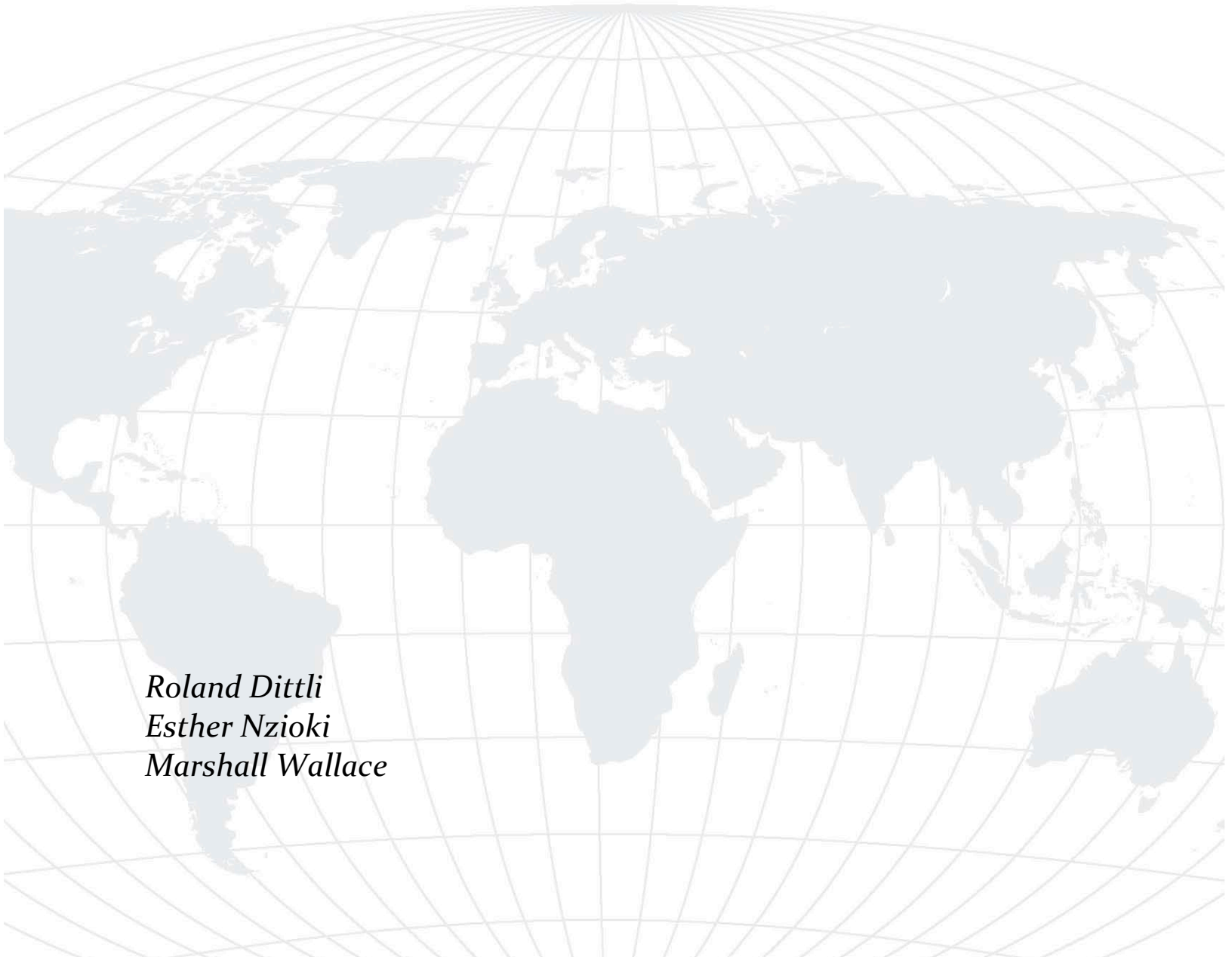


DO NO HARM PROJECT

Integration of DNH in Kamwokya Christian Caring Community; Kampala, Uganda

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This document was developed as part of a collaborative learning project directed by CDA. It is part of a collection of documents that should be considered initial and partial findings of the project. These documents are written to allow for the identification of cross-cutting issues and themes across a range of situations. Each case represents the views and perspectives of a variety of people at the time when it was written.

These documents do not represent a final product of the project. While these documents may be cited, they remain working documents of a collaborative learning effort. Broad generalizations about the project's findings cannot be made from a single case.

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Not all the documents written for any project have been made public. When people in the area where a report has been done have asked us to protect their anonymity and security, in deference to them and communities involved, we keep those documents private.

Introduction to the Do No Harm Reflective Case Study Series

In 2006, the Do No Harm Project of CDA Collaborative Learning Projects (CDA) set out to determine how Do No Harm (DNH) was being used in the world and whether that use was leading to more effective programming decisions. A series of Reflective Case Studies were written in multiple countries to determine how practitioners in those places are learning, thinking about, using and spreading DNH. Some organizations are experienced and effective in applying DNH principles and framework to their work, while others are struggling. This range of experience provides valuable lessons. Whether implementing DNH in their daily work, in their program design and monitoring, or in shaping policies and organizational procedures, the cases look at where in their work people find it easy to use DNH, where they find roadblocks, and how (or if) they overcame them.

Acknowledgements

This case study would not have been possible without the openness of the Kamwokya Christian Caring Community. We were welcomed as though we were old friends and given complete access to every part of the organization. Many people gave their time to talk with us and they allowed us to follow them around during their daily work, even as we asked question after question. We thank all of them for their time and generosity.

Uganda

Uganda became a British protectorate in 1894 and Britain drew borders around and through land that had formerly been separated among various tribes. Tribes, especially in outlying areas, did not know that these arbitrary international borders existed and could restrict their movement. In 1900, the British signed an agreement giving autonomy to Uganda in a constitutional monarchy controlled by the chiefs of various tribes.

