FAILURE REPORT: Learning from our failures to ensure we Do No Harm

As the world scrambles to respond to the COVID-19 pandemic, aid and development agencies have found themselves on the frontline of responding to the risks posed by the virus. Responding to COVID-19 may introduce potential harm –to the staff and fieldworkers working in communities.

How do we ensure that we do not do harm, as we undertake our work? Where have we had poor judgement, and what have we learnt from this to ensure that harm is avoided in the future?

In the context of promoting transparency, we believe that it is important to identify and share our failures so that other international development organisations can avoid the same pitfalls and continue to uphold the principle of 'Do No Harm'. The 'Do No Harm' principle reminds aid practitioners of the importance of recognising the potential for negative effects associated with aid intervention. The Do No Harm principle prioritises human welfare by protecting safety, safeguarding, preventing sexual abuse and harassment, fraud, exclusion on the basis of gender.[1] CBM Australia employs a rigorous practice of self-monitoring and self-reflection to ensure that harm is avoided in the future.

This report highlights where we fell short of our Do No Harm objectives, or where we recognised the risk and acted on it. The purpose of this report is to outline what we have learnt from these situations. We hope these accounts demonstrate our commitment to grow in both our programming and as an organisation.

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[1] Core Humanitarian Standard (CHS) principle 3. Accessed 12 May 2020 from https://corehumanitarianstandard.org/

At risk for those at-risk: Staff and the risk of harm during the COVID-19 pandemic

Where we could fail:

The global COVID-19 crisis has created an unprecedented challenge for groups working in international development and amongst vulnerable communities. While it is necessary for development groups such as CBM Australia to respond to the crisis quickly to ensure that the communities we support are protected from the virus, we must also recognise that our response will require staff to work in communities where people may have the virus, putting staff at risk. If we do not take adequate care and design a program that will be responsive but also prioritises our staff and partner staff's health and well-being, we may put them in a risky situation.

What we must learn:

Program design must be aware of all the risks that people face, not just those in the communities we help, but in some cases the position of staff members in responding to crises, may be exposed to harm. To ensure we minimise harm, we must continue to do regular risk assessments to reflect the changing situation during crises. We must ensure our communications with the field staff the risks and options, and also to the donors to ensure they are aware of how the program is proceeding. Staff and partners should be given a chance to voice their concerns and have choices about how they will be involved without negative consequences.

Using numerical benchmarks to indicate program success

Where we failed:

CBM Australia supported a program in South Asia designed to improve economic development for people living with disabilities and other marginalised groups through a series of activities. The program used targets to indicate how many beneficiaries should be reached through this program the aim was to engage 90% of the eligible population of people with disabilities within that area.

To ensure the project reached this aim, a set number of people would need to enrol in each activity. The question of harm arose when it became clear that the people with disability who were already socially active in the community got most involved in the project, while the most marginalised people with disabilities did not receive the same benefit, because it took more time and effort to involve them.

The harm in using numerical benchmarks to demonstrate success within the program is that the numbers do not ensure the benefit is felt throughout the community. There was concern that in order to reach set quotas people with disabilities might have been coerced into participating, or once enrolled there might not have been adequate support for their needs, or may have had to forego paid employment to participate.

What we learnt:

Using targets can incentivise poor and exclusionary practices. In this instance, educating the partner on alternative markers of success would ensure that these practices were not repeated. The implementing partner had a strong emphasis on reaching quantitative targets while qualitative targets relating to inclusiveness were not yet as well upheld, valued or understood. We realised that while we can suggest good practices, it can take time to build up a shared understanding and organisational alignment. In this instance, CBM Australia had a role as a "critical friend", but also had an obligation to help the partner effectively reach people with disabilities who were at the margins.

