

Scoping Visit to Liberia - Summary of Findings²

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² All of the findings laid out in this report represent the best summary of information shared by the Liberian government and local stakeholders during an in-country visit in October/November 2019. It is possible that some of the information provided was misinterpreted, and so further engagement with stakeholders should occur before critical program decisions are made based on the content of this report.

Executive Summary

Based on conversations and feedback shared by key officials within the Liberian Ministry of Health, local NGOs, and major development partners, there are several areas where a non-profit organization’s support in Liberia could lead to meaningful increases in syphilis screening and treatment. As of now, syphilis screening has remained stagnant in Liberia for the last decade or more. The government (namely, the National AIDS and STI Control Program or NACP) has taken preliminary steps to introduce a dual HIV/syphilis rapid test that will enable higher screening rates. As it moves forward, NACP would benefit from a partner that is able to provide additional capacity to develop, execute, and monitor introduction and scale-up of dual test coupled with syphilis treatment

In this report, we detail: (a) estimates of syphilis prevalence in Liberia; (b) description of the overall healthcare system; (c) barriers in syphilis screening and treatment; (d) the government’s plans in regard to introducing and scaling-up dual testing, and; (e) the stakeholders which may be involved in potential maternal syphilis efforts.

Syphilis Prevalence

The [Spectrum-STI](#) model estimated that the prevalence of active syphilis in 2016 was **8.53%**. The Spectrum-STI modelers used the data reported by countries into the Global AIDS Monitoring System (GAMS) and applied a smoothing curve to take into account realistic changes in prevalence year-on-year. The modelers also validated outlying point estimates with country focal persons and down-weighted estimates they believed were biased (most often accounting for situations where a small subset of the population was tested).³

The government reported the following estimates in the Global AIDS Monitoring System over the last 5 years:

2017	2.7% ⁴
2016	missing ⁵
2015	7.1%
2014	11.3%

³ Based on a conversation with Eline Korenromp who developed the Spectrum-STI model.

⁴ The 2017 estimate likely came from the sentinel surveillance survey completed in 2017. The facility reported data for 2017 would have yielded a prevalence of 6.9%. There were 14,941 pregnant women tested for syphilis and 1,033 tested positive and were placed on treatment.

⁵ The data provided for 2016 by the government would have implied a syphilis prevalence of 64.6%. Of the 17,516 women tested for syphilis during ANC, 11,323 tested positive and were placed on treatment.

Based on information shared by local stakeholders, the estimates the government provides in GAMS are often taken directly from facility-reported data.⁶ Via monthly reporting, facilities submit data on two relevant indicators: (1) the number of women who attended ANC and were tested for syphilis; (2) the number of women who tested positive for syphilis *and were placed on treatment*. Facility data was shared with Evidence Action during the visit, and the data reported in GAMS for 2014 and 2015 match what we calculated when dividing indicator #2 by indicator #1.

There are several potential biases with the GAMS data that affect the likelihood these estimates accurately reflect syphilis prevalence:

1. The number of women screened is less than 10% of all of those who are pregnant each year. As a result, it's very likely that providers are selecting women for testing who are either symptomatic or who the providers have a reason to believe have syphilis. This would suggest the syphilis prevalence estimate is an overestimate.⁷
2. Syphilis testing is done via lab-based testing. Thus, only women who attend health facilities with laboratories get tested (and laboratories are concentrated in urban areas). Since syphilis prevalence is often higher in rural areas, which suggests this bias may lead to an underestimate in what is reported.
3. The indicator identifying the number who are positive is conflated with the number who are treated. It's possible that if a woman tested positive but was not treated, she would have been omitted in the reporting on the "number of women who are positive *and* were placed on treatment." This issue in the data reporting likely results in an underestimate of syphilis prevalence.

Taken together, **there are reasons to believe the data captured via facility reporting is an overestimate in some ways but an underestimate in others.**

In 2017, the National AIDS and STI Control Program conducted a sentinel surveillance survey for HIV and syphilis. **The average active⁸ syphilis prevalence across the sentinel sites was 2.7%.** The government reported the sentinel surveillance results in GAMS for 2017 rather than the facility-reported data.⁹

⁶ In health facilities, women have been historically screened for syphilis using lab-based RPR tests. These tests detect a protein that is excreted when a person has one of several infections (active syphilis is among these). Therefore, if we were to use the government-reported data directly, we would need to discount it to account for the lack of specificity of the RPR test. The Spectrum-STI prevalence estimate we rely on makes this adjustment and reports active syphilis prevalence directly.