In the 1970s and 1980s Ugandans suffered human rights abuses under the military dictatorship of Idi Amin and his successor, the democratically elected Milton Obote. After a series of military coups, in 1986 Yoweri Museveni was installed as president. Under Museveni's leadership, there have been a number of democratic and economic reforms. Human rights abuses, especially those perpetrated by the military and police are down, inflation has decreased and the economy has grown. Uganda's 1995 constitution restored political parties, but upheld a long-standing ban on political activities. This ban was maintained by a 2000 referendum. In 2005, however, another referendum opened Uganda up to multiple parties and Museveni was re-elected in 2006 in multi-party elections.

In 1993, Museveni restored the traditional kings of Uganda to their positions. The kings had no political power, but their traditional authority was recognized until their death. Upon a king's death, his power was not transferred to an heir. Ugandans know who the heirs to their tribal kings would have been, and many of these heirs are now in Parliament. In 2008 the last traditional king of Uganda died.

Since the mid-1980's the conflict between the Ugandan government and the Lord's Resistance Army (LRA) has been driving the people of Northern Uganda into internally displaced person (IDP) camps and settlements in the South. Since the August 2006 truce was declared between the two parties, conditions have improved and a permanent cease-fire was signed in February 2008 in Juba, Sudan. However, attacks on civilians have continued from armed Karamojong cattle rustlers, remaining LRA rebels and undisciplined military forces.

The UN estimates that nearly 1.6 million people have been displaced by fighting in the North, and that the LRA kidnapped over 20,000 children during the conflict. The government's IDP policies, adopted in 2005, were some of the first ever adopted and are among the most comprehensive of any government. However, the government has failed to fully implement these policies so many of Uganda's IDPs have still not been reintegrated into their home districts.¹

The Ugandan government has launched a vigorous campaign against HIV/AIDS. In the 1990s, up to 30% of the population was infected with the disease and since the 2000 the infection rate has been in the single digits and continues to decline. In 2001, infection rate was 7.9% among adults. By 2007, the infection rate had declined to 5.4%.² However, infection rates in the densely populated slums of Kampala have historically been much higher than the national average. In 2005, the rate of infection in Kampala was estimated by Caritas and KCCC to be 28% compared to 6.5% in the country as a whole.

Kamwokya

Kamwokya parish is located in the capital city of Kampala, Uganda. The two square-mile area of the parish is home to 20-30,000 people, according to a 2008 census targeting the resident population. Kamwokya is made up of unplanned settlements with poor drainage and waste disposal systems. The population of the parish has highly transient characteristics; residents move from one parish to another and within the slum as they seek better housing, affordable rent and employment opportunities. The community is comprised of multiple tribes, refugees from neighboring conflict-afflicted countries, IDPs from the Northern Uganda, and families that are affected by HIV/AIDS. On average, a Kamwokya family has six to ten members sharing a six square meter mud/brick shack. Many families are headed by women, and some by children who have been orphaned due to AIDS.

The Kamwokya Christian Caring Community, Kampala, Uganda

Kamwokya Christian Caring Community (KCCC) was established in 1987 to provide care to those infected and affected by HIV/AIDS in Kamwokya, a slum area of Kampala.

A group of Roman Catholic residents of Kamwokya started the organization because they felt the Bible called upon them not only to pray, but also to perform service for their community. This decision occurred at the time that HIV/AIDS became prevalent in Uganda. The group was proactive in their approach. KCCC started a clinic to help those diagnosed with HIV/AIDS recover from diseases contracted because of their compromised immune systems.

In a short time, people involved in KCCC realized that it was not enough to help someone get well through visits to the clinic; they needed to create a structure that would help people use available therapies to treat their illnesses. The organization found that they could not trust that people were taking their medication when they were outside the clinic. They also recognized that when an individual becomes sick, their family's other needs are not met: children drop out of school and parents may lose jobs or businesses to stay home. As household income and earning power drop, food availability goes down. A sick person cannot heal without proper nutrition.

¹ "Northern Uganda: National and International Responsibility." Statement by Roberta Cohen to the Panel on the Human Challenge in Northern Uganda. Brookings Institution. April 30, 2007.

² "2008 Report on the Global Aids Epidemic: HIV and AIDS data 2007 and 2001". Annex I. page 215 UNAIDS

KCCC wanted to break this cycle of cascading effects of illness. They set out to develop the capacities to address each issue they identified.

The organization trains Community Health Workers (CHWs) through a rigorous six-week program. Initially, this all-volunteer force made home visits to comfort people and ensure they were taking necessary medication. Currently, the group consists of approximately ninety volunteers, each the equivalent of a licensed nurse. The CHWs perform baseline needs assessment surveys and talk to patients' families, children and neighbors. Each of the volunteers grew up in Kamwokya and they are trusted by the community. The CHWs work with people to make sure they are taking responsibility for their lives, their work and their families.

In addition to healthcare, KCCC focuses on youth and children in Kamwokya, because they have identified children as the most affected by poverty. There are few children in Kamwokya with no guardians. Many children came to Kamwokya from rural areas with their families. When their parents have difficulties finding work, some children are left with relatives in Kamwokya while their parents return to their villages. KCCC started a primary school and youth programs for these children, many of whom would be forced to beg or turn to gangs without the opportunity to attend school. It is a point of pride for KCCC that there are no child beggars in Kamwokya.

From their start as a Bible study group with a dedication to community service, KCCC has grown into an organization with departments dedicated to healthcare, mental health, child welfare, education, vocational training, advocacy and micro-finance (see Appendix II). KCCC operates as a faith- and community-based organization, whose mission is to improve the quality of life of the most disadvantaged and vulnerable people in Kampala by enhancing their capacity to identify and address their social, health, economic, spiritual, cultural and development needs.

Do No Harm in KCCC (See timeline in Appendix I)

KCCC and Do No Harm Training

In 2006, Caritas Switzerland organized a follow-up Do No Harm training in Uganda for two of its partners, KCCC and Mbarara Archdiocese HIV/AIDS Orphans Project. Caritas employed the expertise of John Okanga, a trainer from the Local Capacities for Peace Office based in Nairobi. Okanga worked as the lead trainer in collaboration with Peter Biyansi, Rita Atukwasa, Annete Nyongore and Esther Nzioki as co-facilitators. The workshop had two objectives. First, it was to build on the capacity and knowledge of the four co-facilitators previously trained in Nairobi by providing them an opportunity to apply their understanding of the tool as they co-facilitated with the LCPP trainer. Second, the Do No Harm workshop would introduce the tool to more partners in Mbarara and in KCCC.