Data collection and sensitive questions: what we leave behind

Where we failed:

While being part of a program in a Pacific-island country designed to help understand the gender roles in collecting water in a remote community, the CBM Australia team realised they had introduced an unintended risk of harm to the participants. The team had been asking who collected water, how long it took and what challenges existed for people with disability, and for women with and without disability, in essence, the questions were discussing the difference in men and women's workloads. These questions raised the question of harm, because the women sharing these personal stories angered and embarrassed the men. We knew there were high levels of gender-based violence in this community, but we did not think about what might happen once we left, or how our questions might exacerbate this

CBM Australia had assumed the partner would follow-up with the people who had shared their experiences, to ascertain whether the discussions had caused any repercussions, or if there was further support they needed. However, it was unclear to what extent this process occurred or if it was handled appropriately - as there were difficulties with tracking the follow-up once we had left the community. We also discovered that the referral and support services that did exist lacked the sufficient capacity to address the key concerns.

What we learnt:

The problem was that we did not appropriately consider the ramifications of our questions or actions. When supporting partners to collect monitoring and evaluation data in the field, organisations need to ensure that support is available for staff to be able to effectively manage and respond to gender based violence disclosures. Current and future training and advisory work requires adequate resourcing to ensure that due diligence and high quality practices are followed, to ensure possible unintended effects are evaluated effectively – as much as possible in advance. Strengthening our advisory work with partners means ensuring that project feedback mechanisms are accessible and appropriate, particularly when we are working with adults and children with disabilities. This way we can monitor for any unintended harmful outcomes as well as positive change.

We’re just a little DPO - you’re expecting too much!

Where we failed:

CBM encourages active consultation with disabled people’s organisations (DPOs) for advice and direction in program design and implementation. However, when working with smaller DPOs, such as those in Timor-Leste, they might feel there is pressure to prioritise our activities, and at the expense of their own activities. There are also situations when we expect them to provide their input free of charge.

We often draw on people from DPOs to raise awareness of issues by telling their personal stories of hardship – it helps emphasise our messages. However, asking people living with disabilities to recount their story of discrimination and to keep repeating the challenges that come with living with their impairment may not be a positive experience for them.

What we learnt:

Working with DPOs means having good processes in place, including having ways they can raise complaints or concerns. This usually takes time to evolve both systems and levels of trust. We have prepared a brief risk checklist that partners can use to consider safe and appropriate ways to work with DPOs. It will increase awareness of risks often overlooked, and provide simple guidance for program designers and implementers and funders, using a do no harm approach. This is particularly crucial for smaller, new or emerging DPOs that are still developing their identity, purpose and structures.

We know there are many forms of discrimination that disempower adults and children with disabilities. It is important to be aware of the ways we can reduce risk, increase safer practices and use a range of strategies to safeguard dignity and wellbeing for people with disabilities. We should not assume that people are happy to talk publicly about their disability.

Where are my drugs? Not having a Plan B

Where we failed:

Working in challenging political terrain can introduce new and often unanticipated challenges to programs. Undertaking a program designed to strengthen the capacity of an African Ministry of Health to provide primary healthcare services, it became evident that the political landscape might affect the delivery of a successful outcome.

Initial phases of the project progressed well with the training of local healthcare workers in the provision of counselling and medication for mental health conditions. Key activities that were undertaken included strengthening services and referral, and training primary health care workers. Where challenges arose was when delivery channels for drugs were obstructed by conflict, and there was a delay in government-paid salaries to workers in healthcare services, resulting in difficulty in accessing supplies and making the provision of medication difficult.

Such reliance on the delivery channels and government functioning risked leaving people with mental health conditions without access to much-needed medication. The question of harm here was the lack of alternative supplies or back up plans for times when supply was low or accessing medication was difficult. People, who were already facing multiple risks of discrimination and vulnerability, were now facing greater risks of harm.

What we learnt:

This project illustrated the risks involved with working governments in unstable political climates, and without adequate supplies, particularly medication. The lesson that can be drawn here is that in future projects with similar approaches, we will need to include the provision of alternative contingency supplies of medication, for example through a partner NGO. Additionally, alternative support and care options for people involved in the project are identified ahead of time.

The kids are in school, but are they ok?