⁷ Eline Korenromp, the epidemiologist who developed the Spectrum-STI model, and Melanie Taylor, the WHO's focal person on maternal syphilis, have both indicated that syphilis prevalence estimates derived when only a small number of women are screened are likely upward biased for the reason described here.

⁸ The sentinel survey was able to detect active syphilis and does not need to be discounted further because the RPR test was confirmed with a syphilis-specific antibody test, TPFA.

⁹ The facility reported data for 2017 would have yielded a prevalence of 6.9%. There were 14,941 pregnant women tested for syphilis and 1,033 tested positive and were placed on treatment.

Description of the Healthcare System

Physical and Human Infrastructure

There are four levels to the health care system in Liberia. The lowest level of care is provided by community health assistants (CHAs) or community health volunteers¹⁰ (CHVs). CHAs, who are paid, are located in communities that are over 5 km from the nearest health facility. The program is regulated by the government and a standardized curriculum is delivered to all CHAs via implementation partners. The curriculum covers community disease surveillance, prevention, and control; maternal health focused on encouraging ANC attendance; child health focused on treating malaria, diarrhea, pneumonia, and malnutrition; and identifying danger signs for key NCDs and NTDs. CHAs do rapid testing for malaria for children under-5 but do not use any other diagnostics.¹¹

The next tier of the health system is composed of clinics. Clinics account for the bulk of healthcare facilities in Liberia (as of 2012, 379 of 470¹² health facilities were clinics).¹³ Clinics offer antenatal care, delivery services, outpatient care, and basic laboratory testing mainly consisting of rapid tests, dipsticks, and basic TB microscopy. Clinics do not have a doctor but are instead staffed by approximately seven health professionals -- nurses, midwives, a physician's assistant, a registrar, lab aids, etc.

Following clinics, there are 54 health centers in Liberia. Health centers are larger facilities that have laboratories, more staff, and offer inpatient care in addition to the services a clinic provides. Finally, the top tier is composed of district and county public hospitals and several private hospitals. There are 37 hospitals in Liberia, two of which offer blood transfusion services.

Approximately 54% of healthcare facilities are public while the remainder are private. Most of the private facilities are located in Montserrado County, where Monrovia is located -- 70% of health facilities in Montserrado are private.

Trained lab aids, nurses, and midwives are able to administer rapid tests, and nurses and midwives are able to administer injectables -- as a result, syphilis screening and treatment can be done effectively at the lowest level health facility.

¹⁰ CHVs are implemented in an ad hoc fashion by various NGOs and development partners. CHVs are unpaid volunteers whose role varies by location and they work in communities that are within 5km of the nearest health facility.

¹¹ The government is in the midst of reviewing the CHA policy and determining whether the services they provide should be expanded.

¹² The number of health facilities has grown in Liberia and stakeholders put recent estimates closer to 600 facilities.

¹³ See [full list of health facilities](#) in Liberia from 2012.

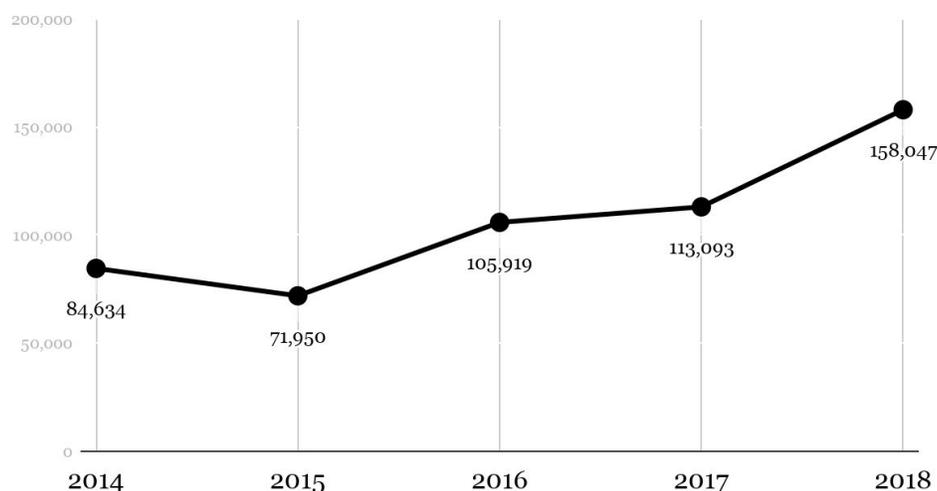
Antenatal Care and HIV PMTCT

All health facilities in Liberia offer at least some fraction of the full set of antenatal care services. According to the 2013 DHS¹⁴, 95.9% of women attended at least one antenatal care visit. 79.7% of women who attended antenatal care were seen by a nurse or midwife while 18.7% were seen by a doctor. 83.7% of women went to a public facility for their antenatal care, 11.3% went to a private facility, and 3.3% went to both.