Three more people from KCCC, Robert, the school Headmaster at Sister Miriam Duggan Primary School at the time, Magdalene, the Head of the Child Welfare Department, and Robert Francis, the Head of the Vocational Training Centre attended the workshop. In total, there were 30 attendants at the 4 day workshop held in Mbarara, Uganda.

After the Training: Organizational Uptake of Do No Harm

After the first training in 2005 in Nairobi, Peter and Rita, in a fifteen minute session, sensitized the entire staff of KCCC on the Do No Harm tool during the morning praise. They highlighted key concepts, such as the *Connectors* and *Dividers*, as a means of reviewing programming to help inform project implementers

build on the strengths of their interventions and to reduce the harm that may result from their activities with the community members. Morning praise is a 30-minute meeting that KCCC holds each morning for all staff from all departments. In these meetings the staff sing and pray together and afterwards update each other on key issues of importance, new concepts or ideas and share their experiences. It is a session that is meant to bind the staff together, give them a chance to catch up and rejuvenate them as they start their day.

After the meeting, Do No Harm became so familiar to staff, that it was used as a running joke around the office. Every time someone suggested an activity or a course of action, whether at the project intervention level or at the individual level, they were jokingly asked, “Hey...are you sure you are not doing harm?” or, “...by doing that, are you doing harm or good?” In this fashion, the Do No Harm concept spread throughout the organization and was taken up by individuals as they worked in the various departments. Even though most did not fully grasp all the details of Do No Harm, the most important concept of assessing whether their work was harmful or helpful was well understood. In the course of discussions during this field study, it was evident that when Do No Harm was mentioned, a lot of the staff were aware of what the concept was about and were actually using it in their daily work.

After three more KCCC staff were trained at a second training in 2006 in Mbarara, those staff led re-sensitization at the morning praise. The joking continued, and more interest was created. Moreover, one staff member said that the Do No Harm tool became stronger because there were more people in the organization who understood it were able to explain the concepts.

Subsequently, another meeting was organized with the top management to brief them on the tool in detail and find the way forward in streamlining the tool into their work. One requirement agreed upon at the training in 2005 in Nairobi by all Caritas Switzerland partners was to have the partners draw up a Do No Harm analysis during the project design phase, and this should be attached to any proposal they submitted for funding. At the management meeting, after hearing an update from Peter and Rita after the training, the Executive Director, Francis Mbazira, said, “The first thing that came to mind was, ‘*that is so obvious*’. We have been doing that; we just did not give it a name.”

Nevertheless, the management team went ahead and supported the streamlining and mainstreaming of Do No Harm by suggesting the formation of a *Do No Harm* task force. The task force was charged with several responsibilities that ensure that Do No Harm was taken up and integrated within all the KCCC departments. The key decisions included:

- The task force would sensitize the head of each department
- The Department Heads would then introduce staff working under them to the Do No Harm tool
- The task force would review the KCCC program with DNH in mind
- The Do No Harm analysis would be factored into the KCCC operations
- Finally after two years, the task force would lead an evaluation of the use of Do No Harm in KCCC.

The task force organized an in-house training in June 2007 which failed to take off because people were “too busy”.

Changing strategies, one department was selected in which Do No Harm would be applied. The Child Welfare Department was selected because it was ready to begin a new project and other departments would learn from its experiences with DNH. This process is ongoing and an evaluation came up at the end of 2008. The members of the task force mentioned that they downloaded more Do No Harm

materials from the CDA website in 2006, 2007 and 2008 that they used as a format to analyze the Give Hope project in the child welfare department to develop a comprehensive list of dividers and connectors and programming options.

Do No Harm in a Non-conflict Setting

One struggle the five staff trained on Do No Harm tool faced was how to apply the Do No Harm concept in a non-conflict setting. During the training, the tool was presented as applicable in conflict-afflicted areas. However, staff could not understand how to translate this concept into their context in Kamwokya, which had a unique set of problems (poverty, poor infrastructure and competition for scarce resources) but no overt conflict. The staff realized that by taking the word 'conflict' and replacing it with 'tension', DNH made sense to them and became applicable to their context. They asked themselves, "Do the interventions we do create more tension among the families or among the communities?" and "How do people perceive us?" As a result they were able to view the tool differently and it became more useful to them.

KCCC's motto is "loving, caring, sharing, and values," by serving their people. The organization wanted to be accepted by the community and help the community to grow.

"We realized that we deal with silent wars, not gang related wars; silent wars for resources and how they are distributed. And we have to ask ourselves, 'Are we building bridges or erecting walls?' We wanted more of the bridges than the walls."

Peter Biyansi—Head of Fundraising

Magdalene, the Head of the Child Welfare Department views Do No Harm as a way of thinking and not a tool. The staff have taken up the tool and given it their own version of localized definitions of the terms connectors as 'helpful' and dividers as 'harmful'.

The task force (those who had been previously trained) did not introduce the *Implicit Ethical Messages* and the *Resource Transfers* concepts to most of the staff because they felt that it might be confusing. They decided to frame these concepts into words that get to their meaning without causing confusion. Using the revised definitions, they have analyzed one of the projects and are using the analysis in the course of their work.

KCCC is drafting a Strategic Plan for the next five years. Most of the staff interviewed mentioned that the DNH analysis is useful in informing various programming options that they will be undertaking in addressing the community's needs.

The Application of Do No Harm in the Child Welfare Department

As with other departments in KCCC, the Child Welfare Department implements a whole range of activities and represents an important cornerstone of KCCC's integrated/holistic approach to poverty reduction and development.

