted relationships within the target area, working closely with LGAs, health facilities, and community networks.

Financial and Administrative Capacity:
Must maintain sound financial systems, internal controls, and grant management capacity to ensure transparent and accountable use of public funds.

Monitoring, Evaluation, and Learning (MEL):
Must possess data systems, trained personnel, and the capacity to report on national indicators and contribute to evidence-based program improvement.

Figure 1: CSOs Eligibility Criteria for Social Contracting

Governance, Transparency, and Safeguards:
Must operate under a functional governance body, uphold integrity and human rights, and enforce safeguarding, anti-fraud, and accountability policies.

3. Institutional Arrangements for Social Contracting in Tanzania

3.1 Introduction

The institutional arrangements for social contracting in Tanzania define the roles and responsibilities of all actors to ensure coherent governance, practical implementation, and accountability. At the national level, TACAIDS coordinates the HIV response and ensures oversight of integrated community HIV interventions. At the same time, the MoH provides policy guidance and serves as the contracting hub for nationally defined service packages. The MoCDGWSGs oversees the registration and regulatory matters concerning non-governmental organizations in the country. The PORALG integrates social contracting into council planning and supervises local implementation. The Public Procurement Regulatory Authority (PPRA) regulates procurement processes under the Public Procurement Act (2024).

At the council level, Council Directors and Council Health Management Teams (CHMTs) manage local contracting, supervise service delivery, and report performance. Implementers—including CSOs, CBOs, FBOs, and not-for-profit providers—are responsible for delivering agreed-upon service packages, while independent verification agents, such as universities, audit firms, and CLM coalitions, validate the results. Development partners complement these structures through catalytic financing, technical assistance, and capacity development during the transition to full domestic financing.

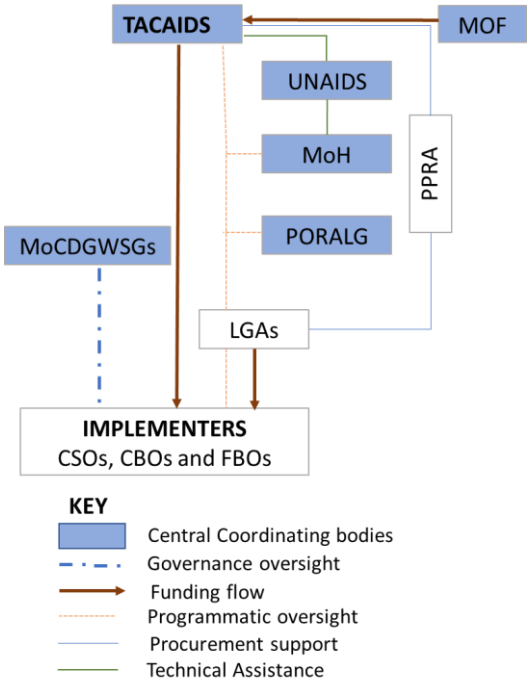

Figure 2: Implementation Arrangements

Together, these arrangements create a robust ecosystem that balances government stewardship, community inclusion, effective service delivery, and accountability—ensuring that social contracting not only extends services but also embeds equity, transparency, and sustainability within Tanzania's health and development response.

3.2 Conceptual Framework of Social Contracting in Tanzania

The Tanzania HIV Social Contracting Framework establishes a structured partnership between the Government and non-state actors to strengthen the national HIV response. It defines how domestic and external resources are mobilized, pooled, and managed to support Civil Society and Community-Led Organizations (CSOs and CLOs) in delivering equitable, community-based HIV and related health services. The framework ensures that public funds are used transparently and efficiently, while leveraging the comparative advantages of CSOs and CLOs to extend reach, build trust, and foster inclusion. Through dual-level financing, technical oversight, and robust accountability systems, it fosters a sustainable, decentralized, and community-led HIV response that aligns with national goals of equity, efficiency, and epidemic control. The framework is built on three interlinked pillars:

- Financing and Resource Mobilization – Domestic and external resources are consolidated through government systems (including the AIDS Trust Fund and Council budgets) to fund CSOs/CLOs transparently and efficiently.
- Governance and Accountability – Oversight and coordination are ensured through a multi-tier governance structure that promotes alignment with national HIV priorities and results-based management.

- Service Delivery and Community Impact – Qualified CSOs and CLOs implement defined service packages that reach key and vulnerable populations, ensuring equity, inclusion, and community ownership.

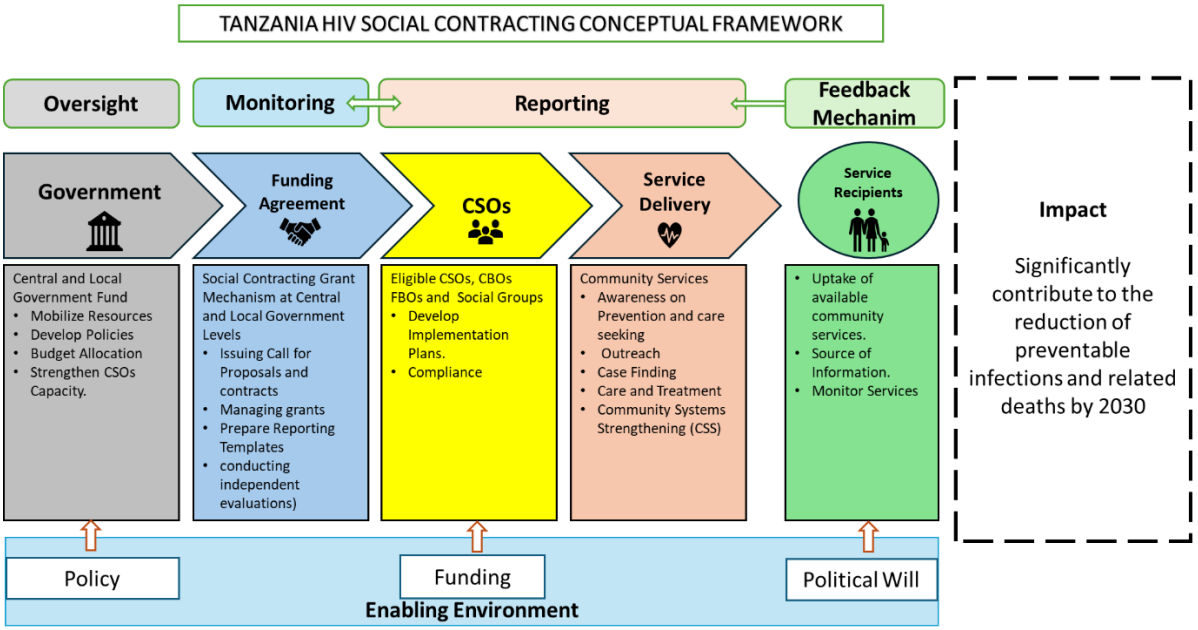

Figure 3: Conceptual Framework for Social Contracting in Tanzania

3.3 Social Contracting Structures

The Tanzania Social Contracting Framework establishes a dual-path financing and governance structure that enables the Government to formally engage Civil Society and Community-Led Organizations (CSOs/CLOs) in the delivery of HIV, TB, malaria, RMNCH, NCD, and related health services. Under the leadership of the Prime Minister's Office, the framework ensures transparent resource allocation, coordinated oversight, and effective service delivery across national and local levels.

At the central level, resources mobilized from domestic and partner sources—including the AIDS Trust Fund (ATF)—are pooled and administered through the Social Contracting Grants Management Unit (GMU) under TACAIDS. The GMU, supported by an Independent Evaluation Committee, manages proposal appraisal, contracting, disbursement, and performance monitoring for qualified CSOs and CLOs.

At the local government level, PO-RALG coordinates implementation through Local Government Authorities (LGAs). Funds are allocated within Comprehensive Council Health Plans (CCHPs) and managed by Council Social Contracting Units, facilitated by the Council HIV/AIDS Coordinator (CHAC). These councils contract CSOs to deliver community-level HIV services aligned with national priorities.

This structure institutionalizes social contracting as a government-led mechanism, ensuring that public funds are used efficiently while leveraging the comparative advantage of CSOs and CLOs in reaching underserved communities. It embeds clear accountability, verification, and reporting channels, linking national coordination with decentralized implementation.

3.4 Roles of Key Actors in the Social Contracting Mechanism

3.4.1 Ministry of Health (MoH)

The Ministry of Health is the primary custodian of the national HIV response at the technical and policy levels. Through NASHCoP, the ministry provides technical leadership in implementing HIV and AIDS services across the continuum of care, including integration into broader health systems.

Roles and Responsibilities:

- Define the technical standards and clinical protocols for HIV-related services eligible for social contracting (e.g., HIV prevention, treatment adherence, retention in care).
- Ensure that contracted services align with the Health Sector AIDS, STIs and Viral Hepatitis Strategic Plan (NASHCoP SP).
- Ensure that services contracted to CSOs are evidence-based, quality-assured, and responsive to the needs of KVPs and PLHIV.
- Coordinate with Regional and District Health Management Teams (RHMTs/DHMTs) to support implementation, supervision, and reporting at subnational levels.
- Monitor the integration of contracted CSO services into the national Health Management Information System (HMIS) and routine performance monitoring systems.
- Provide capacity building and participate in joint supportive supervision to CSOs delivering HIV services, in partnership with other stakeholders.

3.4.2 Ministry of Finance (MoF)

As the custodian of national public finances, the Ministry of Finance plays a critical role in authorizing and overseeing public expenditure, including allocations to non-state actors through social contracting mechanisms.

Key roles in social contracting

- Approve annual budget allocations for social contracting under government funds (e.g., ATF, health budget lines).
- Provide guidance on public financial management, reporting, and audit requirements.
- Ensure that contracting procedures align with the Public Finance Act and related procurement regulations.
- Facilitate integration of social contracting expenditures into the national Medium-Term Expenditure Framework (MTEF).

3.4.3 President's Office – Regional Administration and Local Government (PO-RALG)

PO-RALG is responsible for coordinating service delivery at the regional and local government levels, including supervision of local health systems and community-based responses.

Key roles in social contracting

- Support implementation and oversight of social contracts at the council and regional levels.
- Facilitate coordination between CSOs, local government authorities (LGAs), and health facilities.
- Ensure inclusion of social contracting within Comprehensive Council Health Plans (CCHPs).
- Participate in local-level monitoring and evaluation of contracted services.

3.4.4 Tanzania Commission for AIDS (TACAIDS)

The TACAIDS, serves as the national coordinating authority for the multisectoral HIV and AIDS response. TACAIDS provides strategic leadership and policy oversight to institutionalize government

engagement with CSOs, ensuring that community-based HIV and public health services are efficiently delivered, accountable, and aligned with national priorities.

Roles and Responsibilities

- Serve as the lead coordinating agency for the AIDS Trust Fund (ATF) and overall social contracting process where the ATF is the primary funding mechanism.
- Lead the design, administration, and issuance of social contracts, including calls for proposals, selection of CSOs, contract negotiation, and performance monitoring.
- Ensure alignment of contracted interventions with the National Multisectoral Strategic Framework (NMSF IV) and national targets for HIV epidemic control.
- Facilitate inter-agency coordination with the Ministry of Finance, PO-RALG, CSO representatives, and other stakeholders.
- Maintain a national registry of accredited CSOs eligible for social contracting and oversee annual updates and reviews.
- Ensure timely and transparent reporting to national oversight bodies, including Parliament, on the use of ATF funds and outcomes of social contracting.

3.4.5 AIDS Trust Fund (ATF): Fund Management and Disbursement

The AIDS Trust Fund (ATF) is a national financing mechanism established under the AIDS Prevention and Control Act No. 28 of 2008, to mobilize and manage domestic resources to support Tanzania's multisectoral HIV and AIDS response. The ATF is centrally positioned to serve as the primary funding vehicle for social contracting, enabling the government to allocate public resources directly to Civil Society Organizations (CSOs) and other non-state actors.

Roles and Responsibilities

- Resource Mobilization and Pooling
- Mobilize funds from multiple sources, including:
    - Government budget allocations
    - Levies from public and private institutions (e.g., corporate social responsibility contributions, levies on goods/services)
    - Donations and grants from development partners
    - Maintain a dedicated and ring-fenced fund specifically allocated for HIV prevention, including CSO-led service delivery.
- Financial Planning and Allocation
    - Develop and implement an annual disbursement plan for ATF resources in consultation with TACAIDS, MoH, and other relevant institutions.
    - Prioritize funding for strategic interventions, including those implemented by CSOs serving KVPs, PLHIV, and underserved communities.
    - Ensure allocations are aligned with national strategies (e.g., NMSF IV and HSHSP V) and evidence-based priorities.
- Disbursement to Implementing Partners
    - Facilitate timely and transparent disbursement of funds to contracted CSOs and community actors, based on approved proposals and signed agreements.
    - Use performance-based financing models where possible, linking disbursements to milestones and deliverables.
- Grant and Contract Management
    - Support TACAIDS and the Contracting Authority in issuing calls for proposals, reviewing applications, and managing contractual obligations.
    - Ensure compliance with Public Finance Act and ATF Regulations (2022) in all disbursement and financial reporting procedures.
- Financial Oversight and Risk Management

    - Maintain robust financial tracking and reporting systems to monitor fund flows, detect risks, and ensure compliance with national and donor standards.
    - Commission annual audits of ATF accounts and contracted entities, and respond to audit recommendations.
- Transparency and Public Accountability
    - Publish annual ATF reports, including a breakdown of funded projects, disbursement levels, and outcomes achieved through social contracting.
    - Engage with stakeholders, including Parliament, development partners, and civil society, to ensure accountability and public trust

3.4.6 Civil Society Organizations (CSOs): Implementation of Community-Level HIV Services

Civil Society Organizations (CSOs) play an indispensable role in Tanzania's HIV response, particularly in reaching key and vulnerable populations (KVPs) and People Living with HIV (PLHIV) with tailored, community-centered services. Through social contracting, CSOs become formal partners in service delivery, advocacy, monitoring, and accountability. Their proximity to communities, peer-led models, and cultural competence enables them to serve populations often underserved by public health systems.