According to the National AIDS and STI Control Program, **approximately 425 facilities are able to provide HIV PMTCT services**. In 2010, there were only 79 PMTCT facilities, so the government has been actively expanding the service and has plans to continue doing so over the coming years. At PMTCT-capable facilities, the HIV screening rate during pregnancy is above 95% but the national screening rate has remained below the WHO threshold of 95% because of the numerous facilities that do not yet offer the service. Facilities who have not been trained by the National AIDS and STI Control Program do not offer PMTCT because they are not designated to receive commodities.

According to the government's facility-reported data, the number of women screened for HIV during ANC¹⁵ has been steadily increasing since 2014:

Number of women tested for HIV at ANC



¹⁴ There is an ongoing DHS in Liberia currently that should provide updated information on ANC attendance sometime next year.

¹⁵ Of note, there are at least 200,000 pregnant women each year in Liberia, using the estimated population data and assuming 5% of the population is composed of pregnant women (the government's adjustment).

Decentralization

The country has been shifting toward a decentralized form of governance, led primarily by the health sector. As a result of this effort, every county¹⁶ has a County Health Team (CHT). There is also an ongoing process to establish District Health Teams (DHT) for each district though many are not yet fully staffed or as well equipped as the CHTs. Members of the CHT are tasked with supervising the DHTs; there are several districts per county.

The CHTs and DHTs have representatives for each key function within the Ministry of Health -- monitoring and evaluation specialists, pharmacists, NACP focal persons, maternal health focal persons, community health focal persons, etc. The CHTs create their own County Operational Plans and propose budgets to the Ministry of Health to cover operational activities such as staff salaries and last-mile distribution.

Among the development partners, USAID's upcoming program on health systems strengthening and the World Bank's efforts through the Global Financing Facility have largely provided support directly to the County Health Teams rather than at the central level. The government has also required any NGOs or development partners who work within some part of a county to expand their service to cover the entire county; district-specific programs are no longer allowed.

Procurement, Distribution, and Supply Chain Management

Program-specific teams estimate annual commodity quantifications based on the milestones programs are expected to reach that year. For example, the NACP will estimate how many ARVs and test kits are needed. Then, procurement is done by the Central Medical Store and takes place on a somewhat ongoing basis -- if funding is available, purchases can be made monthly, quarterly or annually. The government's procurement process can take an estimated six months or more to receive commodities after an order is put in.

Certain commodities are procured separately by donors and donated to the Central Medical Store. **The Global Fund supports almost all HIV commodities, buying both test kits and ARVs; the remaining gap for HIV is filled by UNICEF, UNFPA, and PEPFAR.** The Global Fund and USAID provide malaria commodities, UNFPA and USAID provide family planning commodities, and UNICEF provides immunization and other essential child health commodities. Typically, commodities are procured by donors once a year -- orders are placed from October to November and commodities are delivered in mid-April to mid-May, though the exact timeline can depend on existing stock levels.

The Supply Chain Management Unit (SCMU) of the MoH manages the integrated distribution of nearly¹⁷ all commodities, including HIV; the **government prefers a single integrated**

¹⁶ There are 15 counties in Liberia.

¹⁷ UNICEF maintains a separate supply chain for immunizations.

distribution system as opposed to parallel systems. There are twenty-seven implementing partners involved in the supply chain in Liberia. When commodities arrive in the country (either through a government purchase or through a donation), they are delivered to the Central Medical Store. From here, the supplies are distributed to either County Depots or directly to health facilities if in Montserrado County with technical assistance support from Chemonics. The County Depots then undertake last-mile distribution and deliver the commodities to health facilities with financial support from the Global Fund and the World Bank Global Financing Facility.