Key activities of the Child Welfare Department (CWD) are:

- Establishing, managing and overseeing foster homes
- Counselling children infected or affected by HIV/AIDS
- Providing school fees sponsorships for orphaned and other needy children
- Providing informal education for needy and HIV/AIDS orphans with no sponsorship

- Facilitating positive parenting seminars
- Overseeing children through school and home visits
- Facilitating parent/guardian meetings
- Training community-based counsellors for children

The department includes both full-time staff and volunteers, of which 40 are trained community-based counselors. CWD works on the basis of a long-term engagement with its beneficiaries. The people and families supported by the CWD are often involved in the activities of other departments too, like Youth, Health, Vocational Training, or Counselling Departments. The initial selection of beneficiaries (which KCCC refer to as 'clients') is done partly upon recommendation from their community-based volunteers, partly through a list of selection criteria, and partly by an individual judgment call. Concerning the latter element it was stressed that a fixed set of criteria must leave enough room to make a *character assessment* of the applicants.

Why the Child Welfare Department?

The Child Welfare Department was selected to pilot the integration and implementation of DNH within KCCC for two reasons. First, the head of the department underwent DNH training in Mbarara in 2006. She stated that she was initially quite skeptical about DNH because she perceived it as an instrument for projects in "conflict areas" or "war zones." However, her skepticism was soon replaced by curiosity and a readiness to look critically at her department's work and its effects.

Second, the CWD is one of the departments heavily involved in the distribution of material goods to beneficiaries and it deals frequently with many of the key people and institutions in Kamwokya. Particularly the "giving" part of their work was prone to creating tensions in the community, and the CWD staff cited a number of examples of how their work – or the way they implemented it – directly contributed to the emergence of tensions:

"At one point we were handing out mattresses to needy children. Before long, some children came back to us crying, because their caretakers had taken away the mattress from them. It didn't take us long to realise that we were creating tensions within the family structure if we hand out something to the child, without taking the needs of the household heads into consideration."

"There were cases where people were actually lying in order to get support from KCCC. Cases of Muslim families pretending to be Catholic because they thought that this would increase their chances for getting support. We asked ourselves, 'Is this what we want to create in our community?'"

"We had some cases where several relatives claimed to be the legal caretaker or guardian of a child. But this only happened after that child had qualified to receive support from us. So they started to fight as a result of the support that was made available by us."

"We had chosen a number of orphans for whom we provided clothes and shoes etc. and for whom we paid the school fees. At one occasion, I overheard a child of a very poor family saying: 'I wish my parents would die, so that I can go to school and get a pair of shoes too.'"

The training in Mbarara was important to increase the level of awareness of the head of the CWD. This gave a name to something which until then was perceived as “a problem” and by adding a certain sense of urgency to solving this particular problem. In the words of Department Head, Magdalene Ndagire:

“One thing I particularly realized during the Mbarara training is the issue of substitution effect. This is a considerable problem for us as a church-based organization, as the church is known to give, to care and to be responsible. So, once a child gets accepted into our welfare or education program, people relax and tend to relinquish their responsibility for this child. They think that now the church takes care of everything.”

How was DNH integrated into the CWD?

The integration of DNH into the CWD was done by Magdalene Ndagire. She introduced DNH in the monthly department staff meetings, focusing on the core concepts and message of DNH (what is “harm,” connectors and dividers, and how the department’s work relates to them). She aimed at sensitizing her staff about the basic tenets of the tool and allowing them to jointly apply “DNH thinking” during planning and implementation of their work.

“After having introduced the topic at our departmental meetings we applied it during planning sessions. Like this, I was able to check whether or not people understood the concept. We also referred to it a lot in our strategic plan.”

Simultaneously, the DNH task force drafted a DNH analysis paper. It includes a dividers/connectors analysis from the perspective of the Orphans and Vulnerable Children (OVC) Program, implemented by the Child Welfare Department. It also identifies programming options to reinforce existing connectors and minimize the influence of potential dividers. This analysis laid out the organisation’s understanding of DNH on paper, in order to get feedback and further input from the visiting DNH consultants in the course of the study tour.

At the management level of KCCC, it was mentioned that after the initial sensitization people started to refer to DNH in all sorts of professional and personal situations and to apply DNH terminology in a joking and light way. It seems that this almost playful exposure to DNH helped in spreading the concept and – ultimately – gaining acceptance among KCCC staff. It probably also helped to give the tool a positive spin; one employee mentioned, “In my view, DNH is a friendly tool.”

What Elements of the DNH Framework Are Being Used; What Elements Are Not?

A distinction can be made between applying DNH as *a way of thinking* or *a concept*, and applying it as a tool, i.e. using the DNH framework. In the case of KCCC’s Child Welfare Department, the active users of DNH apply it mainly as a concept. Key terms of DNH – like “harm” or “connectors/dividers” - are in frequent, explicit and habitual use. This finding also applies to staff that has not undergone formal DNH training. In that sense DNH is not so much seen as an analytical or programming tool but as a concept that can be applied to many other situations as well. As one employee put it, “Do No Harm is something to work with for life. Once you have started you can’t stop.”

Through our discussions, it became clear that the DNH thinking has been taken up and integrated into the work of the department. One important step in this process was the reframing of the question, “Are we doing harm?” KCCC staff asked, “What do we mean by the term ‘harm’ in the context of our work

environment and our kind of work?” This initial question got reformulated into various new questions, specifically applicable to the KCCC environment and the situation in Kamwokya:

“We ask ourselves, ‘Are we dividing or breaking families? Will our work create tensions in or among families? Does our work have the potential to lead to domestic violence?’”

“We asked, ‘Are we building bridges or are we building walls?’ This thought has since grown ever bigger.”

So, the DNH elements in most frequent use are the three key terms mentioned above (harm, connectors, dividers). It seems that these terms relate very directly to experiences of KCCC staff (“Our work created problems”) and can be easily reframed and applied to any specific context. None of the persons interviewed mentioned problems in understanding what ‘harm’ or ‘dividers’ mean in their particular context. This fact probably accounts for the widespread and intuitive use of these key DNH terms.

The dividers/connectors analysis developed by the DNH task seems to have been helpful as it assisted KCCC in rationalizing what the department was doing all along (i.e. stressing family values, avoiding politics) and reflected their approach on a more conceptual level. In some instances it helped to clarify their understanding of certain issues:

“We talked about education and the value of educating our children as a connecting factor among all residents of Kamwokya. But then we had to dig deeper and specify what exactly we are talking about. In the end we concluded that only the education of boys is actually valued by everybody, not so much the education of girls.”

