

# Catholic Relief Services, Contraception, and the Mikolo Project

March 2019

An investigative report on how Catholic Relief Services provided the financial mechanism for a contraception-promoting project in Madagascar.



**CRS**  
CATHOLIC RELIEF SERVICES

image



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Michael Hichborn

The Lepanto Institute was created to present the facts regarding organizations that claim the name Catholic or even Christian, but are acting in opposition to the teachings of our Blessed Lord and His Holy and Immaculate Church. Sadly, organizations like Catholic Relief Services, the Catholic Campaign for Human Development, the Catholic Health Association and many others are giving aid and comfort to the enemies of Christ. Even worse, dissident and apostate Catholics in politics and other prominent arenas are giving a false witness to the faith by claiming to be Catholic while promoting abortion, contraception and homosexuality. As a remedy to this grave situation, the purpose of the Lepanto Institute is to encourage recourse to the Holy Rosary, particularly offered for bishops and priests, while presenting the facts on individuals and institutions such as these.

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## Preface

Over the years, Catholic Relief Services (CRS) has been caught time and again involving itself in the promotion of contraception and condoms. With each new report, CRS has shown an unwillingness to admit any wrongdoing, deflects real concerns with misdirecting responses, and has blamed others for documented evidence printed in black and white.

- In 2015, the Lepanto Institute and Population Research Institute [published a joint report](#)<sup>1</sup> which proved that CRS was responsible for a project in Kenya which included the promotion of contraception. [CRS's response](#)<sup>2</sup> was to [claim a government agency had mistakenly identified](#)<sup>3</sup> it with a contraception-promoting program, deny the evidence, misconstrue the facts, and attack the character of the on-the-ground investigator.
- Also in 2015, the Lepanto Institute and Population Research Institute [published a report](#)<sup>4</sup> proving that CRS was responsible for a condom-promoting program called Shuga. [CRS's response](#)<sup>5</sup> was to ignore the facts, shift the blame, and claim that it was responsible for ending the program. [Documents with CRS letter head](#)<sup>6</sup> proved CRS's response to be false, especially since CRS's own grant proposal to the Federal Government suggested implementing the second series of Shuga, not ending the program.
- In 2016, the Lepanto Institute [published a report](#)<sup>7</sup> which contained inventory charts showing that CRS had received and distributed 2.25 million units of contraception in the Democratic Republic of the Congo. [CRS's response](#)<sup>8</sup> was to deny the clear evidence, shift the blame to another organization, and pin the matter on a clerical error in reporting.

Regardless of how or where CRS has been found to be involved in projects that promote contraception and condoms, it always seems to fall back on this repeated pattern of shifting blame to another agency who "made a mistake," followed by a boiler plate statement regarding its good works.

In this report, we will explore a project in Madagascar in which CRS played an integral role for the promotion of contraception. One of the key objectives of this project, called the Mikolo Project, was to educate women on the use of modern contraceptives, providing condoms, IUDs, contraceptive pills and even injectable contraception to those women who desired it. In order to meet this objective, the success of the Mikolo Project was predicated on providing financial incentives for Community Health Volunteers which would be funded through a self-sustaining financial mechanism. This mechanism, which is called Savings and Internal Lending Communities (SILC) was created and implemented by Catholic Relief Services, which means that CRS knowingly and willingly provided a key component to the success of a project that was intent on spreading grave moral evils to vulnerable people in Madagascar.

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<sup>1</sup> <https://www.lepantoinstitute.org/crs-pepfar-cover/>

<sup>2</sup> <https://www.crs.org/stories/crs-responds-false-allegations-about-kenya-program>

<sup>3</sup> <https://www.lepantoinstitute.org/wp-content/uploads/2015/02/PEPFAR-22.jpg>

<sup>4</sup> <https://www.lepantoinstitute.org/crs-implemented-condom-promoting-video-series/>

<sup>5</sup> <https://www.crs.org/stories/catholic-relief-services-responds-allegations-shuga-video-kenya>

<sup>6</sup> <https://www.lepantoinstitute.org/crs-confirms-implementation-of-condom-promoting-video/>

<sup>7</sup> <https://www.lepantoinstitute.org/catholic-relief-services-stored-dispensed-abortifacient-contraceptives-millions/>

<sup>8</sup> <https://www.crs.org/stories/catholic-relief-services-refutes-allegations-improper-conduct-democratic-republic-congo>

## **Background**

The Mikolo Project is a 5 year, USAID-funded program which ran from August 1, 2013 – July 31, 2018 in Madagascar. The implementing organization for the project was Management Sciences for Health (MSH) and Catholic Relief Services (CRS) was one of the sub-partners. According to the Project Background of page 20 of the Final Performance Evaluation of the Mikolo Project, published by USAID, the primary goal of the project is to **“increase access to ... community based primary health care, especially for women of reproductive age.”** This primary health care for women of reproductive age is specified a little later as including contraception. The evaluation states, **“the project aims to improve access, availability, and use of high-impact services, products, and practices for family planning/reproductive health.”** In order to achieve this, the project utilizes Community Health Volunteers (CHVs). As will be made clear in this report, the role of CHVs is integral to the success of the project, and CRS’s role in it. What must be understood is that the CHVs in this project provide the propaganda and delivery methods for contraception, and they are being financed through the funding mechanism implemented by CRS. In the bottom paragraph on page 20, the Evaluation states<sup>9</sup>:

The **main project activities are carried out by trained CHVs** to ensure the delivery of the continuum of care. These services and practices include: **the delivery of FP (Family Planning) services to women** of reproductive age, including youth

A 2017 USAID report<sup>10</sup> on its family planning programs in Madagascar identified the Mikolo Project as one of the most effective in promoting and spreading contraception in hard to reach areas. In this report, USAID explains the important role CHVs play in the provision of contraception. USAID explains:

**“Community health volunteers (CHVs) play a critical role in providing basic health care services and commodities, including family planning methods,** in rural areas and to underserved populations. One of USAID Madagascar’s community health projects, USAID Mikolo, currently supports nearly 7,000 CHVs across over 500 communes.”

The use of CHVs is central to the success of the Mikolo Project. USAID further explains how the provision of contraception (including contraceptive pills, condoms, and injectable contraception) is a top priority for these CHVs.

**“One important role CHVs play is in providing a range of family planning services for their communities,** filling a much-needed gap in communities where health facilities aren’t easily accessible. CHVs are selected by their communities, trained and supported by their nearest primary health facility, as well as by USAID Mikolo, to **provide a range of family planning services including provision of contraceptive pills, condoms, Depo Provera or Sayana® Press** and counseling on natural methods.”

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<sup>9</sup> FINAL PERFORMANCE EVALUATION OF USAID MADAGASCAR MIKOLo PROJECT (p. 13)  
[http://ghpro.dexonline.com/sites/default/files/WITH%20ANNEXES%20383%20MDG%20Mikolo%20Eval%20Draft4%2012-19-17\\_Mission%20approved.pdf](http://ghpro.dexonline.com/sites/default/files/WITH%20ANNEXES%20383%20MDG%20Mikolo%20Eval%20Draft4%2012-19-17_Mission%20approved.pdf)

<sup>10</sup> <https://www.usaid.gov/sites/default/files/documents/1866/Family-Planning3.pdf>

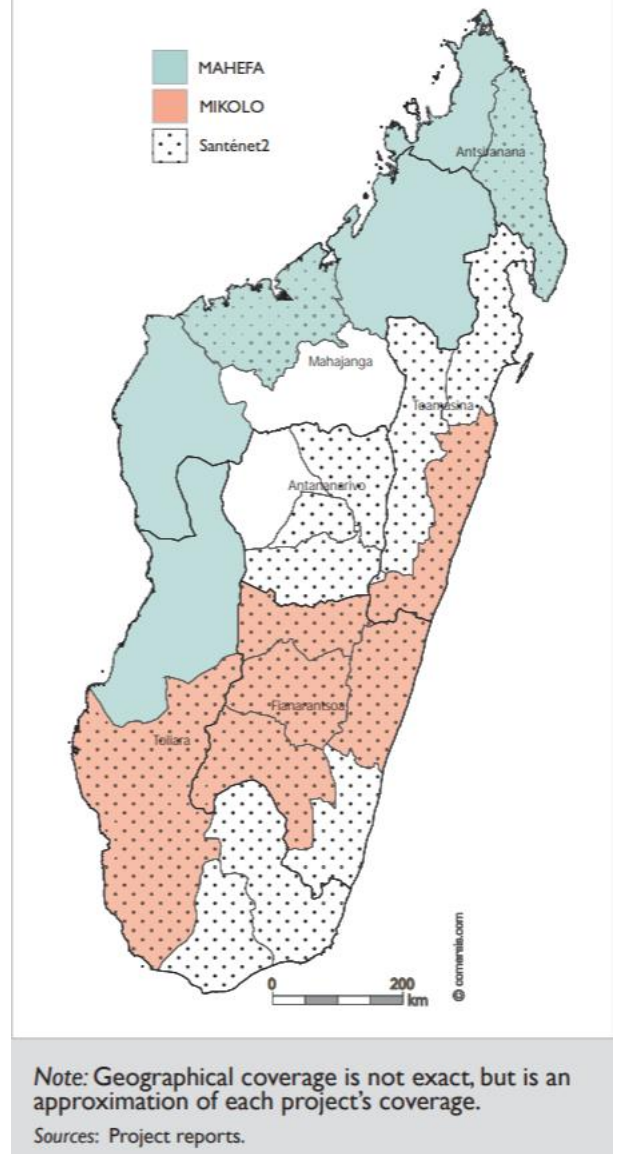
Noting the success of CHVs in their role as contraception suppliers, USAID concludes with this:

“Over the past four years, USAID Mikolo has seen a steady increase in new and continuing family planning users in their intervention areas. **The number of referrals of family planning rose by nearly 2,000 between 2014 and 2016.**”