When there is a stock out, the facility sends a request to the County Pharmacist who looks to see whether the commodity can be supplied from the County Depot. If not, the County Pharmacist sends the request to the SCMU who checks the request against the last delivery, the last balance of the commodity in the Logistics Management Information System (see [below](#)), and historical patient load. If it is a program-specific commodity like ARVs, then the request may also be sent to the program team for approval. If the facility's request is deemed valid, a request is sent to the CMS to "pack and pick" whereby the CMS packs the needed commodities and the County Health Team arranges to come pick the supplies.

Data Reporting

There are three main systems for health data collection in Liberia. **The primary source of data on health care is the Health Management Information System (HMIS)** which is administered by the Ministry of Health. The system is a paper-electronic hybrid. Facilities fill in paper HMIS forms that are then collected by either District or County Health Teams. The district/county M&E specialists input the data from the paper forms into the electronic HMIS. Data forms are collected and inputted monthly. The Health Information Systems (HIS) Unit of the Ministry of Health does data validation remotely and via periodic in-person joint auditing with the local CHT or DHT.

The National Public Health Institute of Liberia (NPHIL) has its own disease surveillance system. The purpose of this system is to monitor nineteen priority conditions, including maternal and neonatal death, in real time. At this stage, HIV and syphilis are not among the monitored priority conditions. Each county has two paid surveillance officers and each district has at least one paid surveillance officer. Unpaid volunteers report to district surveillance officers. The main purposes of this system are to: (a) identify any priority conditions where the patient remains in the community and does not interact with the a health facility; (b) refer suspected patients to the health facility for testing; (c) investigate instances of the priority conditions, namely maternal and neonatal death; and (d) report data to the central government weekly.

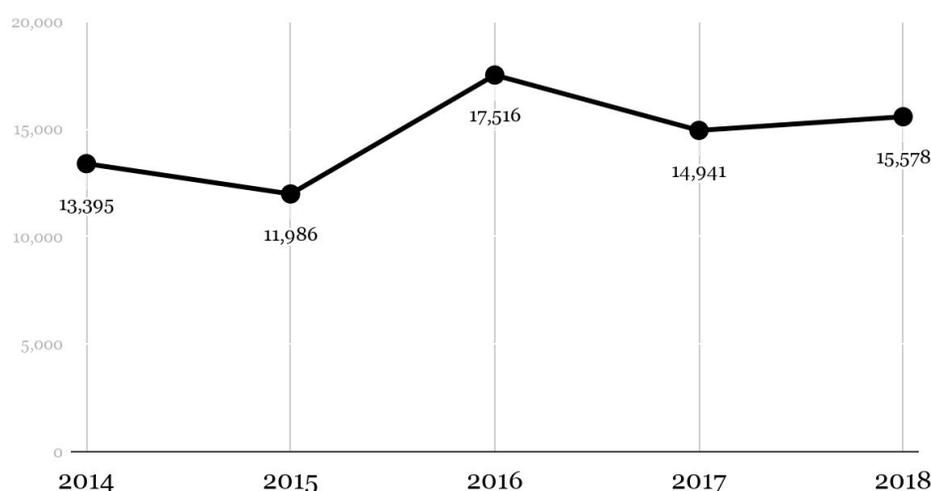
Finally, **the government has been introducing a Logistics Management Information System (LMIS)** that operates similarly to HMIS; there are paper forms at the facility level but data is inputted electronically at the county level. LMIS reporting is intended to be quarterly.

The purpose of the system is to capture data on commodity usage, the quantities disbursed to facilities, current stocks on hand, and any stocking request for the next distribution cycle. Currently, since LMIS is relatively new, only 30% of facilities have been brought into the system thus far. There is a separate system at the Central Medical Store, mSupply, that is meant to track incoming and outgoing commodities at the central level.

Barriers to Syphilis Screening and Treatment

The key reason for low rates of syphilis screening in Liberia is the lack of testing reagents across the majority of facilities where women seek antenatal care. Syphilis testing is exclusively lab based RPR testing, and as described [above](#), very few health facilities in Liberia have laboratories capable of doing this testing. Policy wise, syphilis testing is already a mandatory component of antenatal care, so the real challenge is in ensuring health providers are able to test women without needing to refer.