KCCC staff often referred to DNH as a *tool*, i.e. “The tool helped us to do xyz better or to understand xyz”. But the actual DNH tool – the DNH framework with its seven analytical steps – is not really being applied, at least not its complete form as introduced during trainings.

Whereas widespread and explicit use of Do No Harm *vocabulary* could be found in the case of connectors/dividers, this was not the case with regard to resource transfers (RTs) or implicit ethical messages (IEMs). However, even as the terminology is not being used, these aspects of DNH are being considered in the CWD. The examples cited by CWD staff about instances of their work causing problems in the past gives proof of a considerable level of awareness and experience about how many things can go wrong with resource transfers. In the case of IEMs one staff member mentioned:

“I think we are aware of IEMs but we frame the issue differently. We focus on KCCC’s core organisational values (‘loving, caring, sharing and service’) and the message of the particular project. Then we ask our people to behave in a way that is not confusing this message”.

What Has Changed in the Department as a Result of DNH Application?

During our interviews, KCCC staff mentioned a number of instances where the application of DNH resulted in specific work-related changes. These changes took place on many levels.

The Head of the Child Welfare Department mentioned how the DNH training had helped her to realize potential substitution effects of her work. Therefore she modified the key message during meetings with parents/care takers:

“This realization made us change the central theme of our meetings with parents and of our work in general. We stressed that they as parents or caretakers are the main responsible persons for the welfare of their children. We also started to organize children-parents meetings.”

Other changes took place regarding how CWD implemented its work. One staff member mentioned:

“After the DNH sensitization, we understood that the level of participation is influencing the outcome of the activity. We realized that we needed to expand participation by the community.”

Therefore, project staff started to consult in earlier stages of the project development, and to involve community members more in decision-making than before. The application of DNH thinking led to an increase of community participation. As a strategy to avoid creating tensions and conflicts, the CWD staff chose to include both beneficiaries and community leaders in deciding “who is getting what.”

At the same time, CWD staff used DNH thinking during planning stages:

“For every activity we conduct, we discuss potential dangers and opportunities that can arise from it. We ask, ‘Can it create conflict?’ The way we try to find an answer to this is to think ‘How will people perceive us if we take x or y decision?’”

This remark hints at an important ability: the ability to change perspective and to anticipate. CWD staff put themselves in the shoes of their beneficiaries and looked at KCCC. Together with the early and meaningful participation by the community and an intimate understanding of their context, these elements probably go a long way in explaining KCCC’s considerable success, both in avoiding ‘doing harm’ and in implementing sound community development. The CWD seems to “get the details right”. The role of DNH was not to *create* these abilities, as they were already in place. But the application of DNH – according to the KCCC users – assisted users in asking the right questions and helped staff apply these important abilities.

This example illustrates how the application of DNH thinking helped the CWD to get the details right:

In order to improve attendance at the CWD’s regular parents meetings, the department decided to prepare some goods to handout to those parents who show up first to the meeting. It was planned to give a range of different items. When one of the members went to the store to buy the presents, she realized that some of the items were much more expensive than the others. She anticipated that it would probably create tensions among the parents if some received expensive handouts (in this case blankets) and some cheaper ones. She took a decision on the spot not to buy blankets - for which they had budgeted, but to make a selection of items which were all in a similar price range.

Some of the staff mentioned frustrations occurring during their work due to the limited resources and capacities available to them. Whatever KCCC does, it simply is never enough to assist all persons and to

address all the pressing needs in Kamwokya. This forces people to make tough decisions and risk creating friction in the community. The obvious fact that one organization cannot help everyone is not of much help in the day-to-day activities and decision-making. From the interviews it seems that the application of DNH was of some help in this regard:

“We used DNH in the training sessions with volunteers. The essence of our message was that we have limitations and certain parameters we can’t change, so let’s be open and clear about that with our clients. As a consequence, one could say that DNH has helped us being more open and confident with the truth.”

Do No Harm in Other Departments

Examples of DNH application and subsequent changes in programming decisions are not limited to the Child Welfare Department. During our discussions such examples were also reported in other departments of KCCC.

The Sister Mary Duggan School and the Vocational Training Centre stopped giving out items (books and tools, respectively). They realized that the beneficiaries or their family members had often sold the books or tools given to them by KCCC. They instead created a library and a tool bank so that people still had access to books and tools, but both the ability and the incentives to sell the items was limited.

DNH was applied during the planning discussions concerning privatisation of the small loans scheme, the KCCC Empowerment Cooperative Savings and Credit Society Ltd (SACCO) (see Appendix II): *“We had the impression that men felt that women had gained more power, because we gave them a loan. We now aim at increasingly bringing men on board, too. Also, we easily identified potential dividing effects of our work. For example, some beneficiaries—post-test group members—had preferential treatment, so that their applications for grants got reviewed quickly, and some did not have to pay interest on their loans. We have changed this practice so that today everybody started to pay some interest on their loans.”*

What was the contribution of DNH to these changes? One interviewee mentioned that it did not add something fundamentally new to the organisation’s thinking, but rather that it accelerated discussions and the finding of better solutions:

“You people just gave it a name. We were also before any DNH training asking ourselves, ‘How will this activity affect our community and our people?’ People in this organisation always tried to be as sensitive and responsive to the community’s needs as possible. With DNH the concept only became clearer and as such it accelerated and increased our discussions. DNH helped thinking about these issues on a more conceptual level, but we already worked in the right ways.”

In other words, DNH gave KCCC a vocabulary to better understand what has not worked well in the past and why. Words like “harm”, “connector” or “divider” are in frequent use today and surface now in many conversations with project staff, even of those that have not undergone formal DNH training. It helped to reflect and test the “connective effect” of their work, which they see as crucial for their community-based approach to development.

Lessons Learned

It is not necessary to use the full DNH Framework to be effective

KCCC does not use DNH in the standard form of the Framework or explicitly use all of the concepts. Rather, KCCC has adapted DNH to fit into the context in which they work and the culture of their organization. While other organizations have struggled, trying to integrate all the components of DNH into their local context and work, KCCC has instead reframed DNH to fit their needs.

