

DO NO HARM IMPLEMENTATION STRATEGY for Care and Support of Orphans and Vulnerable Children

DNH recognizes that in the implementation of development assistance, there is a possibility of inflicting unintended harm, particularly in relation to vulnerable populations such as children and people living with HIV (PLHIV).

“Do No Harm” is a basic ethical principle most commonly recognized as it is applied to health and medical research. “Do No Harm” means that in the implementation of health activities, be it treatment or intervention, the implementer will not, intentionally or otherwise, harm the subject. In “Ethics in HIV-Related Research within CRS,” the types of harm are identified as emotional or psychological, social, physical, financial, legal or moral harm. From the delineation of these types of harm, it can be inferred that the “Do No Harm” ethical principle is applicable to a multitude of disciplines. For this reason, as well as it is in keeping with Catholic Social Teaching (CST), CRS has initiated the Do No Harm (DNH) implementation strategy for its orphan and vulnerable children (OVC) programming.



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DNH is a plan to actualize and apply this ethical principle throughout CRS’ OVC programming. DNH recognizes that in the implementation of development assistance, there is a possibility of inflicting unintended harm, particularly in relation to vulnerable populations such as children and people living with HIV (PLHIV). DNH is intended to systematically and uniformly control and mitigate unintended, potential harm. DNH increases the awareness of implementers, provides strategies to identify, minimize and overcome harm — potential or actual — and provides a framework for consequences for those who do not comply with these standards. The principle of DNH provides the ethical foundation for every aspect of program design, implementation and evaluation.

OVC are often the recipients of care and support, which is much needed. However, even in the administration of support, its very presence may cause harm to individuals, families, communities, national institutions, as well as implementation staff. Individuals and families may experience internal and external stigmatization, discrimination, sexual harassment, exploitation, violence, conflicts within families, and/or emotional harm. Communities may experience jealousy as a result of the support; pre-existing safety nets may be undermined; and corruption and/or misuse of funds and materials may result from a well-intentioned project. Implementation staff may experience fatigue, emotional stress, envy, or even face retribution from communities. Using DNH, the potential for harm can be identified and addressed to minimize its consequences.

To adhere to CRS ethical and CST principles, all CRS projects must consider the possibility of unintended harmful consequences in design, implementation, and monitoring and evaluation (M&E) activities. A systematic and thorough analysis of potential harmful consequences of the project should be documented in the project proposal M&E plan including detail as to how the

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project will minimize or eliminate the risk of the harmful consequences.

COLLECTING INFORMATION FROM CHILDREN

As always, researchers should function within appropriate national and international legal guidelines and ethical standards. This is of particular importance when working with children. To fully understand the effects of interventions targeting children, it is critical to have direct feedback from those same children. Children provide a depth and breadth of information into a program that may not otherwise be possible. While sometimes sensitive and challenging, this type of feedback is essential for a number of reasons:

1. As direct beneficiaries, children's perspectives can provide insight into the direct effects and impact of the intervention.
2. Children do not experience life and events in the same way as adults. Children may have a very different response and interpretation of events than adults, so it is not safe to assume that an adult perspective reflects a child's.
3. According to the Declaration of Universal Human Rights and the Rights of Children, children have a right to be heard. This right includes the right to provide feedback of development programming that impacts them.
4. Adults in a host family or community may be unaware of the problems facing children or may only be superficially aware of the issues.
5. Host family members and/or other adult community members may contribute to the harm to a child, willfully or not, may not be aware of this harm and/or willing to report the problem.
6. CRS and/or partner staff and volunteers may contribute to harming a child and may also be unwilling to report it.

With the information obtained from children, feasible and acceptable solutions to their potential issues can be properly targeted.

ETHICAL CONSIDERATION IN DATA COLLECTION INVOLVING CHILDREN

In order to ensure that OVC projects are progressing as planned, it is often necessary to collect data directly from the children involved in the projects. However, there are many ethical issues involved in data collection



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KEY PRINCIPLES OF ETHICAL RESEARCH WITH CHILDREN INCLUDE:

1. Obtain informed consent from children and their parents/guardians, and ensure they feel able to withhold their consent and discontinue involvement at any point.
2. Children's confidentiality should be respected, except where they are at risk of harm.
3. Allow adequate time to prepare adults, children and young people. Don't rush.
4. Be clear about how the information is going to be used and who will participate in the analysis.
5. Be clear about roles, relationships and power.
6. Never use your own authority or age to pressure a child to participate in the interview, evaluation, or discussion.
7. Be kind, considerate and gentle with the child during the interview.