Roles and Responsibilities:

- Service Delivery
    - Implement approved HIV service packages under social contracts, including:
    - HIV prevention (e.g., PrEP promotion, condom distribution, behavior change communication)
    - HIV testing, linkage to care, and adherence support
    - Psychosocial support and stigma reduction
    - Gender-based violence (GBV) response and referral services
    - Community-led monitoring (CLM) and client feedback mechanisms
    - Deliver services in hard-to-reach areas, high-burden regions, and among populations at increased risk, such as female sex workers, MSM, PWUD, AGYW, truck drivers, fisherfolk, and miners.
- Compliance with Contractual Obligations
    - Fulfill technical, financial, and administrative requirements as outlined in the signed contract or grant agreement.
    - Submit timely narrative and financial reports, including service delivery data, output indicators, and budget utilization summaries.
- Monitoring, Evaluation, and Learning
    - Collect and report program data using standard tools aligned with national M&E frameworks (e.g., HMIS, DHIS2).
    - Participate in joint supervision and performance reviews with government and development partners.
    - Document lessons learned and adapt programming to respond to emerging needs or gaps.
    - Community Engagement and Empowerment
    - Facilitate meaningful participation of PLHIV, KVPs, and affected communities in service planning, delivery, and feedback.
    - Promote rights-based, stigma-free, and inclusive approaches that reflect the lived realities of those most impacted by HIV.
    - Conduct community mobilization, peer education, and outreach to increase service uptake and health literacy.
- Accountability and Transparency
    - Ensure proper use of public funds in line with public financial management and donor compliance standards.

    - Maintain transparent governance structures, functional financial systems, and internal controls.
    - Participate in external audits, capacity assessments, and monitoring visits.
- Coordination and Collaboration
    - Align activities with district and regional health plans, and collaborate with health facilities, local government authorities (LGAs), and other CSOs.
    - Engage in relevant technical working groups, civil society platforms, and national consultations related to the HIV response.

3.4.7 Independent Evaluation Committee / Accreditation Body

To ensure fairness, credibility, and quality assurance in the social contracting process, Tanzania will establish an Independent Evaluation Committee (IEC) or Accreditation Body responsible for overseeing the selection, accreditation, and performance appraisal of Civil Society Organizations (CSOs) engaged in the delivery of HIV services. The Committee may be composed of representatives from government, academia, private sector, PLHIV networks, and development partners, with clear terms of reference and ethical conduct requirements.

Roles and Responsibilities:

- CSO Pre-Qualification
- Develop and manage a standardized CSO pre-award qualification framework, including criteria related to:
    - Legal registration and compliance
    - Technical expertise in HIV service delivery
    - Financial management systems
    - Strategic, medium, and small or new grantees
    - Community trust and track record
    - Maintain an updated national database of accredited CSOs eligible for contracting.
- Proposal Review and Selection
    - Participate in transparent and impartial evaluation of proposals submitted under social contracting calls.
    - Apply agreed evaluation criteria (technical merit, cost-effectiveness, equity considerations) and score proposals competitively.
- Performance Monitoring and Spot Checks
    - Support TACAIDS and MoH in conducting mid-term and end-of-cycle performance reviews of contracted CSOs.
    - Recommend renewal, scale-up, or discontinuation of contracts based on objective assessments of delivery, quality, and community outcomes.
- Safeguard Objectivity and Accountability
    - Ensure that decisions regarding CSO selection and renewal are free from conflict of interest and political interference.
    - Facilitate external audits, community validation exercises, and technical quality assessments to maintain credibility in the process.

3.4.8 Donors and Development Partners: Technical Support and Catalytic Funding

Development partners and donors have played a critical role in Tanzania’s HIV response. They are expected to continue supporting the institutionalization of social contracting through a mix of technical assistance, policy dialogue, and financial support.

Roles and Responsibilities:

- Technical Assistance

    - Provide support to the Government of Tanzania (e.g., TACAIDS, MoH, MoF) in:
    - Designing social contracting systems, guidelines, and tools
    - Building capacity of government and CSOs on grant management, M&E, and financial accountability
    - Strengthening digital systems and data use for program oversight
- Catalytic Financing
    - Offer bridge funding, pilot financing, or matching funds to demonstrate proof of concept and facilitate the transition to domestically funded contracting models (e.g., via the AIDS Trust Fund).
    - Co-finance integrated HIV service packages, particularly for KVPs, PLHIV, and underserved populations, in collaboration with government resources.
- Policy Advocacy and Knowledge Sharing
    - Support national efforts to mobilize political commitment for social contracting and sustainable HIV financing.
    - Facilitate south-south learning, regional technical exchanges, and documentation of promising practices from countries with successful social contracting models (e.g., Thailand, Vietnam).
- Accountability and Alignment
    - Participate in joint reviews and coordination forums to ensure alignment of partner investments with national strategies and the National Social Contracting Guideline.
    - Encourage adherence to principles of transparency, ownership, and value for money.

3.2.9. Office of the Controller and Auditor General (OCAG)

CAG is mandated to ensure transparency and accountability in the use of public funds through independent audits.

Key roles in social contracting:

- Conduct regular financial audits of social contracting mechanisms.
- Verify adherence to contractual terms, value for money, and risk mitigation measures.
- Report audit findings to Parliament and recommend corrective actions.

3.5 Coordination and Sustainability Planning

To ensure effective coordination, accountability, and long-term sustainability of social contracting in Tanzania, a multi-stakeholder Social Contracting Task Force (SCFTF) will be established.
The SCFTF will serve as the national technical and policy advisory body responsible for guiding the design, validation, and phased implementation of social contracting mechanisms. Beyond its advisory role, the Task Force will act as a bridge between donor-supported initiatives and domestically financed systems, ensuring that social contracting remains financially viable, efficient, and nationally owned.

Composition

The Task Force will comprise representatives from government institutions, civil society, and development partners to foster inclusive and evidence-based decision-making.
Membership includes:

- **Government:** Ministry of Health (MoH), Tanzania Commission for AIDS (TACAIDS), President's Office–Regional Administration and Local Government (PO-RALG), and Ministry of Community Development, Gender, Women and Special Groups (MoCDGWSG).
- **Civil Society and Community:** Representatives from national CSOs and community networks such as NACOPHA, KVP Forum, and other accredited CLOs.
- **Development Partners:** UNAIDS, and other bilateral or multilateral agencies providing technical or financial support. UNAIDS – as a technical co-lead and permanent member of the

Social Contracting Task Force (SCFTF) – together with other bilateral and multilateral agencies providing technical or financial support.
- The Secretariat will be co-chaired by TACAIDS and the Ministry of Health, with technical support from UNAIDS.

Roles and Responsibilities

The Task Force will perform both strategic and operational functions to strengthen coordination, financing, and governance of social contracting. Its specific roles include:

- Conduct annual financing needs and gap analyses to guide resource planning and allocation.
- Monitor transition progress, donor commitments, and alignment with national sustainability plans.
- Advocate for increased domestic resource mobilization through the AIDS Trust Fund (ATF), Basket Fund, and national budget allocations.
- Review the efficiency, equity, and impact of social contracting resource distribution.
- Oversee performance monitoring, evaluation of grantee results, and verification of fund utilization.
- Support the refinement of financing models, including performance-based disbursement and integration into public financial management (PFM) systems.
- Facilitate stakeholder coordination, policy dialogue, and knowledge exchange on sustainability and transition planning.
- Develop and periodically update a Transition Roadmap that progressively shifts funding from external to domestic sources.
- Promote integration of social contracting within the Medium-Term Expenditure Framework (MTEF) and sectoral plans.
- Track progress on sustainability milestones, including institutional capacity building, system integration, and performance accountability.
- Organize annual learning forums and technical consultations to share lessons and good practices.

Accountability and Reporting

The Task Force will convene quarterly meetings to review progress and provide policy direction. It will submit reports to TACAIDS and MoH leadership, and share key outcomes with relevant ministries, development partners, and national coordination bodies. The Secretariat will maintain comprehensive documentation of meetings, decisions, and progress to ensure transparency, learning, and institutional memory.

4. Social Contracting Service Packages

4.1 Introduction

The eligible services and packages under Tanzania's social contracting framework are designed to strengthen the health system by leveraging community-based and non-state actors to deliver interventions where they create the most significant impact.

HIV services remain central, covering prevention for adolescent girls and young women (AGYW), adolescent boys and young men (ABYM), and key and vulnerable populations (KVPs); community-based HIV testing and linkage to care; treatment adherence and retention support; and community-led monitoring (CLM) to capture client feedback and improve service quality.

The implementation package fosters an integrated, comprehensive, community-driven response that complements facility-based care, enhances equity, and accelerates progress toward universal health coverage (UHC) and epidemic control.

Beyond HIV, the framework extends to other priority public health areas:

- Tuberculosis (TB): community contact tracing, sputum transport, and support for tuberculosis preventive therapy (TPT).
- Malaria: social and behaviour change campaigns, community mobilization for indoor residual spraying (IRS), and distribution and correct use of long-lasting insecticidal nets (LLINs).
- RMNCAH and Adolescent Health: demand creation for HPV vaccination, tracing of antenatal (ANC) and postnatal (PNC) defaulters, and mobilization for adolescent sexual and reproductive health (SRH).
- Non-Communicable Diseases (NCDs): community-based screening, referral, and health promotion for early detection of hypertension, diabetes, cervical cancer, and related conditions.
- Emergency / Outbreak Preparedness and Response: community-based surveillance, event reporting, and risk communication during health emergencies.

4.2 HIV Services

In Tanzania, social contracting is anchored in the HIV response as its central focus—serving as a strategic vehicle to sustain HIV prevention, treatment, care, and community-led accountability mechanisms. The framework prioritizes the implementation of integrated community-based and rights-driven HIV services that extend the reach of the health system, dismantle barriers created by stigma, discrimination, and punitive legal environments, and advance national epidemic-control goals.

All service packages must be people-centred, gender-transformative, and inclusive, ensuring meaningful participation of women, men, adolescents, and key and vulnerable populations. Program design should intentionally address gender inequalities, promote human rights, and create enabling environments that foster dignity, safety, and equitable access to HIV and related health services.

Table 2: HIV Social Contracting Service Packages

S/n	Intervention Area	Service Packages	Description
01	HIV Prevention Services	• Condom distribution and promotion • Peer-led education and outreach (e.g., AGYW, ABYM, truck drivers, miners, fisherfolk, MHR, WHR) • PrEP and PEP promotion • Harm reduction for PWUD/PWID	Implementers deliver peer-led outreach tailored to priority groups, mobilizing prevention commodities, promoting PrEP literacy, and strengthening referrals for GBV survivors. Services must ensure confidentiality, safety, and gender sensitivity.
02	HIV Testing and Linkage to Care	• Community-based HTS (including self-testing) • Index testing & partner notification • Linkage to ART initiation and care	Outreach/mobile HTS complemented by HIVST. Implementers ensure assisted linkage to care, focusing on hard-to-reach areas and gaps in the first “95” of UNAIDS targets.
03	Treatment Adherence & Retention	• Differentiated service delivery (e.g., community ART groups) • Peer navigation & defaulter tracing • Psychosocial support groups • Treatment literacy	Partners strengthen adherence and retention by establishing ART refill groups, adherence clubs, defaulter tracing, and promoting viral load literacy.
04	Community-Led Monitoring (CLM)	• Beneficiary feedback collection • Scorecards, exit interviews, dialogues • Advocacy briefs	CSO/PLHIV coalitions monitor service delivery, report barriers, and inform improvements. CLM findings also guide performance-linked payments.
05	Stigma, Discrimination & GBV Response	• GBV prevention & survivor support (LIVES approach) • Human rights literacy & legal support • Sensitization of leaders & providers	Implementers reduce stigma and GBV by providing first-line support, establishing referral pathways, and strengthening rights-based awareness among PLHIV/KVPs, leaders, and service providers.
06	Structural Interventions & Vulnerability Reduction	• Economic empowerment & social protection linkages • Addressing harmful gender norms • Violence Prevention & Response (VPR) • Policy advocacy	Partners link priority groups (e.g., AGYW, WHR, single mothers) to livelihoods and social protection, run community dialogues, implement VPR, and advocate for structural reforms to reduce HIV vulnerability.
07	Meaningful Participation in Policy	• Support PLHIV/community reps in planning/reviews • Technical support to CSOs for advocacy	Implementers ensure inclusion of PLHIV and community actors in policy platforms and strengthen CSO advocacy for laws, policies, and budgets aligned to community needs.

4.3 Other Prioritized Public Health Interventions

4.3.1 Tuberculosis (TB)

Within Tanzania's social contracting framework, Tuberculosis (TB) services are designed to bring prevention, diagnosis, and care closer to the community, ensuring timely access and continuity of treatment. Community-based and non-state actors play a pivotal role in bridging gaps that health facilities alone cannot fill.

Key areas of focus include:

- Community Contact Tracing: Engaging local organizations and community health actors to identify and follow up with household and close contacts of TB patients. This ensures early detection of new cases, reduces transmission, and strengthens linkage to care.
- Specimen and Sputum Transport: Supporting timely transport of sputum and other diagnostic samples from households and remote communities to laboratories. This reduces delays in diagnosis and improves access for populations living in hard-to-reach areas.
- Treatment Support and Adherence: Mobilizing peer supporters, community volunteers, and CSO-led networks to provide home-based education, treatment literacy, defaulter tracing, and psychosocial support. These interventions help patients complete their treatment regimens and prevent drug resistance.
- Support for TB Preventive Therapy (TPT): Promoting the uptake and completion of TPT, particularly among high-risk groups such as children and people living with HIV, through awareness, follow-up, and adherence monitoring at the community level.