KCCC has boiled down the lessons of DNH into one simple question: “Is this going to cause harm?” This straightforward, unambiguous question, even when offered jokingly among staff, has created a pattern of routinely stopping to reflect on the underlying seriousness of the question and consider how their actions could go wrong, particularly in creating interpersonal or intergroup tensions.

KCCC has many examples (some of them in the text above) of where the simple question about harm caused them to stop and re-evaluate.

DNH Still Makes Sense in Situations of Little Violence

One of KCCC’s initial challenges was in fitting DNH into their generally nonviolent setting. They actively wondered if these concepts made sense in Kamwoyka.

By reframing the concepts of Dividers and Connectors to more accurately reflect their community and its circumstances, they made DNH work. While Dividers and Connectors can refer to those things in a society which contribute to overt violence or active community engagement in peaceful activities, they do not need to carry so much weight in all situations. Dividers and Connectors can also exist in people’s daily lives, reflecting more mundane struggles with illness, domestic violence, and poverty.

KCCC demonstrates a crucial creativity in adapting the utility of DNH. They are willing to change and reshape the core ideas and lessons of DNH to fit into their local context.

There is No “Right” Way to use DNH

Upon arriving at KCCC, we were asked by KCCC staff, “Are we using DNH correctly?” There was a sense of uneasiness that because they were not using the full Framework or all of the concepts, that they were not actually using DNH.

While KCCC’s use of DNH does not follow the exact way it is generally outlined or presented in training sessions, what is more important is how an organization integrates DNH lessons in a logical and useful way in their context. KCCC demonstrates a clear integration of DNH into their daily routines. They have found a way to use DNH principles in a way that makes sense to them and makes their work better and more effective. In this sense, they are using DNH exactly right.

Organizational Characteristics and Mindsets (Culture) Affect Broad Uptake

KCCC has a history of pragmatism and optimism. They always ask themselves what else they can do to further help the people of Kamwoyka. They feel a need to be clear about the circumstances and to be honest about their capacities. Part of this is due to an ability to analyze their own mistakes and develop options. This mentality existed before the introduction of DNH. We repeatedly heard people tell us that DNH was not new to them, but that the language of DNH helped them to be even more focused.

In KCCC there is an openness toward failure and mistakes that is remarkable. They have a strong sense that everything is a lesson and a “failure” today can be turned around into tomorrow’s success. We have seen organizations feel threatened by the introduction of DNH, as taking the concepts means opening identifying and discussing the organization’s mistakes. KCCC was never threatened as they already had a positive attitude of learning from mistakes.


Another remarkable characteristic of KCCC has been the organization’s willingness to forego funding if a donor suggests a project that will not have a positive impact. A crucial part of that characteristic has been KCCC’s commitment to educating their donors (and potential donors). KCCC does not refuse funding, but attempts to work with donors to make sure a programme or project will have its intended impact.

Finally, there is a commitment to learning and education in KCCC. The organization makes use of opportunities to learn new things (such as DNH), sending key individuals to trainings, and also makes sure everyone in KCCC learns at least the core of the topic. When an individual or team learns new concepts that would be useful to KCCC, they are given the responsibility to teach their colleagues in the way that makes most sense according to the context. DNH principles were introduced in this way with two senior staff that were committed to the teachings of DNH and who spread its core ideas throughout the rest of the organization.

All of these characteristics originate at the top of the organization among senior staff and the same mentality is employed by staff members at all levels in the organization.

Because of these characteristics inherent to KCCC, DNH lessons were readily integrated into their system, helping to clarify and highlight the importance of issues they were already considering. In fact, many of the staff commented on the applicability of DNH into all aspects of life both inside and outside of work, even saying that once they started using DNH, they could not stop. They equate DNH as a “tool for life”.

APPENDIX I: Timeline of Do No Harm exposure at KCCC



1994	Start of the Do No Harm tool
2005	Two KCCC members trained on Do No Harm tool in Nairobi organized by Caritas Switzerland and swisspeace. Trainers: Sonja Bachman and Anita Muller Sensitization of all KCCC staff and management of the Do No Harm tool
2006	Three KCCC staff trained on Do No Harm tool in Mbarara, Uganda organized by Caritas Switzerland. Trainer: John Okanga Local capacities for peace Nairobi office Co facilitators: Peter and Rita (KCCC); Annete Nyongore (Mbarara); and Esther (Caritas Switzerland) Re-sensitization of all KCCC staff and management of the Do No Harm tool Formation of the 5 member Do No Harm tool task force
2008	Implementation of the Do No Harm analysis in the Child Welfare Department Evaluation of the implementation of the Do No Harm tool by CDA, Swiss Peace and Caritas Switzerland.

APPENDIX II: Other KCCC Departments

Health Care

The health care programs of KCCC fall into four categories: preventative programs, diagnostic medicine, treatment programs and programs to increase referrals from the community to the health centers. The organization provides immunizations for young children, HIV testing and counseling and community education and sensitization on hygiene, sanitation and prevention of diseases. Diagnostic and treatment programs are run through KCCC's clinics and home health workers. Preventative programs are run through the Treasure Life Youth Center. KCCC has also begun dispensing Antiretroviral therapies to community members with HIV/AIDS.

The Clinic

The KCCC Clinic has been an ongoing project of the organization for over 20 years and has served over 12,000 patients in that time. The clinic is open to anyone from Kampala, not only those who live in the Kamwokya parish. The clinic provides Anti-retroviral drugs (ARVs), Tuberculosis treatment, immunizations for children, malaria treatment and preventative medications, education about sanitation and hygiene and home-based counseling services through the Community Health Workers (CHWs)

The Community Health Workers and the lower-level Health Monitors that work for KCCC also have clients outside of Kamwokya. The Health Monitors make home visits to clients like the CHWs, but rather than providing counseling and other forms of monitoring for patients like the CHWs, the Health Monitors collect data to track illnesses in the communities.

In the course of daily work by a CHW, the worker walked by the vending stall of a client and noted that the client had missed work that day. The CHW went to his home for a visit and said, “You weren’t at work today, where were you?” The client told the worker he had not felt as if he could work, and had stayed home. The CHWs remind their clients how important it is to go to work to be able to feed themselves and their families and they closely monitor their clients’ attendance at work.