The Mikolo Project builds on the work of SanteNet2, which CRS also participated in. Under SanteNet2, CHVs were used to meet program goals, much of which included increasing contraceptive prevalence. But unpaid volunteer work proved to be unsustainable as CHVs routinely reported stockouts and needed incentivization to continue being away from their own work (mainly farming) and families. A USAID report titled, "USAID/Madagascar and Community Health Volunteers: Working in Partnership to Achieve Health Goals"<sup>11</sup> showed (page 7) how the Mikolo Project overlapped six regions of the SanteNet2 Project (image right). Page 8 of this report provided some background on USAID’s work with CHVs, the obstacles to goal achievement, and the work of various USAID-funded projects to overcome those obstacles. According to the report:

“From 2009 to 2014, USAID health assistance was limited by US government restrictions, focusing only on private sector health services such as social franchising, nongovernmental organization (NGO) service delivery, social marketing, and **community-based service delivery through CHVs to provide family planning**, maternal and child health, and malaria services. Despite these challenges, over the past five years alone, Americans invested over \$250 million in population and health programs in Madagascar to improve the survival, well-being, and productivity of the Malagasy people. USAID has worked with a network of more than 17,000 CHVs who cover about 1,200 communes in Madagascar. The majority of CHVs are women; they are selected by their own communities. The CHV system provides health services to 9.5 million people or about 64% of the population in rural areas. **Over the past eight years, three USAID-funded projects—Santénet2 (2007-13), MAHEFA (2011-16), and MIKOLO1 (2013-18)—have worked in**

Figure I. Geographical Coverage of Three USAID-funded Projects in Madagascar



<sup>11</sup> <http://www.chwcentral.org/sites/default/files/USAID%20Madagascar%20CHV.pdf>



**partnership with CHVs. Together, the projects have** implemented innovative community health services and systems, scaled up the provision of community-based diagnosis and treatment for simple pneumonia, diarrhea and malaria, **as well as of oral and injectable contraceptives through family planning and reproductive health.**

After explaining the prominent role CHVs play in providing health care in rural communities, this report states that for the most part, CHVs receive a modest income from the products they sell to members of their communities. The CHVs under the Mikolo project, the report explains, receive greater financial incentives:

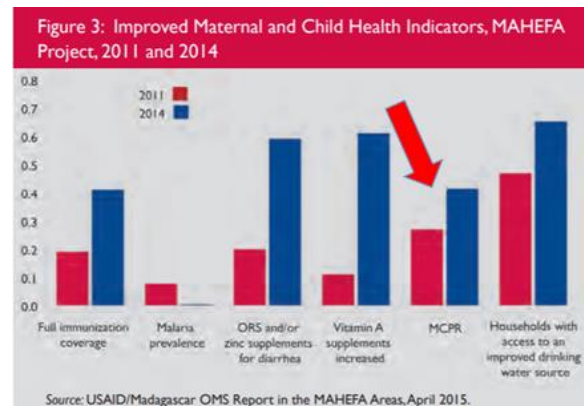
“Under the MAHEFA and MIKOLO projects, for example, CHVs earn money from user fees from the sale of medicines and commodities, and receive per diem for attending trainings and meetings. Selected **CHVs may have access to credit through project-established Savings and Internal Lending Communities (SILCs)** or may be chosen to participate in certain income-generating activities.”

Under the heading, “CHV Package of Services,” USAID indicated the contraceptive services provided by CHVs in Madagascar:

**Volunteers also provide community-based family planning services.** These services include counseling, pregnancy screening, method eligibility screening, **and provision of short-acting contraceptive methods.** CHVs inform and refer clients for **long-acting and permanent methods** available through mobile outreach and private and public service providers. **CHVs socially market many of the products that they distribute; this modest income serves as a motivation for CHVs and sets Madagascar apart from other countries that pay direct stipends. CHVs also provide a link to youth peer educators in the community to reproductive and other health services.**

On page 4 of this 2015 document is a chart tracking certain benchmarks and goals pertaining to CHVs, including the growth in the use of modern contraception (right). The report says, “The modern contraceptive prevalence rate (MCPR) rose significantly, with CHVs providing almost half of the family planning messages to women of reproductive age.”

In October of 2015, USAID published a brief titled, “African Strategies for Health.”<sup>12</sup> In this document, USAID published a table of activities related to various projects, including the Mikolo Project. This table illustrates both the contraception-promotion of CHVs and the fact that CHVs are financed by SILCs.