4.3.2 Malaria

Under Tanzania's social contracting framework, malaria interventions are structured to harness the strengths of community-based and non-state actors in reaching households and vulnerable groups that often remain beyond the consistent reach of facility-based services. By leveraging local trust and networks, these actors can drive behaviour change, improve prevention coverage, and strengthen linkages to care.

Key malaria service areas include:

- Social and Behaviour Change (SBC) Campaigns: Community-led organizations mobilize awareness on correct and consistent use of malaria prevention tools, educate households on early care-seeking behaviours, and address myths and misconceptions that undermine uptake of interventions.
- Community Mobilization for Indoor Residual Spraying (IRS): Local actors work with households and leaders to prepare communities for IRS campaigns, ensuring high coverage, improved acceptance, and reduced resistance to spraying interventions.
- Distribution and Proper Use of Long-Lasting Insecticidal Nets (LLINs): CSOs and community groups support mass distribution campaigns and household-level education on correct usage, replacement, and maintenance of LLINs—especially in high-burden and border regions.
- Linkage and Referral Support: Community implementers strengthen referral pathways for prompt malaria diagnosis and treatment, ensuring early access to services and reducing severe disease outcomes.

4.3.3 Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH)

The social contracting framework in Tanzania prioritizes RMNCAH interventions to ensure that women, children, and adolescents receive timely, equitable, and people-centered care. By engaging civil society and community-led actors, the framework strengthens outreach, reduces service gaps, and builds trust with households that face barriers to accessing facility-based services.

Key RMNCAH service areas include:

- HPV Vaccination Demand Creation: Community organizations mobilize parents, guardians, and adolescent girls to increase awareness and acceptance of HPV vaccination, addressing myths and stigma while ensuring timely uptake.
- Antenatal and Postnatal Care (ANC/PNC) Defaulter Tracing: CSOs and community health groups identify and follow up on women who have missed ANC and PNC appointments, linking them back to care and reducing risks of maternal and neonatal complications.
- Adolescent Sexual and Reproductive Health (SRH) Mobilization: Youth-led and community-based actors provide age-appropriate information, peer education, and safe spaces to empower adolescents to access SRH services without fear of stigma or discrimination.
- Maternal and Newborn Health Support: Community actors promote skilled birth attendance, emergency preparedness, and early recognition of maternal and newborn danger signs, strengthening linkages with health facilities for timely referral.

4.3.4 Non-Communicable Diseases (NCDs)

Tanzania's social contracting framework extends to Non-Communicable Diseases (NCDs), acknowledging their increasing burden on individuals, families, and the healthcare system. By leveraging civil society organizations (CSOs), community-based organizations (CBOs), and grassroots networks, the framework enhances early detection, prevention, and support at the community level—complementing facility-based care and reducing the strain on hospitals.

Key NCD service areas include:

- Community-Based Screening: CSOs and community actors provide routine screening for hypertension, diabetes, breast cancer, and cervical cancer at community gatherings, outreach events, and household visits. Early detection enables timely referral and treatment, thereby reducing the risk of severe complications.
- Referral and Linkages to Care: Community implementers strengthen referral systems for individuals identified with NCD risks, ensuring they access appropriate diagnostic and treatment services at health facilities.
- Health Promotion and Behaviour Change: Local organizations conduct campaigns to raise awareness about NCD risk factors such as tobacco use, harmful alcohol consumption, poor diet, and physical inactivity. They promote healthier lifestyles and support families in adopting sustainable, preventive behaviors.
- Peer Support and Self-Care Models: Community groups establish support networks for people living with NCDs, offering psychosocial support, adherence counseling, and linkages to social protection schemes. These groups empower individuals to manage their conditions and reduce long-term health risks.

4.3.4 Outbreak and Emergency Preparedness and Response

Tanzania's social contracting framework acknowledges the crucial role of communities in identifying, preventing, and responding to outbreaks and emergencies. By engaging CSOs, CBOs, FBOs, and other non-state actors, the framework ensures that preparedness and response measures are rooted in local realities, trusted by communities, and rapidly deployed where they are most needed.

Key areas of focus include:

- Community-Based Surveillance: Local actors are mobilized to conduct event-based surveillance, identify unusual health events, and promptly report them to health authorities. This strengthens early warning systems and accelerates response.
- Risk Communication and Community Engagement: CSOs and community groups lead health education, rumor management, and dissemination of accurate information during

emergencies such as cholera, COVID-19, or other emerging threats. They ensure that messages are clear, culturally appropriate, and widely accessible.

- Preparedness and Resilience Building: Community networks are engaged in emergency drills, local preparedness planning, and stockpiling of essential supplies. They also help mobilize households to adopt preventive practices and strengthen resilience against shocks.
- Support During Epidemic Response: Non-state actors can provide rapid mobilization for case finding, contact tracing, home-based care, safe referrals, and psychosocial support during outbreaks. Their close community ties make them critical partners in maintaining trust and ensuring adherence to public health measures.

5. Financing and Payment Models

5.1 Introduction

The financing and payment models for social contracting in Tanzania are designed to ensure sustainability, predictability, and accountability while incentivizing performance and equity. Funding will be drawn from a mix of sources—including the AIDS Trust Fund, domestic health budgets (MoH, PORALG, and LGAs), the Health Basket Fund, and transitional counterpart financing from partners such as the Global Fund, PEPFAR, PMI, and Gavi. Payments to implementers will follow results-based models that combine a base tranche for start-up and operational continuity, tariff-based payments per verified service output (e.g., PrEP initiation, TB contact screening, HPV dose delivery), and performance bonuses for equity-driven or integrated programming results, such as reaching hard-to-reach populations, exceeding service quality standards or compounded impactful results. By blending domestic resources with performance-linked disbursements, this model not only ensures value for money but also strengthens Tanzania's pathway toward sustainable, community-led health financing.

5.2 Sources of Financing

The sustainability of social contracting in Tanzania will rely on a mixed financing model that blends domestic resources with transitional support from development partners. The primary sources of financing include:

- AIDS Trust Fund (ATF): A dedicated domestic mechanism mobilized from national earmarked levies, contributions, and government allocations to finance HIV and AIDS interventions. Under social contracting, the ATF will be a core source of funding for community-based HIV services, including prevention, treatment support, and community-led monitoring.
- Domestic Health Budgets: Allocations from the Ministry of Health (MoH), and PORALG will be directed to fund priority public health services beyond HIV—such as TB contact tracing, malaria mobilization, reproductive health services, and outbreak preparedness. The integration of social contracting into annual budget cycles will ensure its long-term institutionalization.
- Health Basket Fund (HBF): As a pooled financing mechanism supported by the Government and partners, the HBF will complement resources for social contracting, particularly for cross-cutting health system activities such as capacity building, supervision, and verification.
- Counterpart Financing from Development Partners: In line with transition and sustainability commitments, development partners—including the Global Fund, PEPFAR, the President's Malaria Initiative (PMI), Gavi, and others—will provide co-financing and catalytic support during the early years. These contributions will bridge gaps while Tanzania progressively increases domestic allocations, ensuring continuity of essential community-led services during the transition period.

5.3 Payment Models

Sustainable financing is a cornerstone of the social contracting mechanism for prioritized public health intervention responses in Tanzania. Funding modalities under this guideline recognize the need to blend domestic and external resources in a harmonized, transparent, and accountable manner. This section outlines the available and potential funding sources that can be used to support social contracts with Civil Society Organizations (CSOs) and Community-Led Organizations (CLOs).

These modalities aim to ensure predictable, equitable, and efficient resource flows while enhancing value for money, reducing donor dependency, and supporting the scale-up of community-led HIV services.

5.3.1 Budgeting and Costing

A robust and transparent budgeting and costing system ensures that financial proposals are realistic, efficient, and aligned with national standards, while enabling the government and technical partners to assess value for money. All budget submissions under social contracting must adhere to standardized costing approaches that facilitate comparability, cost control, and performance-based financing.

5.3.2 Standardized Costing Tools

To promote equity, consistency, and fiscal discipline, social contracting will apply nationally recognized costing frameworks, including:

- Unit Cost Models
  Define the average or maximum allowable cost per service unit delivered (e.g., cost per person tested, cost per peer education session, cost per person reached with HIV prevention). Commonly used in output-based or hybrid models. Enable fair allocation and control inflated costs.
- Per Capita Costing
  Used for budgeting at the population level (e.g., cost per beneficiary group, cost per PLHIV or KVP reached in a geographic area). Useful for interventions targeting entire subgroups (e.g., all AGYW in a district). Supports the equitable distribution of resources based on need or burden.
- Activity-Based Budgeting
  Provides detailed line-item costs associated with implementation, including staff, logistics, monitoring and evaluation (M&E), and overheads. Suitable for input-based or blended disbursement models.

5.4 Budget Development Guidelines

All CSOs submitting proposals under social contracting should use official budget templates provided by the contracting authority; justify all cost estimates based on realistic market rates, procurement standards, and service delivery plans, identify cost-sharing or in-kind contributions where applicable, and review unit costs to reflect inflation and delivery realities.

Budgets submitted by CSOs will be reviewed by the Contracting Authority’s finance team, with technical support from the Ministry of Finance and other relevant agencies. Proposal Budgets exceeding national cost norms or showing inefficiencies may be returned for revision or adjusted during contract negotiation. Upon approval, budgets become an integral part of the contract agreement, and any major changes during implementation will require prior written approval.

5.4 Disbursement Approaches

To ensure the effective, timely, and accountable disbursement of funds to Civil Society Organizations (CSOs), the social contracting mechanism in Tanzania will apply flexible and performance-sensitive disbursement approaches aligned with public finance laws and the financial management capacities of both government agencies and CSOs/CLOs.

Table 3: Disbursement Approaches

Approach	Disbursement	Description
Funding Models	Output-Based Funding	Disbursements are tied to achievement of defined outputs (e.g., number of people reached, number of referrals made, adherence support sessions conducted). Payments are made after verification of service delivery and may be based on agreed unit costs. Encourages efficiency and performance-driven implementation.
	Mixed Funding Models	Combines both input-based and output-based elements. For example, a portion of the grant may be provided up front for operational costs, while additional disbursements are triggered based on achievement of outputs. Offers flexibility while maintaining incentives for results.
Tranche-Based Disbursement	Initial Advance	A start-up tranche (e.g., 20–30% of the total contract amount) is disbursed upon signing of the contract to facilitate immediate implementation and procurement of inputs.
	Performance-Based Tranches	Subsequent disbursements are made in phased intervals (e.g., quarterly or biannually), based on: Submission of technical and financial progress reports Achievement of agreed milestones or service delivery targets Verification by the Contracting Authority or Monitoring Team
	Final Disbursement	The final tranche (e.g., 10–15%) may be withheld until submission of the final report, completion of all deliverables, and financial reconciliation.

Global best practice highlights that effective payment models require robust unit costing, inclusion of both direct and indirect costs (administration, safeguarding, monitoring), and regular updates to reflect inflation and programmatic shifts. Linking payments not only to quantity but also to service quality and equity outcomes ensures that the system delivers value for money while addressing Tanzania's most pressing public health needs.

- Base tranche + milestone payments to ensure continuity.
- Tariff-based payment per verified output (e.g., PrEP initiation, TB contact screened, HPV dose delivered).
- Performance bonuses for equity-focused results (hard-to-reach populations, hotspots).

In Tanzania, the disbursement approach selected should consider the size of the grant, the nature of services, risk assessment, and the maturity of the implementing partner. The government will be responsible for assessing the eligibility of the contracted CSO based on the relevant funding modality.

6. Granting and Contracting Process

6.1 Introduction

The granting and contracting process provides a clear, step-by-step framework for how the Government of Tanzania—through the TACAIDS and Local Government Authorities (LGAs)—will engage non-state actors in delivering community-based health services under social contracting.

The process begins with planning, where annual needs assessments define priority service packages and geographic lots. This is followed by procurement and selection through the NeST e-procurement system, in line with the Public Procurement Act (2024). Contracting then formalizes agreements using standardized service templates with clear Key Performance Indicators (KPIs), roles, and payment terms.

During implementation, contracted CSOs, CBOs, and FBOs will deliver approved service packages, report into DHIS2 and programme registers, and engage communities through Community-Led Monitoring (CLM). Finally, verification and payment ensure accountability by linking disbursements to independently validated results.

6.2 Institutional Roles and Responsibilities in the Contracting Process

The social contracting process in Tanzania is driven by a coordinated framework involving key government and regulatory institutions. The Ministry of Health (MoH), Tanzania Commission for AIDS (TACAIDS), and the President's Office – Regional Administration and Local Government (PORALG) jointly lead the planning phase, conducting annual needs assessments to identify service delivery gaps, define priority service packages, and allocate resources from domestic and partner funding sources. During the call for proposals, TACAIDS, working with the Public Procurement Regulatory Authority (PPRA), ensures that the process adheres to national procurement standards by issuing transparent Requests for Proposals (RFPs), setting clear eligibility criteria, and promoting open competition.

In the subsequent stages, institutional roles are clearly defined to maintain accountability and quality assurance. The MoH, PORALG, and Ministry of Finance (MoF) collaborate with civil-society networks to evaluate proposals, ensuring that selected organizations demonstrate technical competence, equity focus, and value for money. TACAIDS and the MoH then conduct pre-award assessments to verify organizational capacity and manage associated risks. Finally, the Contract Approval Committee approves or conditionally approves implementers and oversees the signing of standardized contracts that define deliverables, timelines, and performance expectations. Table 5: Institutions' Roles in Contracting Process.