Though the clinic provides treatment of HIV/AIDS and other sexually transmitted diseases, they do not dispense condoms or other methods of birth and disease control. KCCC does not perform any family planning services because of its Catholic origins. Rather, staff channel people to other family planning centers in the community. KCCC staff agree that the organization could promote condom usage in its HIV/AIDS prevention strategies and distribute them in the clinic, but that it would not be in keeping with the character of the organization or its mandate to do so.

Prevention

The Youth HIV/AIDS prevention program consists of three separate projects: The Treasure Life Center; The Motivation and Personal Development Skills Program; and the All Star Academy Outreach Training Groups. Each quarter, the projects reach over 1,000 youths to teach them about HIV/AIDS, substance abuse and children’s rights.

The Treasure Life Center

The Treasure Life Center was built on land which formerly housed a drug den. KCCC purchased the land, razed the building and built the Center and a sports field. Each day, over 120 young people from Kamwokya and neighboring villages participate in the center’s sports and recreation activities. Many of the youths that belong to the center were formerly involved in drugs. The Center provides workshops, skills training and a venue for participation in sports, drama and dance. The Treasure Life Center also provides peer counseling. Youth peer counselors have learned the Do No Harm language from other employees and volunteers of KCCC. These peer counselors have not been trained in Do No Harm but, like the KCCC office staff, they employ the joking, “Are you doing harm?” phrases with each other.

Motivation and Personal Development Skills Program

The goal of the Motivation and Personal Development Skills Program (MPDSP) is for youth to understand that they can change to achieve their goals and that it is possible to avoid behavior that exposes them to HIV/AIDS and other STDs. Program participants share their experiences and how these have shaped their personal outlook and behavior. Youths participate in lectures, brainstorming, personal reflection and group discussions. The MPDSP was created because KCCC staff noted that their prevention and education programs were ineffective; Kamwokya youth were still engaging in risky behaviors. “We concluded that for preventative programs to be effective, they needed to move from being prescriptive to being diagnostic: no matter how many programs tried to encourage individuals to change their behavior and attitudes, without a change in perceptions in the individual, no lasting change was possible.”³ The program is designed to help youth identify and build upon their strengths while learning new skills for their futures. The fundamental idea behind this program is that if youth “perceive

³ KCCC Website www.kamccc.org/pages/health-care/prevention.php

life as belonging to them”⁴ they will have a more vested interest in their future and be less likely to engage in risky behavior.

The All Star Football Academy

This football training program works with children from ages 6 through 17. The Academy holds clinics for youth to learn soccer skills. These clinics are run on the weekends and children are reached through primary schools. On average, 60 youths participate in each clinic, totaling over 10,000 annually. Through the skills development programs at the football academy, more than 33 participants in the program have been granted scholarships to various schools.

However, many of these youths come from the poor neighborhoods in Kampala, so the academy goes beyond simply teaching soccer skills. Academy instructors and peer educators also teach the youths about their rights and raise awareness about child abuse. These programs also address the stigma surrounding children whose parents have HIV/AIDS. The football academy also reaches out to adults through community sensitization programs, parent seminars and capacity building programs for coaches.⁵

Mental Health

In recent years, working with the HIV/AIDS community, KCCC has noted growing numbers of people with mental illness in Kamwokya. These people are often stigmatized and discriminated against by the community and so rarely get the treatment and support they require. KCCC began offering mental health services in October 2004, in partnership with Basic Needs. The program offers increased access to mental health services, practical education and income generation for people with mental illnesses, drug treatment and community sensitization. One of the first mental health professionals in Uganda began working for KCCC after he retired. Within two years of the program’s implementation, 360 had accessed the services. Of those, 56 people were affected by both mental illness and HIV/AIDS.

Education

The idea of education is universally valued in Uganda, however, the realities of education for girls and boys are quite different. Sending girls to school is not widely accepted as necessary. Many donors offer sponsorships for girls to attend school because they are not proportionally represented. Community members bristle at this idea of educating girls over boys. KCCC has had to work with the community in Kamwokya, including all of the various tribal groups, to make sure that girls’ education is accepted and that they will allow their girls to attend school.

One of the greatest challenges for girls’ education is making sure that girls finish school. Many girls in Kamwokya become pregnant, are sent away to their parents’ home villages or are married off by their families. In order for KCCC to accept money for an education sponsorship they need to be sure that the sponsored girl will finish school.

Following through the entire school curriculum is a challenge for KCCC in boys’ education as well. Many donors sponsor boys through primary school, then cut off sponsorship as they reach puberty. At that age, without a school or a job to go to, many boys turn to street gangs.

⁴ Ibid

⁵ Ibid

Primary School

KCCC established the Sr. Dr. Miriam Duggan Primary School in the Catholic Church building to attract and teach the youth of Kamwokya who would otherwise be on the streets. Two years ago, the school moved out of the church building and into a building built with a \$90,000 grant from Caritas Switzerland. The school is staffed by volunteer teachers who teach a curriculum approved by the Ministry of Education. The school educates over 500 pupils from grades one through seven. Tuition is not free for any student, though the majority of students at the KCCC school are sponsored by KCCC's partners.

Of the students who attend the primary school, 20% are considered complete orphans (those who have lost both parents), 60% are considered partial orphans (those who have lost one parent), 15% are classified as needy children due to their families' circumstances and 5% are self-sponsored (their families pay tuition). Those children classified as needy or orphaned are the target categories for the school. Their tuition is sponsored in whole or in part by both local and international NGOs and individuals. The self-sponsored children have been admitted to the school in order to incorporate the entire community and to raise funds to sustain the school.⁶ Every child who receives a sponsorship is required to write a letter to his or her sponsor once a month. The children go to the school's offices and compose their letter with the help of the administration.