Number of women tested for syphilis at ANC



Although a gap in treatment cannot be identified via existing data (see [previous discussion](#)), numerous stakeholders including the NACP identified that there were challenges in ensuring all women who test positive are treated with benzathine penicillin-G (BPG). The challenges are twofold:

1. **There may be inconsistent procurement of BPG at the national level.** It was frequently identified that insufficient BPG was being procured at the national level and that its future procurement could not be guaranteed.
2. **Clinics, which likely provide a large percentage of antenatal care, have to request BPG in order to receive it from the County Depot but many do not.** There is low salience of syphilis treatment because many women are not being screened for syphilis at the clinic level. As a result, clinics are not requesting BPG stocks and gaps

in treatment are likely to arise when dual test screening is brought down to the clinic level.

Dual Test Action Plan

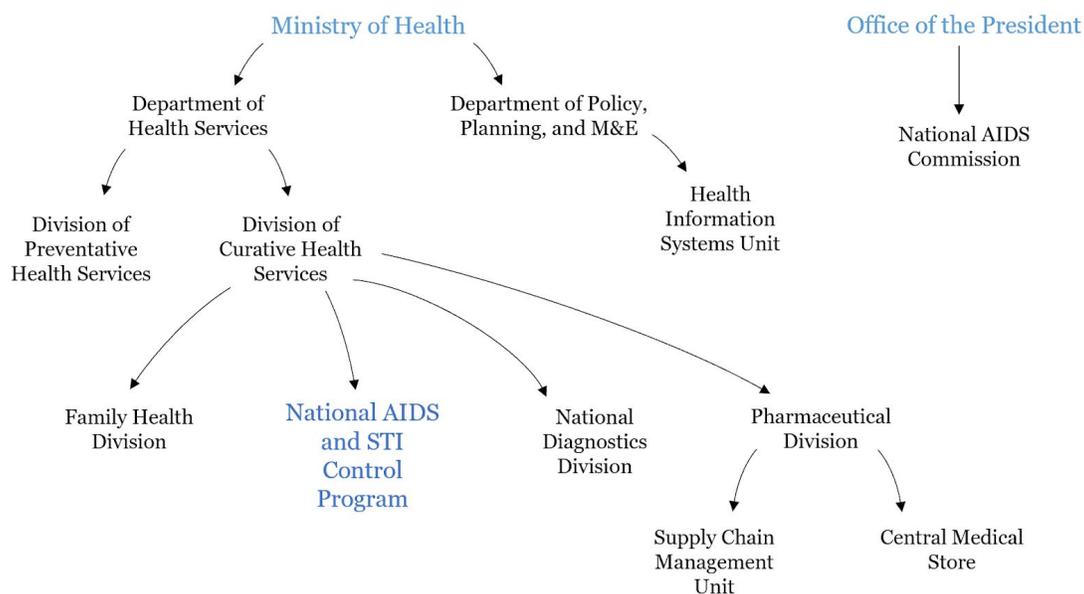
The National AIDS and STI Control Program (NACP) received 11,300 SD Bioline Duo HIV/Syphilis Combo Tests (10,300 from Global Fund and 1,000 from UNICEF) in July 2019. NACP intends to use these tests to **do a small pilot in several facilities** in Montserrado County. Prior to the start of the pilot, health care providers will be trained on the dual test focusing on how to use it, what counseling patients should receive, and what the treatment protocol for syphilis is if women test positive. The pilot will be reviewed after two to three months. The main outcomes will be whether the tests are acceptable from a quality assurance perspective (namely, storage conditions), whether the midwives are able to use the tests effectively, and what the outcomes are for the number of women who are screened, have a positive test result, and get treated.

The intention is to use the results of the pilot to decide whether the country will incorporate a request for national-scale funding of the dual test in its upcoming 2021-2023 proposal to the Global Fund. Global Fund cooperative agreements are created every two years, though annual amendments to what is procured/funded can be made. Currently, the country is wrapping up the most recent 2018-2020 funding cycle. The government is aiming to submit its first draft proposal for the next 2021-2023 funding cycle by the end of March 2020. The contents of the proposal will be informed by the key objectives outlined in the 2021-2025 National Strategic Plan (NSP)¹⁸ for addressing HIV.

¹⁸ The National Strategic Plan is being drafted by a multisectoral group, led by the National AIDS Commission which includes government groups, UN bodies, faith-based organizations, and community-based organizations. There will be a working draft of the NSP by Christmas and a final draft by the end of January. The key focal areas of the NSP will be: (1) reaching the 90-90-90 targets; (2) increasing community involvement in HIV, and; (3) preventing transmission of HIV.