Table 4: Institutional Roles in Contracting Process

Process Step	Lead Agency	Key Responsibilities
Planning	MoH, TACAIDS, PORALG	Conduct needs assessments; define service packages and lots; secure funding.
Call for Proposals	TACAIDS, PPRA	Issue RFPs; publish eligibility and evaluation criteria.
Evaluation	MoH, PORALG, MoF, CSO Networks	Score proposals; recommend shortlist.
Pre-Award Assessment	TACAIDS / MoH	Assess organizational capacity and risk.
Approval & Contracting	TACAIDS Committee	Approve, conditionally approve, or reject organizations; sign contracts.

5.3. Selection and Contracting Process

The process of selecting and contracting collaborators under the social contracting model is designed to uphold fairness, transparency, and accountability, while ensuring that critical services reach communities efficiently and effectively. It balances structured procurement processes with the flexibility to respond to urgent needs or leverage proven expertise. The approach reinforces government stewardship, strengthens civil society engagement, and guarantees that contractual obligations are tied to measurable results. Both calls for proposals and tendering will be used. Each yearly cycle will be guided through the following processes:

- Each contracting cycle begins with a participatory planning exercise led by the Ministry of Health (MoH), TACAIDS, PORALG, and local government authorities. This process identifies service delivery gaps and defines priority service packages to be addressed through social contracting.
- Procurement is carried out using the national procurement platform to guarantee open competition. The system ensures objective evaluation of bids, minimizes bias, and promotes transparency in the selection of CSOs, FBOs, and CBOs.
- Successful organizations enter into formal agreements using standardized contract templates. These contracts outline service packages, key performance indicators (KPIs), reporting obligations, payment schedules, and compliance requirements.

In cases where an urgent response is required, or when a CSO/FBO/CBO has demonstrated strong past performance and proven operational capacity, the Government of Tanzania—through MoH, TACAIDS, PORALG, or another mandated authority—may directly appoint a collaborator. Such appointments are strictly justified and documented to ensure accountability while safeguarding continuity of critical services.

- All implementers—whether competitively selected or exceptionally appointed—must sign a Memorandum of Understanding (MoU) either with the Government of Tanzania (through its mandated authorities) or with the appointed lead implementer/Principal Recipient (PR) or Lead SR. The MoU formalizes roles, obligations, and mutual accountability between parties.
- Contracted organizations must deliver services in alignment with national guidelines, report data into DHIS2 and program registers, and actively engage communities through participatory and inclusive mechanisms.
- Verification review reported outputs through site visits, data validation, and beneficiary interviews. Payments are tied to validated results, ensuring that funds are disbursed only when services are confirmed to have been delivered with integrity and impact.

The selection and contracting process comprises six sequential steps (figure 3):

Figure 4: Social Contracting Process flow

6.2.1 Step 1: Planning

Planning lays the foundation for a credible and demand-driven social contracting cycle. It ensures that priorities, resources, and service packages are grounded in evidence, community needs, and national strategic objectives.

Purpose: To align government priorities, available resources, and community needs in preparation for each contracting cycle.
Lead Agencies: MoH, TACAIDS, PORALG, and LGAs.

Kay actions:

- Conduct an annual needs assessment guided by epidemiological data, programme performance indicators, and feedback from Community-Led Monitoring (CLM) and stakeholder consultations.
- Identify priority service packages across HIV, TB, malaria, RMNCAH, NCDs, and outbreak preparedness.
- Define geographic lots—clusters of councils, wards, or communities—where contracting will expand access and equity.
- Secure funding from the AIDS Trust Fund (ATF)**,** domestic health budgets, the Health Basket Fund, and development-partner co-financing.
- Publish annual contracting priorities, indicative budgets, and lots to promote transparency and predictability.

6.2.2 Step 2: Call for Proposals (Request for Proposals – RFP)

The call for proposals initiates transparent competition among qualified CSOs/CLOs. It transforms planning priorities into actionable opportunities, ensuring fair access and inclusivity across all eligible implementers. (Annex 5)

Purpose: To invite eligible Civil-Society and Community-Led Organizations to apply competitively for implementation funding.

Key Actions:

- Issue public RFPs through multiple channels—government websites, national newspapers, CSO networks, and regional or district noticeboards.
- Provide clear details on funding source, duration, eligibility criteria, scoring methodology, submission procedures, and deadlines.
- Communicate in both Swahili and English to ensure inclusivity.
- Offer optional pre-bid orientation sessions to explain technical and financial requirements.
- Use appropriate procurement platforms to manage applications, maintain transparency, and ensure digital traceability.
- Promote the formation of consortia or joint applications that leverage complementary strengths, enhance geographic coverage, and foster shared accountability.

6.2.3 Step 3: Proposal Submission and Evaluation

This stage ensures that funding is directed to organizations demonstrating the strongest technical merit, efficiency, and community credibility. Through independent and competitive evaluation, government guarantees that every contracted partner delivers value for public resources. (Annex 6a)

Purpose: To select the most capable implementers through a fair, transparent, and merit-based process.

Submission Requirements

- Technical proposal outlining activities, methodologies, timelines, and expected results.
- Detailed budget and justification.

- Organizational profile, registration certificates, previous experience, and recent audit reports.
- Partnership letters (for consortia or networks).
- All proposals submitted within the prescribed timeline; late or incomplete submissions are disqualified unless officially justified.

Evaluation Process

Conducted by an **Independent Evaluation Committee (IEC)** comprising representatives from MoH, TACAIDS, PORALG, Ministry of Finance, academia, PLHIV/KVP networks, and civil-society representatives, with development partners serving as observers.

Proposals are screened for eligibility, then scored on a **weighted scale (100%)** as follows:

- Technical merit and alignment with priorities – 30%
- Cost-effectiveness and value for money – 25%
- Target-population reach and equity – 20%
- Organizational capacity and past performance – 15%
- Innovation and sustainability – 10%
- Highest-scoring proposals are shortlisted for pre-award assessment.

6.2.4 Step 4: Pre-Award Assessment (PAA)

Pre-award assessment acts as a risk-control gateway, ensuring that only organizations with strong governance and financial integrity manage public funds. It reinforces accountability by confirming that selected partners possess the systems and capacities required to deliver results effectively.

Purpose: To verify that shortlisted organizations possess the legal, financial, and programmatic capacity to manage public funds responsibly.

Assessment Focus

- Legal registration, governance structure, and accountability mechanisms.
- Financial management systems, internal controls, and audit history.
- Programmatic capacity, staffing qualifications, and past performance.
- Risk-management, safeguarding, procurement, and data-protection policies.
- Ability to collect, analyse, and report data using national M&E systems such as DHIS2.

A sample PAA checklist is provided in Annex 4.

6.2.5 Step 5: Approval and Contracting

Approval and contracting formalize the government partnership with eligible organizations. This phase ensures that all agreements are legally sound, performance-driven, and aligned with national accountability standards.

Approval Authority
The **Contract Approval Committee**—comprising representatives from programme, finance, procurement, and legal units—reviews PAA findings and issues final decisions:

- **Full Approval:** Eligible for immediate contracting.
- **Conditional Approval:** Contracting contingent on specific corrective actions.
- **Rejection:** With written justification and feedback.

Contracting Process

Contracts are based on standardized **Service Agreement Templates** jointly developed by TACAIDS, MoH, TACAIDS, and PPRA to ensure uniformity, compliance, and accountability. (Annex 7)

Each agreement specifies:

- Scope of services and geographic coverage.
- Key Performance Indicators (KPIs) and reporting requirements. (Annex 8)
- Payment terms linked to verified results.
- Roles and responsibilities of MoH, PORALG, LGAs, and implementers.

Special Provisions-Direct Appointments

In exceptional circumstances—such as public health emergencies, epidemic outbreaks, or humanitarian crises—where time-sensitive action is required to safeguard lives or maintain continuity of essential services, direct appointments may be authorized under the following criteria and safeguards.

- **Eligibility**: Used only in urgent public health or humanitarian situations where competitive procurement would cause harmful delays, supported by a written and approved justification.
- **Safeguards and Accountability**: Implementers must sign an MoU outlining roles, reporting, financial controls, and grievance procedures, with provisions for integrity and anti-fraud compliance.
- **Duration**: Direct appointments are temporary and must shift back to competitive selection once normal conditions return.

6.2.6 Step 6: Contract Award and Signing

Contract award and signing mark the official start of implementation and partnership. At this stage, government commitment, organizational readiness, and shared accountability converge to translate contractual obligations into measurable community impact.

Purpose: To formalize partnerships and initiate implementation.

Key Actions

- Contract awards are issued to the approved CSOs.
- **Contract Types and Duration:** Contracts may be annual or multi-year, depending on service scope, funding availability, and national planning cycles. Multi-year contracts are preferred when service continuity is critical and funding predictability is feasible.
- **Deliverables and Outcomes:** All contracts are results-based and specify measurable outputs, disbursement-linked milestones, and monitoring requirements.
- **Terms and Conditions:** Each contract details payment schedules, responsibilities, termination clauses, and amendment provisions.
- **Signing and Orientation:** Contracts are signed by the contracting authority (e.g., TACAIDS or MoH) and the legal representative of the CSO. A post-award orientation is conducted to:
    - Review performance obligations and reporting timelines.
    - Clarify financial and administrative procedures.
    - Align partners with national coordination, verification, and supervision systems.

7. Implementation, Monitoring and Verification Framework

7.1 Introduction

The implementation, monitoring, and verification framework outlines how Civil Society Organizations (CSOs) and Community-Led Organizations (CLOs), upon contracting, will deliver community-level services that align with national strategies, performance standards, and measurable results. It sets out the service types, delivery models, coordination mechanisms, oversight, and accountability systems that ensure value for money and impact.

7.2 Implementation Framework

The implementation, monitoring, and verification framework outlines how contracted Civil Society Organizations (CSOs) and Community-Led Organizations (CLOs) will deliver community-based health and social services in alignment with national priorities, performance standards, and measurable outcomes. It ensures that all contracted activities are implemented transparently, efficiently, and with strong accountability to both government and communities.

Implementation will be guided by results-based financing principles and anchored in the broader national health architecture, ensuring that every intervention contributes to equitable access, quality care, and sustainability. The framework outlines the key delivery models, reporting mechanisms, verification processes, and feedback loops that collectively ensure value for money and tangible impact.

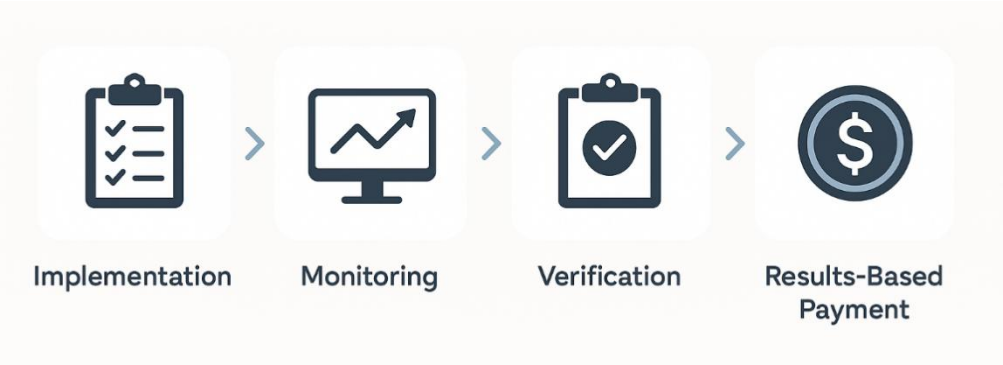

Figure 5: Social Contracting Implementation and Monitoring Framework

7.3 Core Operating Principles

The implementation of Tanzania's Social Contracting Framework is anchored in core operational principles that promote transparency, accountability, equity, and sustainability. These principles guide both government and non-state actors to deliver community-based services ethically and efficiently, ensuring public resources are managed responsibly, community voices are respected, and results contribute to stronger national ownership and lasting impact.

- **Standards and Compliance:** All activities must adhere to national technical guidelines, safeguarding policies (including SEAH and child protection), data protection rules, and contractual terms.
- **People-Centered Delivery:** Peer-led and community-driven approaches will prioritize underserved, remote, and high-burden populations to ensure inclusivity and reach.
- **Systems Integration:** Service delivery and reporting must be fully embedded within national systems such **as** DHIS2**,** CMIS**,** and programme registers to ensure interoperability and alignment.

- **Accountability by Design:** All financing will be results-linked, supported by independent verification, community-led monitoring (CLM), and transparent reporting to ensure fairness and credibility.

Minimum Staffing and Management Requirements

Each contracted CSO or CLO must:

- Appoint focal persons responsible for programme management, M&E/data management, finance, and safeguarding.
- Conduct monthly internal reviews and quarterly joint performance reviews with LGAs and regional health management teams.
- Establish documented referral and linkage protocols with health facilities and social service providers to ensure continuity of care and effective follow-up.

7.4 Service Delivery Models

Service delivery under Tanzania's social contracting mechanism must be flexible, community-driven, and tailored to local realities. CSOs will adopt the most suitable mix of delivery models based on their target population, service type, and geographic setting. The models below are designed to ensure maximum reach, accessibility, and continuity of care, especially for hard-to-reach and underserved populations.

- **CSO- and Peer-led Delivery:** Utilizes trusted community networks and lived experience of peer educators to deliver targeted services to key and vulnerable populations.
- **Facility-linked Delivery:** Strengthens partnerships between CSOs and health facilities for referrals, adherence support, and continuum of care.
- **Mobile Outreach and Hub-and-Spoke Models:** Expands service access through mobile teams, outreach clinics, and decentralized service hubs.
- **Virtual and Digital Delivery:** Leverages digital platforms, telehealth, and mobile tools to provide information, counselling, and follow-up care.