Beyond donor support, KCCC has considered many strategies for sustaining their education programs. These strategies include programs to generate revenue from other community members who use the school building and facilities. They have considered opening a computer training laboratory and internet café, expanding adult education evening classes to include O- and A-level training courses, increasing the proportion of self-sponsored students and opening an overnight car parking lot. KCCC has opened their computer laboratory and created an internet café which generate a modest income for the school. However, the organization rejected the idea of admitting more self-sponsored students on the basis that it would "fundamentally change the character of our mission" and the option of opening a parking lot "for reasons of pupils' safety."⁷

KCCC's eventual goal is to create a self-sustaining private school for the community, which the organization will no longer run. The organizations that sponsor the school are hoping KCCC will make this change soon. They feel it is important that the school no longer be supported by KCCC and its donors. However, KCCC is hesitant to make the shift because if it were to be shifted, it may fail. The school's administrators feel that if the school did not receive support of donors and sponsors, it would fail because so many of its pupils cannot afford to pay tuition.

Vocational School

The KCCC Vocational Training Center (KVTC) is run out of several buildings. KVTC receives some money from KCCC but also accepts money and resources from others. KVTC was established to improve the quality of life for the people of Kamwokya. Each year, 250 members of the Kamwokya community attend vocational training and literacy courses at KVTC. The school offers courses in masonry, carpentry, catering, leather working, tailoring, design and functional adult literacy. In addition to these training courses, the center also strives to educate vocational students on "the importance of family, peer groups and social support networks in relation to HIV/AIDS education by on-going behavioral change seminars."⁸ Each of the courses at KVTC is complemented by an apprenticeship with a local artisan.

⁶ KCCC website: www.kamccc.org/pages/education.php

⁷ Ibid.

⁸ KCCC website: www.kamccc.org/pages/education/job-training.php

Tools and other resources are made available to students who cannot afford them through a rental tool bank.

To be accepted into the program, candidates and their families are interviewed “to assess their financial and motivational background, to discuss with the guardian (if any) how they may be of help, and to identify any psycho-social challenges the candidate may be facing.” Trainees take examinations and the KVTC program is registered with the Ministry of Education’s Directorate of Industrial Training. KVTC students range in age from 15 to 24. In addition to their job training they are required to attend Education for Life courses to address HIV/AIDS prevention, peer pressure, family relations and parenting.⁹

Advocacy

Instead of advocating on behalf of the community, KCCC’s Advocacy Department teaches community members to hold their government accountable for the problems in Kamwokya. The Advocacy department works with individual community members to make them aware of their rights and what they should expect from their government: security, health and social services. The Advocacy Department also addresses domestic violence in the community and works closely with women and children.

The Advocacy Department trains local community leaders in lobbying skills so they can become advocates for their communities. The department also provides awareness training in human rights, children’s health, mental illness, HIV/AIDS and property rights for women. KCCC facilitates dialogue between the community, the media and the government. The goal of the Advocacy Department is to generate enough widespread awareness of rights in Kamwokya that the community will “assert their rights and hold their community leaders and government accountable and responsive to their needs and concerns.”¹⁰

In one instance, a large amount of garbage was piled up on the main road through Kamwokya. Community members were complaining to KCCC, but they did not know what they could do to make the government clean up the garbage. KCCC did not take the issue to the government. Rather, the Advocacy Department worked with the community to identify options and facilitated the community’s solution. The community elected a person to be responsible for communicating with the government on the issue of garbage collection. That person went to local city council with the backing of hundreds of Kamwokya merchants. The city council members, under pressure from the merchants, pushed the city, and now there is regular trash collection in Kamwokya parish.

Micro-Finance

KCCC established a Banking and Micro-Finance system through the KCCC Empowerment Cooperative Savings and Credit Society Ltd (SACCO). The cooperative handles deposits and small loans to people who live or work in the Kampala district. The micro-finance program was initiated to help members of the community with a good record of savings to initiate income-generating activities and move toward financial independence. Once the structure of SACCO was in place, KCCC taught the community how to use it. The organization ran small workshops on how to start small businesses, basic accounting

⁹ Ibid.

¹⁰ KCCC website: www.kamccc.org/pages/advocacy-rights.php

principles and the importance of savings. Cooperative members needed to prove they were able to save a certain amount of money each month before they were qualified to receive a loan.

The goal of the lending program is to ensure that the loans are successful in their purposes. KCCC works carefully with each recipient to ensure that they are able to make their loan payments and set aside additional money for their personal savings each month. Each loan recipient must complete a two-day training course before they receive funds from SACCO.

Originally, the micro-finance programs were geared toward women. The organization encountered problems in the community due to this focus. They found that loan money was being taken by women's husbands and there was an increase in domestic violence. When representatives from the cooperative visited female loan recipients at home, some women were hesitant to talk about their loans in front of their husbands. Some men came to the cooperative to ask why they were not being helped. Bank staff realized they needed to open up lines of credit for men. KCCC organized a venue and gathered people to admit they were wrong to exclude men from the micro-finance program. The program is now open to everyone in Kampala who has taken the finance training courses.

Many of the borrowers from SACCO are members of small groups, which accept pools of funding, which is paid out to each member in turn. Once the member pays the money back into the group pool, the next member can draw funds. The Do No Harm team spoke with a woman who belonged to such a group who was unable to access loan funds because another member of her group had yet to pay back the loan. The woman we spoke with had already paid back a prior loan. KCCC staff members had spoken to the woman who defaulted and are sure that she will be able to repay the amount in time. The staff are working to develop a system to aid people in these groups who are not able to access funds due to a default on a loan to another member of their group. The staff hopes to be able to assist the woman we spoke with to work around the structure of her loan circle.

Another loan recipient runs a stall in the marketplace selling vegetables. The woman chooses the best vegetables from her vendors to sell in her stall. When asked how she manages to get better produce than the other vegetable sellers, she responded, "I get there earliest." She makes several thousand Ugandan shillings per day. Her husband, who works selling goats, makes about one thousand shillings per day. The woman deposits ten thousand shillings into her savings account at SACCO each week. During a recent family crisis, she was unable to make deposits for several weeks in a row. KCCC staff visited her home to speak with her and help her design a plan to get her savings on track. She has planned to deposit 15,000 shillings each week until the difference is made up.

Nearly 1500 people use the cooperative bank, including the staff of KCCC, and SACCO is recruiting more people to the savings and loan programs. The bank now has enough clients that its programs are sustainable, and it no longer requires KCCC's support. SACCO has established a local board of directors and the management of the bank with stay in place, but KCCC will soon no longer run SACCO.