<sup>12</sup> [www.africanstrategies4health.org/.../1/.../chw\\_incentives\\_madagascar\\_brief\\_final.pdf](http://www.africanstrategies4health.org/.../1/.../chw_incentives_madagascar_brief_final.pdf)



Table I. Overview of Activities and Incentives for Community Health Programs

Community Health Program	Overview of Activities and Incentives
USAID Mikolo (2013-2018)	<i>Geographic coverage:</i> Implemented in six regions (Atsinanana, Vatovavy-Fitovinany, Amoron'i Mania, Haute Matsiatra, Ihorombe, and Atsimo-Andrefana), 32 districts, and 375 communes
	<i>Role of CHWs:</i> CHVs provide integrated community case management (iCCM) treatment (diarrhea, malaria, and pneumonia) and <u>short-acting FP methods (pilplan, condoms, cycle beads, Depo-Provera)</u> among other health promotional activities.
	<i>Financial incentives:</i> CHVs are considered unpaid volunteers but receive per diem for attending trainings and meetings and earn money from user fees from the sale of medicines and commodities. <u>Selected CHVs also have access to credit through project-established SILCs.</u>
	<i>Non-financial incentives:</i> CHVs receive training, equipment, and a start-up kit of medicines/commodities. CHVs are supervised regularly by a field technician and can be promoted to a higher level certification based on competency tests. CHVs indicate public acknowledgement, increased knowledge, and improved capacity as motivating nonfinancial incentives.

An interim report (page 31)<sup>13</sup> on CHVs in the SanteNet2 program recommended looking for ways to finance the CHVs for sustainability of the project. The report said:

**Recommendations included determining how to finance the CHV program to make it sustainable.** One representative called for a line item in the Government budget at decentralized levels to cover CHV services. Another said that some FP services were free at health centers but that CHVs had to ask for a fee to recoup the costs of medicines and supplies, though the service was free. This particularly applied with medications that were purchased through the community. Poverty in remote areas precluded asking for contributions from the communities.

**Analamanga's community representatives were concerned about stimulating and sustaining CHVs' motivation. They acknowledged the efforts CHV had to make and cited a need for financial incentives.** One representative explained that the work interfered with a CHV's personal (especially marital) life, since many were approached at night, especially for MNCH emergencies. In one case, a CHV's husband opposed his wife's CHV activity due to the frequent disruptions. **Financial incentives, e.g., compensation for travel expenses, could help retain CHVs. Providing resources to communities to organize incentives was suggested.**

Addressing the financial shortfalls for the funding of CHVs, in particular as they are being used for the spread and promotion of contraception, USAID devised the Mikolo Project to meet certain goals and benchmarks. Foremost among these goals is the independent sustainability of the project itself. Catholic Relief Services, having pioneered the Saving and Internal Lending Communities (SILCs) program and implemented it throughout Africa, joined the Mikolo project so as to establish SILCs as a funding mechanism for community "health." This is the very first time CRS would establish SILCs for this purpose.

<sup>13</sup> <https://www.usaid.gov/sites/default/files/documents/1864/3%20-%20Madagascar%20Community%20Health%20Volunteer%20Assessment.pdf>

## **Catholic Relief Services and the Mikolo Project**

The August-September 2013 Annual Progress Report<sup>14</sup> of the Mikolo Project provides two important pieces of information regarding the intent of the project, and CRS's role within it. Page 4 of this report explains the activities intended for various sub-purposes of the project. Under the heading, "Sub-purpose 2: Increase availability and access to primary health care services in all communes in the Project's six intervention regions," USAID explains the training that will be held for CHVs:

*"Develop, revise, and validate CHV training curricula*

The purpose of this activity is to **collect all existing CHV training curricula and to use this as a basis for adapting curricula that meet the needs of the Project's CHVs. Documents were collected from the MOPH, MAHEFA, FHI 360 and SantéNet2 and pertain to the following topics: RH/FP; community-based Depo Provera;** c-IMCI, including malaria; maternal and child health; nutrition; and water and sanitation."

In other words, the Mikolo project is intended to pick up where former projects using CHVs for the spread of contraception left off.

On page 8 of this report, USAID indicated the beginning of discussions with both Population Services International (PSI) and Marie Stopes International (MSI), indicating that the USAID/MIKOLO Project is particularly interested in the possibility of referring the Malagasy people to mobile clinics for contraceptive services. Referring to discussions with MSI, the report said:

"FP clients to mobile clinics and to MS Ladies (**MSI-trained women in communities who can provide short and long-acting methods of family planning**). We agreed to jointly develop a framework document for collaboration to be completed during the next quarter."

On page 16, USAID identifies and defines the role of Catholic Relief Services in the project. Specifically, CRS is responsible for leading "all activities related to microfinance.":

**Catholic Relief Services (CRS)** – will provide important contributions to the achievement of each of the four USAID/MIKOLO PROJECT sub-purposes. CRS will particularly contribute to sub-purpose 1 and also contribute towards the cross-cutting issues of youth and gender. **CRS will not be asked to provide service delivery related to family planning and reproductive health.** Specifically, it is expected that **CRS will lead all activities related to microfinance.** Drawing from international and Madagascar specific experiences, CRS will facilitate the establishment of commune-level COSAN Savings and Loans Funds (CSLF)/Village Saving and Loans Associations (VSLAs). CRS will establish partnerships with Microfinance institutions and determine the demand for client centered loan products available through COSANs. CRS will play a lead role in the implementation of innovative approaches at the community level such as Mobile Banking and use of mHealth, for example, where appropriate.

**For reasons that will soon become clear, it is important to note that USAID directly states that CRS "will not be asked to provide service delivery related to family planning and reproductive health."**

Whether or not Catholic Relief Services distributed or in any way touched contraception is not at issue.