7.5 Monitoring Framework

Monitoring is a core component of Tanzania's social contracting system, ensuring that contracted organizations deliver quality, equitable, and efficient services. It provides continuous oversight of performance, fiduciary integrity, and compliance with national standards.

7.5.1 Monitoring Modalities

- **Routine Reporting:** Implementers must submit service delivery data through national systems (DHIS2, CMIS, programme registers), accompanied by quarterly narrative progress reports.
- **Supervision and Site Visits:** Joint field monitoring by LGAs**,** CHMTs**,** RHMTs**,** PORALG, MoH, and **TACAIDS** to validate performance and provide technical support.
- **Financial Reviews:** Periodic expenditure and budget reviews, including spot checks of supporting documents to ensure fiduciary accountability.
- **Stakeholder Consultations:** Quarterly multi-stakeholder review meetings with CSOs, community leaders, and facility staff to share progress, identify challenges, and co-develop solutions.

7.5.2 Data Quality Assurance (DQA)

To ensure the reliability of reported data, the following mechanisms will be applied:

- **Quarterly Light DQAs:** Remote verification of reported data through random sampling and phone validation.

- **Semi-Annual On-Site DQAs:** Source verification comparing registers, DHIS2 entries, and reported outputs.
- **Corrective Actions:** Discrepancies will trigger corrective action plans with defined closure timelines tracked by the contracting authority.

7.5.3 Community-Led Monitoring (CLM) Integration

Community-Led Monitoring (CLM) serves as a real-time feedback tool to capture beneficiary experiences regarding accessibility, stigma, discrimination, confidentiality, and service quality. CLM findings will be triangulated with quantitative reports and integrated into performance assessments, influencing both contract renewals and results-linked disbursements.

7.6 Verification and Payment

Verification and payment mechanisms are designed to ensure that funds are disbursed solely based on independently validated results. This process reinforces accountability, transparency, and efficiency in public spending.

7.6.1 Verification

Independent verification teams or agents—such as universities, research institutes, audit firms, or accredited CLM coalitions—will review results quarterly or more frequently if triggered by risk or rapid-response needs. (Annex 9)
Verification methods include:

- Desk review of reports, dashboards, and data submissions.
- Field spot checks and direct observation of service delivery.
- Beneficiary interviews and confidential client feedback.
- Source-document validation and data triangulation with DHIS2 and programme registers.
- Safeguarding and confidentiality compliance checks.

Verification Outputs:

Quarterly verification reports shared with TACAIDS, MoH, PORALG, LGAs, and partners.

Only validated results will qualify for payment.

7.6.2 Results-Based Financing (RBF)

Payments to contracted organizations will be performance-driven and quality-adjusted(Annex 3)

- **Base Disbursement:** Linked to validated outputs against KPIs and milestones.
- **Quality Adjustment:** Payment levels adjusted based on data quality, safeguarding compliance, and adherence to technical protocols.
- **Equity Weighting:** Higher payments for reaching key, vulnerable, and hard-to-reach populations.
- **Incentives:** Bonuses for exceeding targets or demonstrating innovation.
- **Penalties:** Deductions or contract suspension for non-performance, data falsification, or safeguarding breaches.

7.7 Partnerships for Social Contracting

Partnerships are the backbone of successful social contracting implementation. They enhance efficiency, strengthen linkages between community and facility levels, and foster shared accountability for public health outcomes.

7.7.1 Integration with Regional and District Health Systems

All social contracting activities must be integrated into **Tanzania's decentralized health system**. Contracted CSOs will align their interventions with **Comprehensive Council Health Plans (CCHPs)** and collaborate with **Regional and Council Health Management Teams (RHMTs/CHMTs)**. This ensures that community-based services complement facility-level efforts and address local health priorities.

7.7.2 Public–Private and CSO Partnerships

Collaborative partnerships will be encouraged across sectors:

- **CSO–CBO–FBO Collaborations:** Large national CSOs will mentor smaller community groups, strengthening local capacity and extending service reach.
- **Engagement with Private Sector:** Partnerships with private clinics, corporate CSR initiatives, and local enterprises will expand resource mobilization and service access.
- **Joint Programming:** Coordination among organizations serving overlapping populations (e.g., PLHIV, AGYW, key populations) will reduce duplication and promote synergies.

Through these partnerships, Tanzania's social contracting framework will foster innovation, local ownership, and sustainability—ensuring that no community is left behind in accessing essential health and social services.

8. Capacity Development, Accountability and Risk Management

8.1 Introduction

Building on the contracting and verification frameworks outlined in Chapter 7, this chapter defines the enabling environment that ensures Tanzania's Social Contracting mechanism operates effectively, ethically, and sustainably.
Capacity development, accountability, and risk management are the foundation of system integrity, ensuring that both government institutions and Civil Society Organizations (CSOs) possess the necessary skills, systems, and safeguards to deliver quality services and uphold public trust.

Robust capacity, oversight, and protection measures guarantee that contracted partners meet performance standards, adhere to national laws, and protect the dignity and safety of all beneficiaries. These provisions embed the principles of **Do No Harm**, transparency, and shared learning throughout the contracting cycle.

8.2 Capacity Development Framework

8.2.1 Civil Society Organizations

Capacity strengthening for CSOs will focus on the competencies and systems required to manage public resources and deliver results with integrity.
Key areas include:

- **Contract Management:** Understanding procurement rules, service agreements, and performance obligations.
- **Financial Accountability:** Transparent budgeting, cost control, and compliance with national audit requirements.
- **Data Management:** Accurate and timely reporting into DHIS2**,** programme registers, and safeguarding of client information.
- **Safeguarding Compliance:** Implementation of PSEA**,** child-protection, and data-protection policies.

Training will combine workshops, mentorship, e-learning, and peer-to-peer learning exchanges to build and sustain a lasting institutional capacity.

8.2.2 Government Institutions

For the TACAIDS, MoH, PORALG, and the PPRA, capacity development will strengthen stewardship and oversight.
Focus areas include:

- Contract oversight, verification, and results-based payment management.
- Use of the **NeST e-procurement** platform and transparent evaluation processes.
- Financial and risk management to ensure compliance with the Public Finance Act.
- Constructive engagement with CSOs and CLM coalitions to enhance responsiveness and accountability.

8.2.3 Joint Learning Forums

To promote continuous improvement, **Joint Learning Forums** will be institutionalized as annual multi-stakeholder platforms bringing together government, CSOs, faith-based organizations, development partners, and verification agents.
These forums will review implementation progress, analyze verification findings, document best practices, and co-create adaptive strategies to enhance overall effectiveness. Outcomes and lessons will inform future contracting cycles and policy refinements, ensuring the mechanism remains dynamic and evidence-driven.

8.3 Accountability and Transparency Framework

Accountability is a cornerstone of Tanzania's Social Contracting Framework. It ensures that all stakeholders—government institutions, civil society organizations, and development partners—exercise transparency, responsibility, and integrity in the management of public funds and delivery of community-based services. The framework establishes clear lines of oversight, routine performance verification, and mechanisms for redress, thereby maintaining public trust and ensuring value for money.

Accountability ensures that all actors manage public resources responsibly and that citizens can see tangible results from every shilling invested. It is reinforced through three complementary mechanisms—**Community-Led Monitoring**, **Transparency**, and **Grievance Redress**.

8.3.1 Community-Led Monitoring (CLM)

CLM empowers beneficiaries and community coalitions to provide real-time feedback on the accessibility, equity, and quality of services. Findings on stigma, waiting times, confidentiality, and responsiveness will feed directly into monitoring and payment decisions.
By giving weight to community voices, CLM ensures that social contracting remains rights-based, client-centred, and inclusive.

8.3.2 Transparency

Transparency deters misuse and sustains trust.

- All awarded contracts—including service scope, geography, duration, and value—will be published on official government platforms (**NeST**, **TACAIDS**, and **MoH/PORALG** portals)
- Quarterly disclosures will include performance scorecards, payment summaries, and summaries of resolved grievances (with confidentiality preserved).
- Open reporting allows citizens, CSOs, and partners to track both service delivery and financial flows, reinforcing credibility and accountability.

8.3.3 Grievance Redress Mechanism

A structured grievance system will enable both implementers and community members to raise and resolve complaints in a transparent manner.

- Channels include the **NeST** portal, written submissions to contracting authorities, CLM structures, suggestion boxes, and toll-free hotlines.
- All grievances will be logged, investigated within defined timelines, and feedback provided to complainants. Results of investigations and corrective actions will be summarized in periodic performance reports.
- This mechanism guarantees fairness, responsiveness, and accountability across all levels of implementation.

8.4 Risk Management and Safeguards

Risk management and safeguards protect beneficiaries, maintain service continuity, and uphold financial integrity. Central to this is the "**Do No Harm**" principle, ensuring the confidentiality, safety, and dignity of all clients and frontline implementers. These mechanisms ensure that social contracting processes foster trust, uphold human rights, and prevent any form of abuse, neglect, or exploitation.

8.4.1 Safeguarding Policies

Every contracted organization must adopt and enforce comprehensive safeguarding measures covering the prevention of Gender-Based Violence (GBV), Sexual Exploitation and Abuse (SEA), child protection, and other forms of harassment or discrimination. Safeguarding frameworks must include clear reporting channels, survivor-centered response protocols, and staff accountability mechanisms. Implementing partners are required to build awareness among staff, volunteers, and beneficiaries on safeguarding standards.

Compliance will be verified through regular audits, spot checks, and verification missions. Breaches will be subject to proportionate penalties, including contract suspension, termination, blacklisting, or referral to law enforcement or regulatory authorities.

8.4.2 Confidentiality and Safety

Implementers shall maintain strict data protection standards, including secure storage, privacy, and obtaining informed consent from all beneficiaries.
Service delivery must occur in gender-sensitive, stigma-free environments.
Any breach of confidentiality or violation of the *Do No Harm* principle will trigger investigation and, where necessary, contract termination or prosecution

8.4.3 Financial Integrity

Ensuring financial integrity is central to the credibility, accountability, and sustainability of Tanzania's Social Contracting Framework. All contracted Civil Society Organizations (CSOs) and other implementing partners will be required to maintain transparent and auditable financial management systems that comply with national standards and contractual obligations.

To uphold these standards, all social contracting implementers will be subject to regular financial audits, compliance reviews, and spot checks conducted by independent auditors, government oversight bodies, or development partners. These mechanisms are crucial for safeguarding public and donor resources, detecting risks early, and strengthening internal controls to ensure long-term sustainability.

The Government will enforce robust anti-fraud and anti-corruption measures to ensure the prudent use of funds. Any implementer found to have engaged in financial mismanagement, data falsification, or misuse of resources will face appropriate sanctions, including recovery of funds, blocklisting from future contracts, and legal prosecution where applicable.

Non-compliance with financial accountability requirements—such as failure to submit timely financial reports, inadequate supporting documentation, or improper expenditure—will result in corrective actions ranging from formal warnings to suspension or termination of contracts.

8.5 Risk Mitigation Measures

To ensure uninterrupted service delivery and protect both implementers and beneficiaries, the social contracting framework will include robust mitigation measures against common risks. These include the establishment of payment guarantees, such as advance base tranches or reserve funds, to cushion implementers against delays in fund disbursement. —without exposing vulnerable groups to service gaps.

The framework will also integrate contingency plans to address risks such as political interference, stigma, discrimination, or public health emergencies. This may involve alternative contracting arrangements, redeployment of resources, and rapid mobilization of substitute providers in the event of service disruptions. Mechanisms to counter stigma—such as embedding community-led monitoring, enforcing non-discrimination policies, and providing training on rights-based service delivery—will help safeguard the inclusivity and integrity of services. By proactively planning for risks,

Tanzania's social contracting system will remain resilient, flexible, and responsive to changing political, social, and epidemiological contexts. (Annex 10)

Table 5 below summarizes the respective risk areas, mitigation measures, and responsible parties.

Table 5: Risk Areas and Mitigation Measures

Risk Area	Mitigation Measures	Responsible Parties
Fraud / Misuse of Funds: Risk of financial mismanagement, falsification of data, or diversion of resources away from intended services, undermining the credibility of social contracting.	• Conduct independent financial and programmatic audits on a regular basis. • Enforce strict sanctions, including suspension or termination of contracts for non-compliant organizations. • Apply blacklisting procedures to prevent repeat offenders from participating in future contracts. • Strengthen financial reporting standards with spot checks and cross-verification of expenditures.	CAG. PCCB TACAIDS, MoH, PORALG, PPRA,
Service Disruption: Risk of interruptions in service delivery due to delayed disbursements, political interference, or sudden implementer withdrawal, which can leave communities underserved.	• Introduce base tranche or advance payments to cushion CSOs against disbursement delays. • Establish a reserve fund to cover emergencies or bridge financing gaps. • Maintain a roster of substitute providers (standby CSOs or FBOs) that can be rapidly mobilized to continue services in case of disruption. • Develop contingency plans for public health emergencies or political shocks.	TACAIDS, MoH, PORALG,
Safeguarding Violations: Risks of Gender-Based Violence (GBV), Sexual Exploitation and Sexual Exploitation and Abuse (SEA), child abuse, or breach of dignity and rights in service delivery.	• Enforce mandatory safeguarding policies, including PSEA and child protection protocols. • Provide regular staff and volunteer training on safeguarding and "Do No Harm" principles. • Strengthen grievance redress mechanisms (hotlines, suggestion boxes, CLM reporting) to allow safe reporting of violations. • Ensure rapid investigation, corrective actions, and sanctions for confirmed violations.	CSOs, FBOs, CBOs, LGAs
Data Integrity: Risk of inaccurate, incomplete, or falsified reporting, which undermines accountability and evidence-based decision-making.	• Conduct verification visits and spot checks by independent agents. • Strengthen Community-Led Monitoring (CLM) to validate data through beneficiary feedback. • Enforce mandatory reporting into DHIS2 and CMIS with regular cross-validation against source registers. - Require corrective action plans for discrepancies flagged during Data Quality Audits (DQAs).	TACAIDS, MoH, PORALG,

9. Monitoring, Evaluation, and Learning (MEL)

9.1 Introduction

Monitoring, Evaluation, and Learning (MEL) is the backbone of Tanzania's Social Contracting Framework. It ensures that contractual investments in community-based health services are evidence-driven, transparent, and responsive to the needs of key and vulnerable populations.