Where we failed:

CBM's partner in the Philippines has had very positive outcomes for supporting children with disabilities through improved healthcare, rehabilitation and parental training. They also support children with disabilities to access school. The challenge here arose in ensuring the consistent quality of these education opportunities for children with different disabilities. The project team realised that children risked harm through additional isolation and discrimination if not supported in the classroom. Thus, it was not sufficient to simply ensure that children with disabilities were physically in school, they needed to access adequate resources to thrive. The harm in this case was the inability to address and advocate for inclusion without national government support. We are addressing and advocating for disability inclusion at a local level, but the government schools involved in the project are managed at a national level. And at a national level, there is little policy action directed at improving inclusion or resourcing for local schools. We continue to tackle inclusion and addressing gaps on a school-by-school basis but acknowledge that there are sustainability issues with this approach.

What we learnt:

This project focused on improving educational opportunities, for children with disabilities, using a community based development approach. The *do no harm* question that arose here was on the role of a locally based advocacy and programming approach, to support children with disabilities to increase access to education, when facing constraints at a national level in support and resources. Key potential risks of harm were putting children with disabilities into unsupported school environments weighed against the alternative of them not having any access to any educational opportunities.

Undermining social cohesion by introducing jealousy within the community.

Where we failed:

Findings from an evaluation from a project in Niger highlighted the risk of doing harm to the social cohesion of the community. The project design involved creating vegetable gardens for the families and individuals living with disabilities as a source of income. While the majority of the community responded positively to the project, the gardens did have the potential to become a source of jealousy within the community. When the project first started community members expressed the wish that they too could have a member of their family with a disability in order to have access to a garden and the benefits this would bring. Commentary of this nature raised concerns that the program was introducing jealousy within the community and the gardens may be looted or damaged as a result of jealous community members who were not benefiting from the gardens.

What we learnt:

Once identified as a potential source of harm to the social cohesion of the community, the project sought to emphasise the change in attitude and mentality of the community. While the aim was always to build an inclusive environment, it became imperative that educating the community became a central pillar in this project. The evaluator felt this aim was met, stating, "With education, the attitudes have changed."

It did raise the question about how to manage CBM relationships with poor people *without* a disability community, and perhaps encourage projects where the benefits are shared more broadly.

Understanding informed consent and the use of photography

Where we failed:

Collecting stories, photos and videos about CBM's work with people with disability is important for our fundraising and advocacy. However, sometimes we wonder if we have done harm in the process. When visiting a project in Bangladesh the team planned to collect testimonies from people with disability for a video. We went to extra efforts to develop a simple graphical story to show to people with intellectual disabilities so they got an understanding of what the film footage and stories would be used for. The chart had smiley and sad faces they could point to, to indicate their consent to be filmed.

While this consent process was clear, the team encountered a challenge when a young girl with intellectual disabilities who was facing a lot of pressure from her mother to participate. While the girl agreed to be involved, it became increasingly clear that she seemed visibly uncomfortable with the idea of being filmed. The question of harm raised here was the concern about whether the young girl might have been in trouble if her mother felt her daughter had lost the opportunity to participate. Here, it is important that our needs do not create adverse reactions for the person whom we film or interview.

What we learnt:

Consent processes for collecting photos and videos must ensure that the person involved willingly gives their consent. These processes need to clearly explain what the photo and videos will be used for, and that the person being photographed can withdraw consent at any time.

We knew that working with people with intellectual disability and mental illness has its own challenges, but we realised we need to think more about how to engage parents or community workers so that they don't pressure interviewees. We know that one of the biggest barriers faced by people with disability is the attitudes of others, so we do not want family members to come away from the process frustrated by the performance of a person with an intellectual disability. We need to respect people's right to be portrayed accurately and with respect. This involves thinking about the finished product, but also about the process by which we sourced the photos and images. And we have to be even more careful when working with poor communities, where there are obvious power imbalances between the donor and their film crew, and the participants as beneficiaries of the project.

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May 2020

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