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<sup>14</sup> [https://usaidmikolo.files.wordpress.com/2014/02/mikolo-annual-report-august-g0\\_30-oct-2013\\_final-english.pdf](https://usaidmikolo.files.wordpress.com/2014/02/mikolo-annual-report-august-g0_30-oct-2013_final-english.pdf)

The problem is that this entire project – which is directed at the spread of contraception – is predicated upon the creation of microfinancing, which is then used to fuel the CHVs who will spread contraception. In other words, Catholic Relief Services is providing the necessary mechanism for funding a project whose specified purpose is the spreading of contraception. The line here about how USAID is not requiring CRS to “provide service delivery related to” contraception is not an exoneration in this case, but is in fact an indictment of CRS’s moral complicity in the spread of contraception. This means that CRS was fully aware of the contraception-spreading nature of this project, knew that the project could not function without the SILCs set up by CRS, and participated in the project anyway.

## **HOW THE PROJECT WORKS**

In June of 2018, MSH (the lead on the Mikolo Project) published an article explaining the relationship between the SILCs established by CRS and the Community Health Volunteers.<sup>15</sup>

“In rural Madagascar, people have limited access to savings programs or credit. This impacts community health when people cannot afford to pay for health care. In partnership with Catholic Relief Services (CRS), the USAID Mikolo Project promoted the creation of savings and internal lending communities (SILCs) at the Fokontany (village) level to encourage individuals and families to regularly save income and to provide them with access to credit on favorable terms.

CRS first developed the SILC approach for general community development, and USAID Mikolo implemented it for the first time in the field of public health. SILC groups offer easy access to financial services for households and health care providers, especially women, as well as social capital. The main objective of SILCs is to provide funding, borrowing, and savings opportunities for community members.

SILCs are groups of 15-25 community members that meet on a weekly basis. Each member contributes money into the SILC fund. Members can borrow money at a fixed interest rate, e.g. to start up a small business. After a full cycle (9-12 months), the total savings accrued throughout the period are distributed to members based on how much each has saved, as a percentage of the overall savings.

This idea of SILC groups is not new to Madagascar; however, what makes the USAID Mikolo model unique is that the underlying premise is that rural development is inherently connected with health. USAID Mikolo-supported SILC groups enable members to both improve their livelihoods and lead healthy lives.

In fact, community health volunteers (CHVs) participate in the SILC groups not only as members, but also as health educators to improve quality of life by considering personal and family health. Life in a rural village is very difficult, and without financial stability simple healthy behaviors may seem out of reach for many families, such as purchasing needed medicines, soap, family planning methods, or healthy food. CHVs encourage these behaviors, and with the SILC program these and other health-promoting activities can become regular habits rather than unattainable conventions.

Further explaining the project and how CRS’s microfinance loans work within the project, both CRS and USAID produced a series of videos that illustrate the relationship between the SILCs and the CHVs.

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<sup>15</sup> <https://www.msh.org/news-events/stories/building-self-reliance-through-savings-and-loans-communities>



In a video titled, “Health Committees' Saving and Loans Funds and Access to Health,”<sup>16</sup> CRS provides a great deal of detail about the COSAN Savings and Loans Funds, which are Savings and Internal Lending Communities (SILCs) whose members are CHVs and members of the Communal Committee on Social Development (CCDS). The video illustrates the manner in which CHVs are funded by SILCs in order to incentivize their health work in the community.

In discussing Community Health Volunteers, the narrator in the video explains that CHVs provide a host of different health-related services to the community, but makes no mention of the fact that the CHVs are also providing information on and distributing contraception. It says:

“Community Health Volunteers are trained volunteers who are committed to helping people with community issues and offer prevention services and health management at the community level. They invite and advise mothers to track the growth of their children. They advise families on good practices related to child birth; practicing the (unintelligible) prenatal consultations; distributing misoprostol to women who are close to giving birth; consulting preventative care; wiping the umbilical cord with chlorhexidine when the baby is born; they warn families of malnutrition risks and advise mothers on child nutrition, namely, cooking demonstrations, eating foods that have a variety of colors.

They take in people who are looking for guidance in their community and assist in managing medications, provided to the people who come to see them. They refer to the basic health centers in their community cases that are complicated and that require medical intervention.

The narrator mentions “prevention services” and discusses various services provided by the CHVs, but never once mentions the fact that under this USAID project, CHVs are also providing information on and dispensing all forms of contraception, including abortifacients. Anyone viewing this video without having any other knowledge, would never realize that contraception was an integral part of the project, and CRS’s savings and loan communities were providing the financial mechanism for it to work.

The video then goes on to explain how the microfinance loans work by pooling together community resources as a means of creating a lending system to other members. When an individual takes out one of these loans, they are subject to pre-determined interest rates and fees until the loan is paid off. Prior to rolling credits that show how CRS scripted and produced this video, ending with a CRS copyright dated 2015, the narrator closes her explanation by concluding:

"It is necessary that the Community Health Volunteers are active members of the SILC groups within their own communities. By integrating the CSLF, the Community Health Volunteers

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<sup>16</sup> <https://youtu.be/IdxTJztXQjY>

reinforce their experience, professional network, and provide the resources necessary to achieve their health projects.