The MEL system promotes real-time learning and adaptive management, enabling government and civil society partners to make informed decisions, improve service quality, and ensure accountability for every Tanzanian shilling spent.
By aligning indicators with national systems (DHIS2, CMIS, ATF) and global commitments (HSSP V, SDGs), MEL transforms social contracting from a compliance tool into a strategic driver of results and equity**.**

A robust Monitoring, Evaluation, and Learning (MEL) system is essential for assessing the effectiveness, efficiency, and accountability of social contracting in Tanzania's prioritized public health interventions response. It enables the Government, CSOs, and partners to track progress, identify gaps, promote adaptive learning, and strengthen evidence-informed decision-making. This section outlines the MEL architecture for social contracting, beginning with performance frameworks and indicator alignment.

9.2 Performance Frameworks with Agreed Indicators

Every social contract will be guided by a standardized Performance Framework jointly developed by the Contracting Authority and the contracted CSO/CLO. These frameworks will include SMART (Specific, Measurable, Achievable, Relevant, and Time-bound) indicators that are linked to results areas, aligned with national HIV indicator sets, and disaggregated to ensure equity in access and outcomes. (Annex 8)

9.3 Common Results, Resources, and Accountability Framework (CRRAF)

The Common Results, Resources, and Accountability Framework (CRRAF) serves as a unifying strategic model for social contracting. It links inputs (resources such as funding and technical assistance) with outputs (service delivery results), outcomes (behavioral and health improvements), and accountability mechanisms (performance-based financing, audits, and evaluations). CRRAF integrates stakeholder roles across government, CSOs/CLOs, and development partners, ensuring results-based contracting, mutual transparency, and shared learning:

- **Inputs** – financial, human, and technical resources (e.g., ATF allocations, partner contributions).
- **Outputs** – service delivery achievements (e.g., CSOs contracted, clients reached).
- **Outcomes** – behavioural and health results (e.g., reduced HIV incidence, improved treatment adherence).
- **Accountability Mechanisms** – verification, audits, evaluations, and public disclosure.

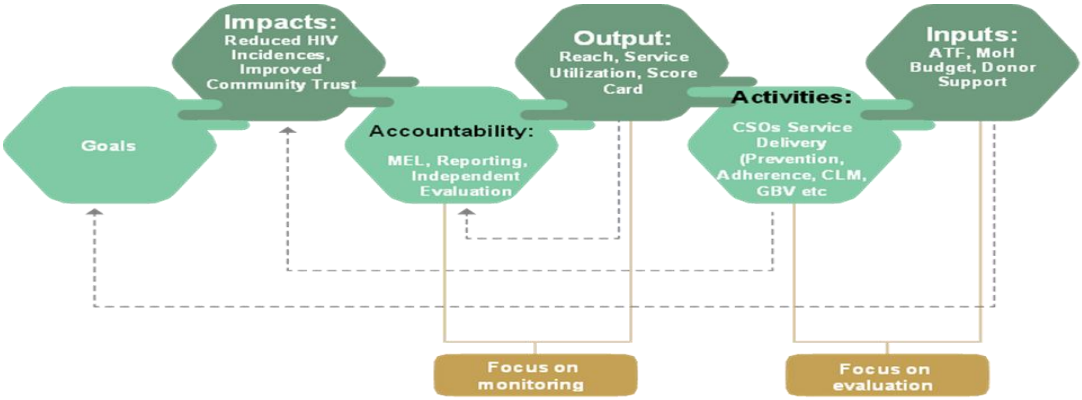

Figure 6: Common Results, Resources, and Accountability Framework (CRRAF)

9.4 Reporting Requirements

To ensure accountability, track progress, and inform decision-making, all CSOs contracted under Tanzania's social contracting mechanism are required to submit regular narrative, programmatic, and financial reports. These reports serve as the basis for performance reviews, the disbursement of subsequent tranches, and national reporting to stakeholders, including government bodies and development partners.

9.4.1 Reporting Schedule

All contracted CSOs must submit quarterly and annual narrative, programmatic (M&E), and financial reports using standardized templates.
Reports form the basis for:

- Disbursement of results-based payments.
- Contract renewal and performance review.

Table 6: Reporting Schedule

Report Type	Frequency	Deadline (from the end of the reporting period)
Narrative Report	Quarterly & Annual	Within 15 working days
Programmatic/M&E Report	Quarterly & Annual	Within 15 working days
Financial Report	Quarterly & Annual	Within 15 working days
Final Project Report	End of Contract	Within 30 working days

9.4.2 Key Report Components

Guided by the timing and format illustrated in Figure 7, all contracted CSOs and CLOs will use a standardized reporting template provided by the Contracting Authority. The reports should follow a standardized format to ensure consistency, comparability, and ease of review. Each report must provide a concise, evidence-based account of activities, outputs, and resource utilization, while emphasizing learning and accountability. A reporting template will be provided.(Annex 11)

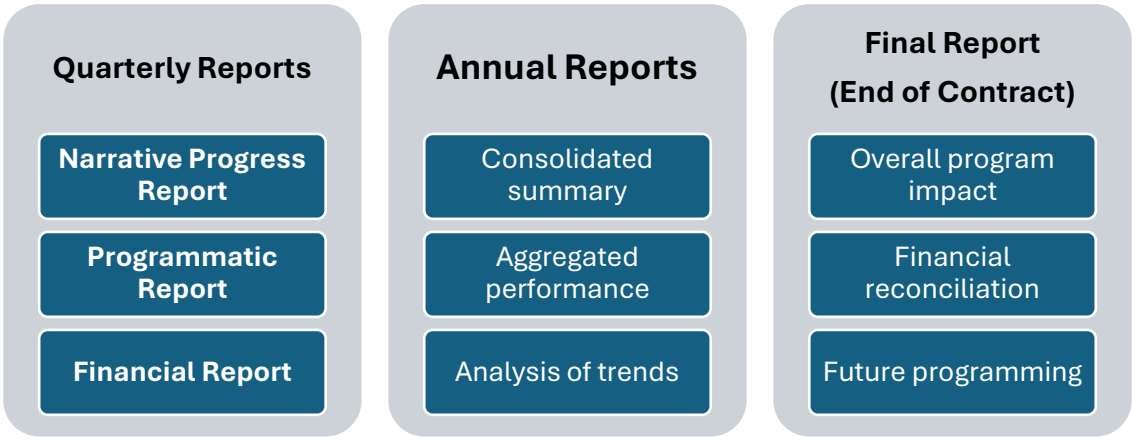

Figure 7 Key Report Component

9.4.3 Submission and Review Process

Timely, accurate, and complete reporting is a contractual obligation. All reports must be submitted to the Contracting Authority (e.g., TACAIDS, MoH, or PORALG) through designated channels, including email, digital submission portals, or physical copies, as stipulated in the contract.

Reports will undergo technical and financial review within 14 working days, followed by written feedback to each organization. Verified and validated reports will then inform subsequent disbursement of funds, contract extensions, and performance reviews.

9.4.4 Capacity Support for Reporting

Standardized reporting templates and guidance will be provided to all contracted CSOs. To strengthen the quality and consistency of reporting, the Contracting Authority will:

- Provide standardized templates and data entry guidelines to all CSOs.
- Conduct periodic capacity-building sessions and one-on-one mentorship, especially for smaller or newly contracted partners.
- Offer technical assistance on data management, indicator alignment, and financial reconciliation.

Non-compliance—such as late, incomplete, or inaccurate submissions—may result in corrective actions, suspension of payments, or ineligibility for future contracting rounds.

9.5 Independent Evaluation (e.g., by Third-Party M&E)

To complement internal monitoring and routine reporting, Tanzania's social contracting mechanism will incorporate independent evaluations conducted by third-party Monitoring and Evaluation (M&E) entities. These evaluations provide an objective assessment of performance, strengthen credibility, and ensure accountability in the use of public and donor funds. An independent evaluation framework should define the purpose, scope, and methodology, roles, and responsibilities of key actors. Programmatic and social contracting indicators will be used to measure progress (Annex 12)

9.5.1 Use of Evaluation Findings

Independent evaluations are a cornerstone of integrity and learning in social contracting, ensuring that investments deliver tangible results and empower communities through evidence-informed action. Evaluation findings inform contract renewal, scaling, or termination decisions; Guide future RFP design and service package refinement; Identify capacity development needs for CSOs; Feed into national M&E and accountability systems (e.g., NMSF reviews, CLMs, PEPFAR COPs, Global Fund grant reporting).

9.5.2 Feedback Mechanism to/from Communities and Government

An effective social contracting mechanism must include structured feedback loops that ensure a timely and meaningful exchange of information between CSOs, communities, and government stakeholders. Community Feedback Loops include CLM Outputs, Community Dialogues, and Reflection Meetings, as well as the use of Digital Platforms. Government Feedback Loops include Routine Review Meetings, Data Sharing with Health Information Systems, and Joint Supervision and Learning Missions. These loops promote transparency, foster trust, and enable continuous improvement in service delivery and accountability. Feedback must not only be collected but also acted upon and communicated back to communities and stakeholders.

9.5.3 Accountability and Risk Management

Accountability and risk management are critical pillars of Tanzania's social contracting framework. They ensure that public and donor funds are used responsibly, services reach the intended populations, and that CSOs and government institutions uphold standards of integrity, transparency, and performance. This section outlines mechanisms to promote openness, manage risk, and address misconduct in the implementation of social contracts.

9.5.4 Transparency Mechanisms

To foster trust and public confidence, the social contracting process must be open, traceable, and subject to public scrutiny. Transparency mechanisms will be embedded across all stages of the contracting cycle, from selection to implementation and evaluation. Specifically, transparency will include publication of awarded contracts, disclosure of evaluation criteria and results, access to reporting results, public engagement and accountability forums, digital access, and data dashboards.

9.6 Grievance Reporting and Processing

A well-functioning Grievance Redress Mechanism (GRM) is a critical accountability safeguard within the social contracting system. It provides a safe, structured, and confidential way for beneficiaries, community members, CSO staff, or other stakeholders to report concerns, raise complaints, or disclose misconduct including Service quality issues (e.g., stockouts, denial of services, mistreatment); misuse or mismanagement of funds or resources; corruption, abuse, discrimination or stigma; Harassment, exploitation, or abuse; violation of rights (including gender-based violence, data privacy breaches, or unsafe practices); and, concerns about contract implementation or performance without fear of retaliation.

This mechanism strengthens community trust, improves responsiveness, and supports corrective action to address gaps and risks in the implementation of HIV-related services.

9.6.1 Grievance Reporting Channels

To ensure broad access and confidentiality, multiple grievance channels will be made available. This includes, but is not limited to, anonymous community reporting mechanisms (Such as Locked suggestion boxes, Toll-free phone lines, and anonymous SMS or WhatsApp numbers); whistleblower and Ethics Hotlines; digital and Online Portals; and Community Feedback Forums.

9.6.2. Grievance Handling and Resolution Process

All complaints are recorded in a confidential grievance log, assigned a tracking number, and categorized by issue type and urgency. Complainants (if known) are acknowledged within five working days. Investigations are carried out by a designated GRM focal person or unit, with support from ethics officers or independent reviewers as needed. Resolution should occur within 15–30 working days, depending on complexity. Outcomes (corrective action, referral, disciplinary steps) are

documented, and feedback is provided to the complainant where appropriate. Complaints not satisfactorily addressed at the CSO level may be escalated to the Contracting Authority, Ombudsman, or legal/oversight bodies. Summary data (types of grievances, resolution rates) are included in quarterly reports, with trends analyzed for systemic improvements.

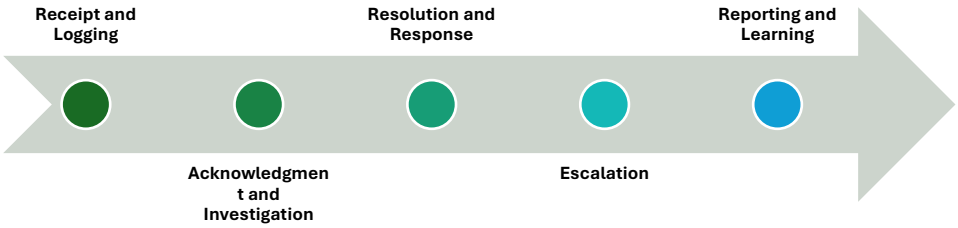

Figure 8: Grievance Handling and Resolution Process

9.6.3 Protection and Confidentiality

A responsive and secure grievance mechanism fosters accountability, deters misconduct, and reinforces community confidence in publicly funded HIV services. Whistleblowers and complainants will be protected under applicable national laws and donor policies. No individual shall face retaliation for filing a complaint or expressing concerns in good faith. Identities are kept confidential unless disclosure is necessary and consented to.