Stakeholders

Background and Organization of Government Actors



National AIDS and STI Control Program (NACP). Sitting within the Ministry of Health, the NACP is responsible for implementing all health program activities related to HIV/AIDS and STIs. The majority of NACP’s funding and attention goes to HIV. Dr. Julia Toomey-Garbo is the Director of NACP. NACP also has its own epidemiology, monitoring and evaluation, and procurement staff.

National AIDS Commission (NAC). The NAC is under the Office of the President and has three core functions: (1) acting as a coordinating body for all HIV/AIDS activities which involves resource mobilization and allocation, policy and guideline development, and research studies; (2) national strategic plan development every five years, and; (3) monitoring and evaluation, including annual reviews every December.

Family Health Division (FHD). The Family Health Division of the Ministry of Health is responsible for coordination and delivery of all reproductive, maternal, neonatal, child, and adolescent health activities. Among their functions, the FHD also chairs the Reproductive Health Technical Committee. In addition, there is a PMTCT focal person within the Family Health Division.

National Diagnostics Division (NDD). The NDD is a technical arm of the Ministry of Health tasked with overseeing the country’s laboratory system, drafting policy for lab services,

coordinating with partners involved in diagnostics, and guiding the process of what diagnostics to import. The NDD was created under technical assistance and guidance from CHAI.

Health Information Systems (HIS) Unit. The HIS Unit oversees the Health Management Information System (HMIS), the Logistics Management Information System (LMIS) and the human resources data system. The HIS Unit has staff for data entry and verification, and finalizes the tools used for all data collection efforts at the health facility. The HIS Unit sits within the Division of Research, Monitoring, and Evaluation, which is headed by Director Luke Bawo.

Supply Chain Management Unit (SCMU). The SCMU's primary purpose is to coordinate all supply chain activities in Liberia, which includes managing the quantification process, warehouse monitoring of the Central Medical Store, managing the LMIS, and chairing the Supply Chain Technical Working Group. The SCMU is led by Director John Harris.

Central Medical Store (CMS). The CMS is the central warehouse for all medical commodities brought into Liberia. The CMS is responsible for keeping track of what is available centrally and for distributing commodities to health facilities in Montserrado County and to County Depots in the remaining counties.

National Public Health Institute of Liberia (NPHIL). NPHIL largely focuses on preventative public health, implementing large scale disease surveillance and conducting research on key public health issues.

Liberia Institute of Statistics and Geo-Information Services (LISGIS). LISGIS is responsible for large scale, country-wide surveys like the census, the Demographic Health Survey, the Malaria Indicator Survey, and the Household Income Expenditure Survey.

Development Partners

USAID. The USAID mission's flagship program in Liberia is the Fixed Amount Reimbursement Agreement (FARA) program and its underlying performance-based financing. Within FARA, the Liberian government is reimbursed for expenses incurred at a certain set of health facilities if those health facilities meet annually adjusted indicators. The purpose of the program is to strengthen maternal and child health; as a result, the indicators are around malaria, family planning, antenatal care, facility-based birth rates, and post-natal services.

UNFPA. UNFPA has three key objectives for its work in Liberia: (1) all family planning needs are met; (2) there are no maternal deaths, and; (3) there are no instances of gender-based violence. To this end, UNFPA provides training to increase emergency obstetric capacity at health facilities, supplies family planning commodities, trains midwives to increase the number of skilled birth attendants, advocates with traditional birth attendants to increase facility referrals, provides comprehensive sexual education to youth and adolescents, manages a

gender-based violence information system across Ministries, and supports implementation of the census and the Demographic and Health Survey.

UNICEF. UNICEF's Child Survival & Development Section focuses on three main areas: maternal and child health, nutrition, and WASH. UNICEF provides support across these areas directly to the Ministry of Health, including providing funding for child essential medicine procurement and managing the end-to-end distribution and storage of immunizations.

WHO. The WHO provides technical support to the Ministry of Health, focusing on maternal, neonatal, and child health, and nutrition. Within its scope of work, the primary focus of the WHO is on ensuring all of Liberia's policies match global standards and any policy implementation is evidence based. The WHO also chairs the reproductive health and health systems strengthening technical working groups and supports some training of health care providers to improve data collection and service delivery.

UNAIDS. UNAIDS' intended mission is to coordinate the response to HIV/AIDS across all UN agencies in Liberia.