Through production of this video, CRS knew about the intimate relationship between their SILCs and the Community Health Volunteers.

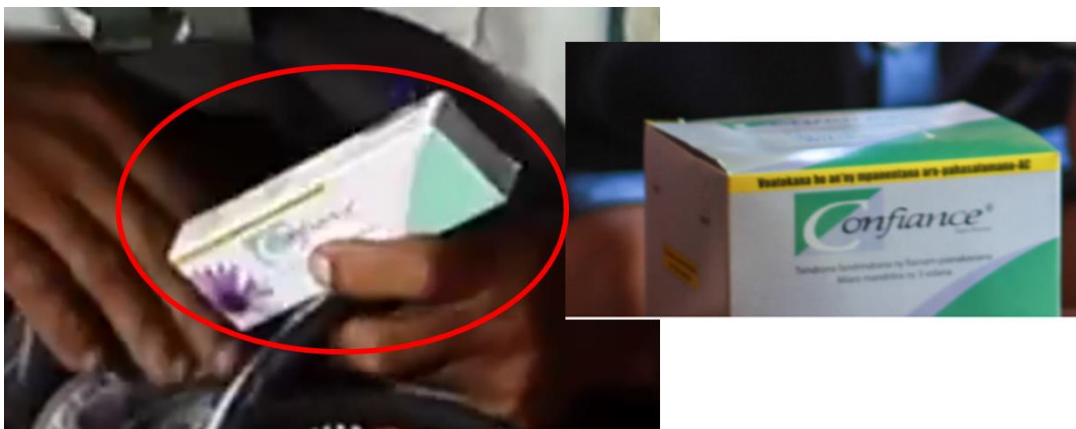
In another video<sup>17</sup> bearing Catholic Relief Services' credits and copyright, the narrator explains the relationship between CHVs and CSLF saying:



“The primary goal of the project is to increase the use of primary healthcare services to local community and the adoption of health enhancing behavior. The project relies on human capital to achieve this goal. The establishment of CSLF or Cosen Savings and Loans funds, which are savings groups of community health volunteers is one way to achieve this. The

CSLF presents an opportunity for community health volunteers to have access to financial opportunities such as credit and savings. This practice also enables them to develop their social capital into the community health volunteer’s professional network.”

While the narrator for the video is saying this, the B-roll footage shows a CHV enter a woman’s hut, where he pulls out a box of something from his backpack (image above). Blowing the picture up (left) reveals that the box being taken from the backpack is a box carrying the label “Confiance.”



A few seconds later, the contents of the box were set out on the table while the CHV examined the instructions on the back of the box. The contents included a small vial and a syringe (see the image

<sup>17</sup> <https://youtu.be/4wfvQdoRtek>



below). According to a document<sup>18</sup> produced by Family Planning Watch, a project of Population Services International, Confiance is an injectable contraceptive equivalent to Depo Provera, produced by the Pfizer corporation.



This video, along with this report, was sent to Catholic Relief Services in September of 2018. After several months, Catholic Relief Services claimed that the video, which bears its closing credits and its copyright, was not their video and that a local production company mistakenly attached CRS's credits and copyright to the end of the video.

The Lepanto Institute saved the video<sup>19</sup> in case anything should happen to the original. After providing CRS with the information regarding the video, the version on YouTube now has the credits and CRS's copyright blurred out so no one can see them.

A video bearing the title, "Julienne Saves Lives in Rural Madagascar,"<sup>20</sup> which is not produced by CRS, explains the promotion of contraception by CHVs, which are funded through the SILCs established by CRS. The central character in this particular video is Julienne, who explains that she is a community health volunteer. At the 2:11 mark of the video, while pointing to a chart showing condoms, IUDs, contraceptive pills, surgical sterilization methods and injectable contraception, she says, "In the continuum of care, the first service we promote is family planning. It is a vital and demanded service in rural and isolated communities."

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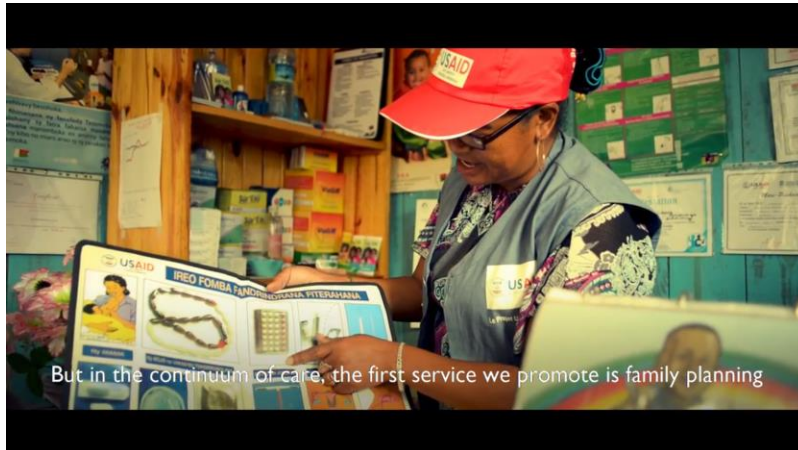
<sup>18</sup> [http://familyplanning-drc.net/media/fpwatch/DRC%202015%20FPwatch%20OS%20Report\\_English%20FINAL.pdf](http://familyplanning-drc.net/media/fpwatch/DRC%202015%20FPwatch%20OS%20Report_English%20FINAL.pdf) (p. 196)