Annex 1: Eligibility Checklist for Implementers

Criteria	Minimum Requirements	Verification Documents / Evidence
Legal and Regulatory Compliance	• Legally registered in Tanzania under relevant legislation (NGO Act, Trustees Incorporation Act, or Societies Act). • Valid registration and operating license. • In good standing with regulatory authority and compliant with national laws (labor, anti-corruption, data protection).	• Certificate of Registration / Incorporation. • Valid operating license or compliance certificate. • Regulatory clearance letter or annual returns.
Financial and Administrative Accountability	• Maintain audited financial statements for at least the last 2 years (CBOs may provide certified accounts endorsed by a mentor NGO). • Functional financial management system and internal control procedures. • An active bank account in the organization's name.	• External audit reports or certified financial statements. • Financial policy/manual and bank statement. • List of finance personnel or an accountant's CV.
Tax and Statutory Compliance	• Possess a valid Tax Identification Number (TIN). • Up-to-date tax clearance certificate issued by TRA. • Compliance with NSSF, WCF, and other statutory requirements where applicable.	• TIN certificate. • Current TRA tax clearance certificate. • Proof of statutory contributions (if applicable).
Governance and Institutional Capacity	• Functional Board of Directors or Executive Committee with clear mandates. • Existence of governance, HR, and internal control policies. • Regular meetings, documentation, and decision-making systems.	• Board charter or governance policy. • Board meeting minutes (last 12 months). • Organizational structure or organogram.
Technical and Programmatic Capacity	• Proven experience implementing HIV, TB, RMNCAH, or related community-based programs. • Demonstrated capacity in DHIS2 or national reporting systems. • Skilled staff, peer educators, or community workers trained under national standards.	• Project reports or completion certificates. • Reference letters from the government or partners. • Staff list, training certificates, or CVs.
Safeguards and Protection Policies	• Institutional policies on GBV/SEA prevention, child protection, anti-fraud, and data protection. • Commitment to uphold human rights, gender equality, and non-discrimination. • Mechanism for grievance redress and community feedback.	• Safeguard policies/manuals • Staff orientation records. • Grievance redress protocol or hotline evidence.
Geographic Presence and Local Engagement	• Active operational footprint in target regions, districts, or communities. • Established partnerships with LGAs, health facilities, and community structures.	• MoU with LGAs or local health offices.

• Demonstrated trust and participation from local populations.	• Field presence verification report or location map. • Letters of collaboration or local endorsements.

Annex 2: Verification and Monitoring Protocol

The Verification Protocol outlines the process for validating service outputs reported by implementers before payments are made. It ensures accountability, data accuracy, and the credibility of Tanzania's social contracting framework.

Roles in Verification & Monitoring

Implementers (CSOs, CBOs, FBOs, private not-for-profit actors):
Submit routine data into DHIS2 and programme registers, provide supporting documents (such as attendance sheets, outreach logs, and financial reports), and facilitate access to sites, staff, and beneficiaries.

Contracting Authorities (MoH, TACAIDS, PORALG):
Review implementer reports, commission independent verification agents, and ensure findings are integrated into payment and performance reviews.

Independent Verification Committees or Agents (universities, audit firms, CLM coalitions):
Conduct quarterly sample checks, site visits, beneficiary interviews, and data audits; verify service quality and safeguarding compliance; issue verification reports that inform payment decisions.

Community-Led Monitoring (CLM) Networks:
Collect community feedback on service accessibility, stigma, and quality of services, and share findings with verification agents and contracting authorities.

Tools and Methods

- Desk Review: Comparison of implementer reports with DHIS2/programme registers; review of financial and activity documentation.
- Field Verification: Random sample checks of service sites; beneficiary/household interviews; observation of quality and safeguarding standards.
- Data Quality Audits (DQAs): Use of standardized checklists to assess completeness, accuracy, timeliness, and consistency of reported data.
- Community Feedback Mechanisms: Integration of CLM scorecards, hotline complaints, and suggestion box inputs into the verification process.

Frequency of Verification

- Routine Verification: Independent verification is conducted quarterly, prior to payment release.
- Ad Hoc Verification: Spot-checks triggered by inconsistencies, complaints, or safeguarding concerns.
- Annual Review: Comprehensive triangulation of DHIS2 data, CLM reports, and financial audits at the end of each year.

Reporting and Use of Findings

- Independent verification agents produce quarterly reports highlighting validated outputs, discrepancies, and quality concerns.
- Reports are shared with MoH, PORALG, TACAIDS, LGAs, implementers, and partners.
- Only verified results are used for payment disbursement.
- Persistent discrepancies, fraud, or safeguarding violations trigger sanctions (suspension or termination of contracts).

Accountability Checklist

- Data Reporting: Timely, disaggregated reporting by sex, age, and population group.
- Verification: Quarterly reviews, site visits, beneficiary interviews, and audits.

- CLM Integration: Community feedback tools and findings factored into performance reviews.
- Grievance Redress: Accessible grievance channels (NeST, hotlines, CLM forums) with documented follow-up.
- Financial Integrity: Transparent financial records, quarterly spot-checks, and risk registers are maintained.
- Risk Monitoring: Early warning indicators (e.g., disbursement delays, underperformance) tracked with corrective actions.

Annex 3: Sample Costing & Tariff Schedule.

The following schedule illustrates possible unit costs and tariffs for priority services delivered under social contracting. Final tariffs will be determined through detailed national costing exercises, considering inflation, geographic variation, and program priorities.

Service Output	Unit Cost (TZS)	Notes
HIV		
HIV prevention session (per AGYW/KVP reached)	20,000	Includes peer educator stipend, IEC materials, and session logistics.
HIV self-test (HIVST) kit distributed and verified	25,000	Covers kit cost, distribution, and follow-up.
PrEP initiation (per person)	40,000	Includes counselling, follow-up visit, and documentation.
ART linkage (per person linked within 14 days)	60,000	Covers community escort/referral and follow-up verification.
ART adherence support group (per member retained at 6 months)	30,000	Includes group facilitation and monitoring.
TB		
TB contact screened (per contact)	20,000	Includes household visit and screening logistics.
Sputum sample transported (per sample)	12,000	Includes collection, safe transport, and tracking.
TPT initiation (per eligible person)	25,000	Covers counselling, initiation, and recording.
TPT completion (per person completing)	40,000	Incentive for follow-up and adherence support.
Malaria		
Community SBC session on malaria prevention	15,000	Includes facilitator stipend and IEC materials.
Household mobilized for the IRS	8,000	Cost of community sensitization per household.
LLIN distribution mobilization (per household)	7,500	Covers demand creation and monitoring of usage.
MCH		

HPV vaccination mobilization (per eligible girl reached)	10,000	Includes community education and mobilization.
ANC defaulter traced and returned	20,000	Covers outreach visit and referral confirmation.
PNC defaulter traced and returned	22,000	Similar to ANC, includes newborn follow-up.
Adolescent SRH education session (per adolescent reached)	8,000	Includes peer facilitator costs and IEC materials.
Emergency Preparedness		
Community health alert reported (per verified alert)	18,000	Covers identification, documentation, and reporting.
Household reached with outbreak information	5,000	IEC materials and community mobilizer costs.
Risk communication session (per community meeting)	25,000	Includes facilitator allowance and materials.

Key Considerations

- Tariffs include direct costs (personnel, transport, supplies) and indirect costs (administration, safeguarding, reporting).
- Rates will be reviewed annually to reflect inflation, service delivery realities, and programme priorities.
- Incentive structures may be applied to equity results, e.g., higher tariffs for reaching remote areas or high-risk groups.

Annex 4: Pre-Award Assessment / CSO/CLO Readiness Checklist Sample

Assessment Area	Key Criteria	Score (Yes = 1, No = 0)
Governance & Legal Status	Legally registered and recognized CSO	
	Operational for at least 2 years (or as per guideline)	
	Board of Directors or oversight body in place	
Financial Management Capacity	Maintains up-to-date financial records	
	Has a functioning bank account in the CSO name	
	Has completed financial audits in past 2 years	
Technical Program Capacity	Demonstrated experience in HIV service delivery	
	Qualified staff for technical and administrative roles	
	Functional M&E system in place	
Risk Profile & Past Performance	No history of misuse of funds or adverse audit findings	
	Good past performance with donor-funded or government projects	
Compliance with National Guidelines	Willingness to follow national costing tools, reporting and standards	
	Clear safeguarding and accountability mechanisms	

Annex 5: Sample Request for Proposals (RFP) Template

[Insert Contracting Authority Name e.g., TACAIDS/MoH]

Request for Proposals (RFP)

For Civil Society Organizations (CSOs) to Deliver Community-Based Services through Social Contracting

1. RFP Title: Community-Based HIV Prevention and Support Services for PLHIV and KVPs in [Region/District Name]

2. RFP Number: RFP/SC/[YEAR]/[UNIQUE ID]

3. Issuing Authority: [Name of Contracting Authority – e.g., Tanzania Commission for AIDS (TACAIDS)]

4. Funding Source: [Indicate, e.g., AIDS Trust Fund (ATF), MoH budget, or donor-supported]

5. Deadline for Submission:

[Date and Time, e.g., 15 July 2025, 4:00 PM EAT]

6. Background and Rationale

[Insert brief background on the HIV context, the purpose of social contracting, and the specific gap or objective being addressed in this RFP.]

Example:
Tanzania is scaling up community-led responses to HIV in alignment with the NMSF IV and HSHSP V. Through this RFP, [Contracting Authority] seeks to engage CSOs to deliver HIV prevention, linkage to care, treatment adherence, and community-led monitoring services in underserved areas.

7. Scope of Work and Priority Focus Areas

Applicants are invited to submit proposals to implement one or more of the following service packages:

HIV prevention services (e.g., peer outreach, condom distribution, PrEP demand creation)

Linkage to care and ART adherence support for PLHIV

Community-Led Monitoring (CLM) and scorecard reporting

Gender-based violence (GBV) prevention and response

Stigma and discrimination reduction

Target populations: [e.g., PLHIV, AGYW, FSWs, MSM, truck drivers, fisherfolk]

Target areas: [e.g., Mwanza Urban, Tanga Rural]

8. Eligibility Criteria

Applicants must:

Be legally registered in Tanzania with at least [2] years of operational experience

Have proven experience working with [target populations or regions]

Demonstrate capacity in technical, financial, and M&E systems

Be accredited or pre-qualified by [TACAIDS/MoH or relevant body]

9. Proposal Requirements

Completed Application Form (Annexed or provided online)

Technical Proposal (max 10 pages) outlining:

Proposed activities, methodology, and expected results

Staffing and organizational capacity

Community engagement strategy

Detailed Budget and Budget Narrative

Copies of registration certificate, recent audited accounts, and key staff CVs

10. Evaluation Criteria

Criteria	Weight
Technical Approach & Relevance	30%
Experience with Target Populations	25%
Cost-Effectiveness & Realistic Budget	20%
M&E and Reporting Systems	15%
Innovation, Sustainability, and Partnerships	10%

11. Submission Instructions

Proposals must be submitted by [email/upload/hand-delivery] to:
[Insert Submission Address or Email]

Use subject line: “Proposal – RFP No. [X] – [Organization Name]”

12. Timeline

Milestone	Date
RFP release	[Insert date]
Proposal submission deadline	[Insert date & time]
Evaluation period	[Insert range of dates]
Contract award notification	[Insert date]
Project start date	[Insert date]

13. Inquiries and Clarifications

All inquiries should be submitted in writing to: [Contact Person Name & Email]
by [Insert deadline for questions].

Annex 6: Scoring Rubric for Proposal Evaluation

Scoring Rubric for Proposal Evaluation

This scoring rubric provides a standardized and transparent tool for evaluating proposals submitted by Civil Society Organizations (CSOs) under Tanzania's social contracting mechanism. The rubric ensures objectivity and fairness in selection while prioritizing technical merit, value for money, and reach to priority populations.

Total Score: 100 Points

Evaluation Criteria	Description	Max Points
1. Technical Approach and Relevance	Soundness and feasibility of the proposed approach; alignment with RFP objectives and national HIV strategies.	30
– Service packages clearly described	– Implementation plan is detailed, realistic, and responsive to community needs.	
– Activities match objectives and timelines	– Integration with district/regional health systems is considered.	
2. Organizational Capacity and Experience	Demonstrated institutional capacity to implement proposed work and manage funds.	20
– Relevant experience with PLHIV/KVP programming	– Staffing structure and technical team are qualified and available.	
– Evidence of past performance and partnerships	– Past compliance with grant management, if applicable.	
3. Target Population Reach and Equity Focus	Clear strategy to reach and meaningfully engage KVPs, PLHIV, and/or underserved populations.	20
– Geographic and population coverage	– Community engagement and peer-led models incorporated.	
– Gender and youth sensitivity demonstrated		
4. Cost-Effectiveness and Budget Realism	Proposed budget is reasonable, justified, and aligned with expected outputs.	10
– Uses standardized cost norms/unit costing	– Evidence of value for money and leveraging of existing resources.	
5. Monitoring, Evaluation, and Learning (MEL)	MEL plan is practical, includes clear indicators, and integrates data use for decision-making.	10

– Baseline, targets, and data sources are clear	– CSO can report to national systems (e.g., DHIS2) and conduct community-led monitoring.	
6. Innovation and Sustainability	Innovative approaches to service delivery, sustainability plans, or partnerships to strengthen implementation.	10
– Involvement of smaller CSOs or mentorship plans	– Plans to transition services into government or community systems.	

Scoring Scale:

Excellent (91–100%): Exceeds all requirements; well-articulated, highly feasible, and innovative.

Good (76–90%): Meets all requirements and is feasible, with minor gaps.

Average (61–75%): Meets most requirements but with some concerns or limited detail.

Below Average (50–60%): Many gaps; feasibility concerns.

Ineligible (<50%): Proposal does not meet basic eligibility or quality thresholds.

Note: Proposals scoring below 60% overall or below 50% in the *Technical Approach* category will not be considered for funding.