Children should be reassured that if they do not want to answer any further questions, they have the right to refuse. Their refusal must be respected even if the adults present disagree.

from children. These issues include confidentiality, end use of research, stigma and coercion. When collecting information from children, maintaining confidentiality is often key to building a trusting relationship with a child. Children are dependent on others for care and support and therefore vulnerable. To collect data from children, informed consent must be obtained from the parent or guardian. “Informed consent” is the voluntary consent to participate in data collection. This consent should be documented via a local government-approved standard release document.

While the guardian gives permission for the child to participate, it is the data collectors’ responsibility to ensure that the information collected can not be used to cause additional harm to the child. This may mean that the information is collected when adults are not present, provided the guardian and child consent. In areas where there is stigma associated with the program, it may also mean that interviews are held in private locations. The child should be reassured that their information will be kept safe and confidential as well as reassured that mitigative actions will be taken where appropriate.



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Data collection can be time consuming. Children in particular may become restless with questioning. Every effort must be made to ensure that data collected from children is not coerced or manipulated. As children are dependent on adults, they may not have the capacity to refuse and adult’s request. When collecting data from children, permission must be obtained from the child continuously to continue interviewing. Children should be reassured that if they do not want to answer any further questions, they have the right to refuse. Their refusal must be respected even if the adults present disagree.

DATA SOURCES

For both monitoring and evaluation (M&E) related to OVC programming, children are often the primary data source. Others who can provide information on the children are also often included as secondary sources. When conducting M&E, the socio-cultural and political context of the project and community must be considered to judge the appropriateness for collecting data from any specific person or social category.

Respondents can be categorized into 4 groups:

1. Direct and indirect child beneficiaries

Data should be collected from direct and indirect child beneficiaries. Children should be encouraged to express themselves and provide their project experiences.

2. Direct and indirect adult beneficiaries

Data should be collected from direct and indirect adult beneficiaries as they may provide insight into unintended negative program effects. Adult household members, particularly grandmothers should be included. Interviewers should be reminded that while adults may provide information on the children, they are unlikely to reveal problems they cause the children.

3. Community members

Data can be collected from informed community members, those who are aware of the OVC and who are familiar with the project. Community involvement may be necessary because OVC beneficiaries may be reticent to report harm in fear of retribution, especially

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when very sensitive, such as sexual abuse or harm done to them by their host. They may also fear that if they report any negative effects concerning the aid they are receiving, it may be withheld as a punishment.

4. Home-visitor volunteers

Home-visitor volunteers, including those providing home-based care, are well placed to provide information on the unintended

negative project effects experienced by OVC. Like adult beneficiaries, it is unlikely that home-visitor volunteers will reveal problems they cause children.



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TYPES OF INDIRECT DATA COLLECTION TECHNIQUES PARTICULARLY APPROPRIATE FOR CHILDREN:

Data collection from children can be done in a variety of ways. However, it is important to remember that developmentally, children are at different levels than adult populations. Therefore, data collection should always be done in an age-appropriate manner. While many programs often employ standardized questionnaires, at times, it is also important to explore other participatory methods including some examples provided below:

1. Children's narratives
2. Role-play/skits
3. Songs
4. Drawing with specific topics
5. Direct observation
6. Visioning the future
7. Development of success indicators by/with children
8. Hypothetical questioning
9. Discussing the child's perception of the effect of their behavior on others
10. Mapping of the child's community

CONFIDENTIALITY

When providing feedback to communities and stakeholders, maintaining confidentiality is critical. The interest of beneficiaries must always be protected and individual names should not be revealed in public or group meetings. Incidences of harm should be reported without using identifying information. However, in some instances, CRS program and partner authorities



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will require full information, which they are required to hold in confidence, to address particular situations of harm.

Confidentiality is necessary for cases of conflict within households and other situations which, if divulged to others, could further or increase the harm. Confidentiality should be maintained for the child as well as the accused individual until the proper channels are used to determine action. ■

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CREDIT

The Do No Harm Implementation Strategy was conceived by Ruth Kornfield in 2006. Daphne Williams and Shannon Senefeld have since worked on the document and the advancement of this concept with ongoing technical feedback from Dr. Kornfield. The CRS Cameroon program was instrumental in piloting initial ideas. This brief was prepared by Daphne Williams. The full report will be published in early 2009.

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PHOTOS

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