<sup>19</sup> <https://youtu.be/LaXoiajOSgw>

<sup>20</sup> <https://youtu.be/9KDxAlhzxL8>



At the 2:45 mark, a woman identified as having a "Health Champion Household" explains that due to Julienne's guidance as a CHV, "Now I regularly use family planning since the service is available at Julienne's community health hut."



USAID's March 2017 Technical Brief on the Mikolo Project explains the role of CHV's in the promotion and provision of contraception.<sup>21</sup> It says:

**“Community health volunteers (CHVs) play a critical role in providing community-based primary health care**, especially to rural populations who live more than five km from a health facility ... They are trained and supported by the nearest health center and USAID projects to provide integrated community case management (iCCM) treatment (diarrhea, malaria, and pneumonia); **short-acting family planning (FP) methods (Pilplan, condoms, cycle beads, DepoProvera)...**”

Page 2 of the same technical brief illustrates the emphasis the Mikolo Project places on the spread of contraception. After identifying CRS as one of the implementing partners, the brief explains that “the project is aligned with Madagascar’s national community health policy and **specifically focuses on reproductive health; family planning**; maternal newborn and child health ...”

Page 4 provides an image of one of the Mikolo Project CHVs explaining different forms of contraception to a woman, and then the report continues on to discuss evaluations for various CHVs in how effective they have been in convincing women to use some form of artificial birth control.



<sup>21</sup> [https://usaidmikolo.files.wordpress.com/2014/11/technical-brief\\_assuring-the-quality-of-community-based-health-services-in-madagascar\\_usaid-mikolo\\_2017.pdf](https://usaidmikolo.files.wordpress.com/2014/11/technical-brief_assuring-the-quality-of-community-based-health-services-in-madagascar_usaid-mikolo_2017.pdf)

## The Impact of the Mikolo Project in Spreading Contraception

In May of 2018, USAID announced that the Mikolo Project had “achieved significant improvements in maternal and child health for Madagascar.” Listed first among its achievements is that Mikolo Project more than doubled the number of individuals using artificial birth control in just 4 years.<sup>22</sup>

Minister of Public Health Mamy Lalatiana Andriamanarivo also commented on the USAID Mikolo project, saying, “We would like development partners to do what USAID Mikolo has done: they’ve left a legacy to the Malagasy health system. They’ve left sustainable impacts with innovative approaches, in collaboration with the MOPH, at all levels of our health system.”

Over the life of the project, USAID Mikolo achieved significant improvements in maternal and child health for Madagascar that include:

- Continuing users of family planning increased from 66,465 in 2014 to 150,557 in 2018
- 130,250 children under five treated for diarrhea with oral rehydration therapy, with the treatments provided by Community Health Volunteers (CHVs) trained by USAID Mikolo
- 302,158 children under five suffering from pneumonia provided with appropriate care

On Twitter, the USAID Mikolo Project has long boasted of its provision and promotion of contraception. On Sept. 15, 2017, posting a picture of supplies, including charts of various contraception methods, USAID Mikolo Project tweeted about the provision of new contraceptive supplies for CHVs.<sup>23</sup>



<sup>22</sup> <https://www.usaid.gov/madagascar/press-releases/05-04-2018-usaid-mikolo-project-celebrates-five-years-strengthening>

<sup>23</sup> <https://twitter.com/usaidmikolo>

On Sept. 26, 2017, USAID Mikolo Project tweeted the call for universal access to “reproductive health,” and announced that Mikolo would be addressing that very thing online.<sup>24</sup>



On Oct. 27, 2017, the USAID Mikolo Project tweeted about how the Family Planning Summit in July 2017 was “just the beginning” of showing how contraception will transform lives and communities.<sup>25</sup>



<sup>24</sup> <https://twitter.com/USAIDMikolo/status/912628820401885185>

<sup>25</sup> <https://twitter.com/USAIDMikolo/status/923954168838094849>

On April 2, 2018, The Mikolo Project tweeted about how its CHVs brought contraception to remote areas of Madagascar.<sup>26</sup>



On June 26, MSH and USAID Mikolo announced the role of the Mikolo Project in helping to draft Madagascar's new law that allows universal access to contraception and enables CHVs to provide short-term contraception.<sup>27</sup>



<sup>26</sup> <https://twitter.com/USAIDMikolo/status/980859194281734145>

<sup>27</sup> <https://twitter.com/MSHHealthImpact/status/1011684995960852485>



Page 1 of this Mikolo Project Technical Brief from March 2017<sup>28</sup> indicated its specific intention to increase the contraceptive prevalence rate among 15-20 year olds. It said:

“The USAID Mikolo Project, in collaboration with the Ministry of Public Health and the Ministry of Youth and Sports, established a Youth Peer Educators (YPE) initiative. The initiative aims to improve youth education and awareness on reproductive health and FP in order to **increase contraceptive prevalence rates among 15-24 year olds** in USAID Mikolo intervention areas.”