Annex 7: Sample Contract Template

CONTRACT AGREEMENT

Between [Contracting Authority] and [Civil Society Organization]
For the Implementation of HIV-Related Services under the Social Contracting Mechanism

Contract No.: [Insert Contract Number]

Date of Signing: [Insert Date]

Contract Duration: [Insert Start and End Dates]

This Agreement is made between:

[Contracting Authority Name], a statutory body of the Government of the United Republic of Tanzania with its principal office at [Insert Address], hereinafter referred to as the "Contracting Authority",

AND

[Name of the Civil Society Organization (CSO)], a non-governmental organization registered under [specify Act], with its office located at [Insert Address], hereinafter referred to as the "Implementing Partner" or "CSO".

1. Purpose of the Contract

The purpose of this agreement is to formalize a partnership between the Contracting Authority and the CSO to implement community-based HIV-related services under Tanzania's social contracting framework, as outlined in the approved proposal and work plan.

2. Contract Value and Payment Schedule

The Contracting Authority agrees to disburse to the CSO a total of TZS/USD [Insert Amount], subject to the terms and conditions herein and upon achievement of agreed deliverables.

Disbursement	Amount (TZS/USD)	Trigger
First Tranche	[Insert Amount]	Contract signing and submission of the inception report
Second Tranche	[Insert Amount]	Submission of Q1 report and indicator progress
Final Tranche	[Insert Amount]	Completion of all deliverables and final report

3. Scope of Work

The CSO agrees to implement the following service packages (tick those that apply):

☐ HIV prevention and behavior change communication

☐ Linkage to HIV testing and ART services

☐ Treatment adherence and retention support for PLHIV

☐ Community-led monitoring (CLM) and advocacy

☐ GBV prevention and response

☐ Stigma reduction interventions

☐ Other: [Specify]

Detailed activities and targets are described in Annex A: Approved Workplan and Performance Framework.

4. Reporting Requirements

The CSO shall submit:

Quarterly narrative and programmatic reports

Quarterly financial expenditure reports

Final narrative and financial report

Performance data aligned with agreed indicators

Reports must follow the formats provided and be submitted within 15 working days of the end of each reporting period.

5. Monitoring and Supervision

The Contracting Authority reserves the right to:

Conduct spot checks and verification visits

Participate in joint supervision with district/regional health authorities

Request additional documentation or explanations where necessary

6. Financial Accountability

The CSO agrees to:

Use funds only for activities agreed under this contract

Maintain transparent and auditable financial records

Submit to annual audits and any required financial reviews

7. Termination Clause

Either party may terminate this contract with 30 days' written notice under the following conditions:

Breach of contract terms

Misuse or misappropriation of funds

Inactivity or failure to meet targets without justification

Mutually agreed termination

Unused funds shall be returned to the Contracting Authority within 30 days of termination.

8. Dispute Resolution

In the event of a dispute, both parties shall first seek to resolve it through dialogue. Failing that, the matter may be referred to arbitration under Tanzanian law.

9. Annexes (Integral Parts of the Contract)

Annex A: Workplan and Performance Framework

Annex B: Approved Budget

Annex C: Reporting Templates

Annex D: Grievance and Compliance Policy

Annex E: Bank Account and Contact Information

Signed:

For the Contracting Authority
Name: _____
Title: _____
Signature: _____
Date: _____

For the Implementing CSO
Name: _____
Title: _____
Signature: _____
Date: _____

Annex 8: KPI Matrix by service package

Service Area	Key Performance Indicators (KPIs)	Measurement Method	Frequency
HIV Prevention (AGYW, KVPs, ABYM)	• Number of individuals reached with HIV prevention education; • % of AGYW/KVPs receiving condoms; • Number of PrEP literacy sessions conducted	Outreach registers, DHIS2, CLM reports	Monthly / Quarterly
HIV Testing & Linkage	• Number of HIV self-testing kits distributed; • % of HIV-positive individuals linked to ART within 14 days	DHIS2, verification sample checks	Quarterly
Treatment & Retention	• Number of community ART refill groups established; • % retention of ART clients at 6 and 12 months; • % of supported clients with documented viral load suppression	DHIS2, ART registers, CLM feedback	Semi-annual
Community-Led Monitoring (CLM)	• Number of CLM reports submitted; • % of facilities/communities with action taken on CLM findings	CLM reports, LGA review	Quarterly
Tuberculosis (TB)	• % of household contacts screened per index case; • Number of sputum samples transported; • % of eligible contacts initiated on TPT and % completing TPT	TB registers, DHIS2, verification checks	Quarterly / Semi-annual
Malaria	• Number of community SBC sessions on malaria prevention; • % of households aware of correct LLIN use; • % of targeted households covered by IRS; • % of households owning ≥1 LLIN per 2 people	SBC reports, household surveys, IRS/LLIN records, DHIS2	Semi-annual / Annual
RMNCAH & HPV	• % of eligible girls (9–14 years) receiving HPV Dose 1 & Dose 2; • % of ANC/PNC defaulters successfully traced and returned; • Number of adolescents reached with SRH info; • % increase in adolescent SRH service uptake	Immunization registers, DHIS2, programme registers, surveys	Quarterly / Semi-annual

Outbreak Preparedness & Response	• Number of unusual health events reported; % of alerts verified and responded to within 48h; Number of households reached with outbreak info; % of community members identifying ≥3 prevention measures.	Event-based surveillance reports, CLM reports, KAP surveys, DHIS2	Quarterly / Semi-annual

Annex 9: Monitoring and Verification Checklist

1. Data Reporting

Implementers submit timely reports.

Data is disaggregated by sex, age, and population group.

Reports are submitted in line with MoH/TACAIDS/PORALG schedules.

2. Verification

Quarterly reviews conducted during verification visit.

Site visits to facilities and communities implemented.

Beneficiary/client interviews carried out to validate reported results.

Financial and programmatic audits conducted as scheduled.

3. Community-Led Monitoring (CLM)

CLM tools deployed to capture feedback on service quality, stigma, and accessibility.

CLM findings are documented and shared with PRs, SRs, SSRs, and collaborators.

Feedback integrated into performance reviews and payment decisions.

4. Grievance Redress

Functioning grievance channels (hotlines, NeST, suggestion boxes, CLM forums).

Complaints logged and tracked with timelines for resolution.

Whistle-blower protection and safeguards applied.

Complaints that are resolved are documented and reported to the relevant oversight bodies.

5. Financial and Risk Monitoring

Implementers maintain transparent financial records aligned with national accounting standards.

Periodic financial spot-checks conducted by PRs.

Risk registers are maintained by PRs and updated quarterly to identify fraud, service disruption, or safeguarding concerns.

Early warning indicators tracked (e.g., delayed disbursements, underperformance, or irregular expenditures).

Corrective actions and sanctions are applied promptly when financial or operational risks are detected.

Annex 10: Risk Matrix and Mitigation Measures

(For Social Contracting Implementation in Tanzania)

This matrix identifies key operational, financial, programmatic, and reputational risks associated with social contracting and outlines mitigation strategies to manage and minimize their potential impact.

Risk Matrix

Risk Category	Potential Risk	Likelihood	Impact	Mitigation Measures	Responsible Actor(s)
Financial	Misuse or misappropriation of funds by CSOs	Medium	High	Require annual audits and quarterly financial reporting Conduct unannounced spot checks	CSO, Contracting Authority, Auditor
	Delayed disbursement of funds is affecting service delivery	High	Medium	Establish clear disbursement schedules Use a phased advance system tied to deliverables	Contracting Authority, MoFP
	Limited CSO capacity in financial management	High	High	Provide capacity building Use hub-and-spoke mentorship models	Contracting Authority, Mentors
Programmatic	Inadequate reach to target populations (e.g., KVPs, PLHIV)	Medium	High	Require peer-led models Prioritize experienced CSOs in scoring	CSO, TWGs, Evaluation Committee
	Weak data quality and performance reporting	Medium	High	Integrate data quality assurance (DQA) Train M&E staff and use standardized tools	CSO, M&E teams, MoH
Operational	Lack of coordination between CSOs and the local government	Medium	Medium	Integrate CSO plans in CCHPs Involve RHMTs/CHMTs in supervision	PO-RALG, CSOs, MoH

	Disruption due to political or legal changes affecting CSO operations	Low	High	Establish MoUs with LGAs Maintain flexible work plans and risk response plans	Contracting Authority, CSO
Reputational	Allegations of favoritism or lack of transparency in CSO selection	Medium	High	Use standardized RFPs and scoring rubrics Publish award results	TACAIDS, Evaluation Committee
	Community distrust or dissatisfaction with services	Low	Medium	Implement community feedback loops Use “You Said, We Did” communication methods	CSO, Community Platforms
Compliance	Non-compliance with contract terms or donor requirements	Medium	High	Regular compliance monitoring Penalties or disqualification for repeat offenses	Contracting Authority, Auditor
	Weak safeguarding (e.g., GBV or PSEA incidents)	Medium	High	Mandatory safeguarding policy for CSOs Train staff and set up grievance redress systems	CSO, TACAIDS, MoH

Annex 11: Standard Reporting Template (Programmatic and Financial)

(Programmatic and Financial Reporting for CSOs under Social Contracting)

Section 1: Cover Page

Report Type	☐ Quarterly ☐ Annual ☐ Final
CSO Name	
Contract Number	
Reporting Period	From: ____ To: ____
Submission Date	
CSO Focal Person (Name & Contact)	

Section 2: Programmatic Report Template

A. Summary of Activities Implemented

Planned Activity	Implemented (Yes/No)	Outputs Achieved	Remarks (e.g., challenges, delays)
e.g., Peer outreach sessions	Yes	40 sessions held	Reached 1,200 AGYW in Mwanza
e.g., Condom distribution	Yes	15,000 condoms	Shortage during Week 3

B. Progress Against Indicators

Indicator	Target (Quarter)	Achieved	% Achievement	Remarks
Number of PLHIV supported with adherence	1,000	950	95%	
No. of CLM scorecards completed	2	2	100%	

C. Beneficiary Data (Disaggregated)

Population Group	Reached (Male)	Reached (Female)	Total	Remarks
PLHIV	420	580	1,000	Includes youth & adults
FSWs	310	—	310	All female
Truck Drivers	190	—	190	

D. Challenges and Solutions

Challenge Faced	Action Taken or Recommended
Delay in receiving the second tranche disbursement	Liaised with the contracting authority to expedite funds

Limited GBV referral sites in rural areas	Engaged local authorities to identify safe spaces

E. Lessons Learned / Success Stories

Provide brief narratives or case studies (1–2 paragraphs) that demonstrate program impact, innovation, or community response.

Section 3: Financial Report Template

A. Summary of Expenditures

Budget Line Item	Approved Budget (TZS)	Actual Expenditure (TZS)	Variance (+/-)	Remarks
Staff Salaries and Benefits	10,000,000	9,800,000	-200,000	Full team retained
Training and Outreach	5,000,000	5,200,000	+200,000	Extra sessions conducted
Supplies (e.g., condoms, kits)	3,000,000	2,800,000	-200,000	Awaiting more stock
Transport and Per Diem	4,000,000	3,900,000	-100,000	Slight savings
Total	22,000,000	21,700,000	-300,000	

B. Advance and Balance Status

Total Disbursed	Spent to Date	Balance Remaining	Next Tranche Requested
TZS 22,000,000	TZS 21,700,000	TZS 300,000	TZS 18,000,000

C. Supporting Documents Checklist

☐ Copies of receipts/invoices for all expenditures
☐ Bank statements and reconciliation report
☐ Payroll documentation
☐ Procurement records (where applicable)

Section 4: Certification

We certify that the information provided in this report is complete and accurate to the best of our knowledge, and that all expenditures have been incurred in accordance with the terms of the contract.

Authorized Representative (CSO)	Signature	Date

Annex 12: MEAL Framework for Social Contracting Processes

Result Area	Indicator	Target/Disaggregation	Data Source	Reporting Frequency
1. Accreditation and Eligibility	Number of CSOs/CLOs accredited	By region, type of CSO, key, and vulnerable population served	Accreditation Database (	Quarterly/ Annually
	Average time taken from EOI to accreditation decision	Mean days	Accreditation reports	Quarterly
2. Proposal and Award Process	Number of RFPs issued	By funding source (ATF, MoH, donors)	Contracting Authority RFP logs	Semi-Annually
	Number of proposals received vs awarded	By region, population group served	Proposal evaluation records	Semi-Annually
	% of contracts awarded to community-led organizations	Target: 50%+ community-led	Award database	Annually
3. Disbursement and Financial Performance	Total funds disbursed to CSOs/CLOs	By region, funding source, organization type	Disbursement logs (ATF, MoF)	Quarterly
	% of planned funds disbursed vs budget	Budget utilization rate	Financial reports	Quarterly
	Average time taken for disbursement post-verification	In days	Finance system	Quarterly
4. Contract Compliance and Performance	% of CSOs submitting timely reports	Narrative, Financial, M&E	Contract management reports	Quarterly
	% of CSOs meeting contractual deliverables/milestones	Based on verification	Supervision reports, IEC spot checks	Quarterly
5. Governance and Transparency	Number of public disclosures (e.g., awarded contracts, funding amounts)	Posted on gov't portals, CSO platforms	TACAIDS/MoH reports	Quarterly

	Number of grievance or audit cases recorded and addressed	% resolved within 30 days	GRM logs, Audit reports	Semi-Annually
6. Capacity Strengthening	Number of CSOs receiving technical or financial management training	By region, topic (finance, M&E, safeguarding, etc.)	Training attendance logs	Quarterly
	% of trained CSOs demonstrating improved systems post-training	Measured by capacity assessments	Post-training follow-up reports	Annually
7. Independent Evaluation and Learning	Number of third-party evaluations conducted	By region, funding source	Evaluation reports	Annually
	% of recommendations from evaluations implemented by CSOs or Contracting Body	Target: ≥75% follow-through	Evaluation follow-up logs	Annually

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