Global Fund (GF). The Global Fund is the primary funder of all HIV/AIDS activities and health commodities in Liberia. GF also provides some support for STI commodities, though this procurement varies year-on-year. There is a portfolio manager for Liberia who is based in Geneva, grant managers in Liberia, and a country coordinating mechanism that focuses on governances, leadership, and oversight.

World Bank. The World Bank's key program in Liberia is the Global Financing Facility (GFF) which supports last mile distribution of commodities across the country.

NGOs

Clinton Health Access Initiative (CHAI). CHAI began in Liberia with a focus on market shaping activities to reduce the cost of HIV treatment. CHAI has helped set up many units within the MoH, including the Supply Chain Management Unit, the National Diagnostics Division, and the National AIDS and STI Control Program. Within HIV, CHAI has supported programs in clinical mentorship, early infant diagnosis, PMTCT, and point-of-care CD4 testing.

Chemonics. Chemonics is the MoH's main technical assistance partner for improving the supply chain. Their activities include supporting the quantification process, coordinating among donors to identify what is being procured, supporting the management of the Central Medical Stores (the central warehouse), supporting commodity distribution from the central warehouse to the county warehouses, and supporting last mile delivery in Montserrado County. Chemonics is also working on further rolling out the Logistics Management Information System.

U.S. Centers for Disease Control (CDC). The CDC is embedded within the National Public Health Institute of Liberia (NPHIL) and works to support maternal health and decrease maternal mortality. A key component of CDC's work is its support to NPHIL's disease surveillance program. Beyond this, the CDC has several cooperative agreements where sub-grantees provide direct support -- examples include Riders for Health which takes specimens from health facilities to reference labs via motorbike and Accel who provided reagents and training to the national and regional reference labs.

Jhpiego. Jhpiego was recently awarded a new USAID contract, 'Strategic Technical Assistance for Improved Health System Performance and Health Outcomes Activities'. Jhpiego will work across twelve counties and aims to strengthen county health teams in strategy and planning, budgeting, quality of supervision, procurement, and using data for decision making. The upcoming grant will also include a focus on integrated services in reproductive, maternal, neonatal, child, and adolescent health -- within antenatal care, they are aiming to increase compulsory testing rates for urine dipstick, malaria rapid test, hemoglobin, and HCG.

President's Malaria Initiative (PMI). PMI focuses on several areas in regard to improving malaria care, including ensuring possible malaria cases are confirmed via testing prior to treatment, providing bednets to pregnant women and newborns, ensuring women are tested at their first ANC visit, and increasing the number of pregnant women on malaria prophylaxis.

Partners in Health (PIH). PIH began program activities in Liberia as a result of the Ebola crisis and committed to spending 25 years in the country. PIH focuses on direct service delivery, monitoring and evaluation, and research. The organization supports two health facilities in Maryland County, J.J. Dossen Hospital and Pleebo Health Center, with a goal of delivering high quality care across all areas by providing staff of all cadres where needed (specialists, generalists, nurses, etc.) and by ensuring the necessary commodities are available on-hand.

Last Mile Health (LMH). Last Mile Health advocated to the MoH to create a national policy to standardize the services provided by community health assistants (CHA) and their training curriculum across Liberia. Once the policy was adopted, LMH began and continues doing direct implementation of the CHA program in three counties. LMH does significant program innovation in their focal counties and then feeds any successful innovations back to the national government to scale across the remaining counties.

Planned Parenthood Association - Liberia (PPAL). PPAL has been in Liberia since 1956 and focuses on sexual and reproductive health rights. PPAL operates two health clinics in Montserrado and Kakata that provide services across a range of areas, including post abortion care, youth friendly services, maternal and child care services, family planning, HIV and STIs, and infertility services. PPAL also does weekly outreach via a mobile clinic that focuses mainly on education and basic reproductive service provision.

Population Services International (PSI) and FHI360. PSI and FHI360 are both implementing programs to increase HIV testing, treatment, and viral suppression among key populations. PSI is also one of the primary recipients for Global Fund funding in Liberia, next to the National AIDS and STI Control Program and Plan International.

Social Impact. Social Impact holds the monitoring, learning, and evaluation support contract with the USAID mission in Liberia. Their activities include storing all of USAID's data, supporting evidence-based decision making, designing monitoring and evaluation strategies and setting up monitoring systems, and holding 'collaborative learning and adapting' workshops to increase development effectiveness.