Page 21 of the final evaluation of the Mikolo Project expounded on the youth program and illustrates the partnering with Marie Stopes International for implantable contraception.<sup>29</sup>

#### New Youth FP Users

The most successful adolescent and youth intervention has been the increase in new and returning FP users associated with the establishment of trained YPEs, as described in the USAID Technical Brief on peer education and contraceptive use.<sup>24</sup> Mikolo trained 2,639 YPEs on the following: a) youth and adolescent reproductive health and other issues, b) how to establish and lead a youth group, and c) their data reporting responsibilities. The YPEs created mixed youth groups with 15-25 members resulting in an estimated 39,600 to 66,000 youth group participants. An increase in FP users among the 15-24 age group was noted in the period following the YPE training in July and August 2015. Between the YPE training and Q1, FY 2017, 1,892 youths became new users. Moreover, within the first four months after the YPE training, returning users among youths increased to 7,205 whereas in the 10 preceding months, there were only 6,226 returning users. Youth leaders reported a wide range of FP promotion activities that were confirmed by members of their own groups. For instance, a few female youth group members reported being referred to their CHV including a few who were then referred to Marie Stopes where they obtained implants. Members of another group reported only learning the abstinence only message. Other contributing factors to the youth FP uptake are likely to be latent demand for reproductive health information and safer sex among adolescents and youth.

Since 2014, both Population Services International and Marie Stopes International were directly involved in the contraception component of the Moloko Project. USAID Mikolo’s wordpress site<sup>30</sup> says:

“The USAID Mikolo Project signed its first official collaboration with USAID partners, **first with #MarieStopesMadagascar spelling out collaboration to promote family planning services and to provide a whole range of FP methods** to address community demands in each of the eight regions where USAID Mikolo Project is working.”

<sup>28</sup> <https://usaidmikolo.files.wordpress.com/2014/11/youth-peer-education-and-contraception-technical-brief-usaid-mikolo-20172.pdf>

<sup>29</sup> [http://ghpro.dexisonline.com/sites/default/files/WITH%20ANNEXES%20383%20MDG%20Mikolo%20Eval%20Draft4%2012-19-17\\_Mission%20approved.pdf](http://ghpro.dexisonline.com/sites/default/files/WITH%20ANNEXES%20383%20MDG%20Mikolo%20Eval%20Draft4%2012-19-17_Mission%20approved.pdf)

<sup>30</sup> <https://usaidmikolo.wordpress.com/partenariat/>

Further down, the article entry explains that the contraception and abortion promoting organization, Population Services International (PSI), had also become a partner of the Mikolo Project:

“A second partnership signed. After Marie Stopes Madagascar, USAID Mikolo Project extended its partnership with PSI Madagascar. A memorandum of Understanding was signed yesterday at PSI office to ensure collaboration between the two USAID partners.”

At the end of the article, USAID Mikolo indicates that a “signing ceremony was held at the beginning of July 2014,” indicating that these two organizations were intimately connected with the Mikolo Project for the spread of contraception, from the very beginning.

### **Conclusion**

When Catholic Relief Services entered into the agreement to participate in the Mikolo Project, they would have known that the spread of contraception by CHVs was among the highest priorities of the project. This is evidenced by several things:

- 1) the earliest reports of the project stating an intention to spread contraception
- 2) the background references to the problems in SanteNet2 regarding lack of financial incentives for CHVs to maintain their spread of contraception
- 3) the stated exemption for CRS that “CRS will not be asked to provide service delivery related to family planning and reproductive health.” This exemption would not have been stated if CRS was unaware of the project’s intentions.

Given this knowledge of the project’s goal to spread contraception using CHVs, and since CRS was responsible for establishing the financial engine for funding the CHVs in their contraception-spreading activities in the form of SILCs, there can be only one conclusion: those CRS employees involved with the Mikolo Project, from top-to-bottom, were in full knowledge that CRS was being willfully used for a project intended to spread contraception. Furthermore, the inclusion of video showing a CHV preparing to administer a shot of the hormonal contraceptive called “Confiance,” with the narrator discussing how the CHVs (funded through CSLF) promote the “adoption of health enhancing behavior” indicates that those involved with the video project also knew that the CHVs were spreading contraception through the financial means established by CRS.

Finally, and perhaps most importantly, CRS leadership was made aware of serious problems with its Madagascar operations prior to the Mikolo project. Population Research International published a report on CRS’ previous activities with the SanteNet2 project and led CRS to implement measures to review its programs for Catholic identity. Unfortunately, serious problems have again surfaced in an area already under the microscope for previous failings.



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