LAYING THE FOUNDATION FOR CARE'S PROGRAM QUALITY & LEARNING DIGITAL LIBRARY

PHASE I

15 August, 2005

Mary Picard, Consultant, with the
Impact Measurement & Learning Team
CARE USA

Table of Contents

Page

I. Business Rationale 1
II. Content Parameters 3
III. Decisions and Decision Making Process 8
IV. Some Key Principles on the Broader Vision for a Knowledge Management System 9

I. BUSINESS RATIONALE

Like any international NGO, CARE continually seeks to actively promote program quality essential for the attainment of the organization's mission and vision. To do so, CARE needs to make resources available to staff that represent its policies and good practices, as well as a knowledge management system that facilitates learning processes in order for organizational knowledge to be continually refreshed. The longer term vision guiding this initiative is the creation of a knowledge management system that promotes program quality in harmony with multiple forms of knowledge sharing in CARE.

The proposed Program Quality & Learning Digital Library is only the first step towards developing a more holistic knowledge management and learning system for CARE. To appreciate the full panoply of issues on knowledge management, more time will be given for consultation with colleagues within CARE and in other development organizations to draw upon the experience and lessons learned with devising strategies for knowledge management. Careful attention will therefore be paid to developing strategies that will achieve the most effective means for staff in all parts of the organization to learn and progress according to their own needs.

Thus, this first phase of establishing this foundation is concerned initially with only one aspect of knowledge management. It relates to the current need for a *library* of resources or, more specifically, explicit knowledge,[1] that clearly identifies to CARE staff and the general public the organization's program policies and recommended good practices. Yet, more fundamentally, while many such policies and practice guidelines exist, CARE lacks the routines, procedures, and staff responsibilities for actually developing, agreeing on and formalizing that which constitutes 'program policy' and 'good practice,' as well for processes for retiring the outdated ones. These two related problems are described briefly, as follows.

⇨ Need for a central site for programming policy and good practice guidelines

There are currently two main sites for the organization's documentation: CARE USA's myCARE portal and CI's Livelink portal. While the either or both of these portals might well contain in their nooks and crannies many documents that would be suitable for such a library, they are not identified as such and so the portals do not currently meet the need for core policies and guidelines to be easily found by interested users. In addition, there are a number of documents that IMLT has already identified as suitable for such a library that have never been uploaded to the portal. The typical mode for disseminating policies is via ALMIS e-messages and attachments, but there is little if any systematic, centralized way to subsequently find and access them. In addition to the two portals, explicit knowledge (i.e., documents) also exists in a number of other CARE web sites (e.g., the CARE UK RBA website, the GDG-hosted PHLS and M&E websites, and a number of separate websites set up by individual CI Members, sectors, RMUs and COs) but this fact muddies rather than clarifies the picture. A new hire in CARE, including program staff in a country office (CO), is expected to wade through various sites without any guideposts that would indicate the organization's set of program policy and good practices.

Evidence abounds of the demand for an explicit knowledge library for core program policies and good practice. Field staff who come to Workweek consistently ask for such a basic framing for where CARE stands with regard to subjects such as a) rights-based approaches, b) holistic analysis of underlying causes of poverty, c) the CI programming principles, d) DME in an age of RBA, and e) requirements vis-à-vis impact assessment. Field staff continue to criticize Headquarters for 'initiative overload,' which, at least from a programming perspective, can be translated into the question: "What am I required to do vis-à-vis new programming approaches/ideas and what are just recommendations for my review?" Similar sentiments were voiced during 2002's "Aligning our work with the CI Vision" process, and there has been quite literally no action taken by CUSA program division since then in response. Regional Management

[1] By explicit knowledge we refer to that which can be written down and transferred through the physical medium of a document – which, we concur, is an end product that has tacit knowledge as its precursor.

Unit (RMU) staff – those who have the most frequent and close contacts with CO program leaders – are among the strongest supporters of the proposed core explicit knowledge library for program quality and learning because they bear the brunt of CO program staff consternation over the surfeit of new ideas, approaches, and practices that emanate from the numerous CI HQs around the globe. Indeed, it was in response to this need that the Program Resources and Learning group of the Program Division identified the development of a program quality and learning digital library as an AOP priority in FY06.

In sum, how do staff decide what is important for them to know? And where do they look for such core policies and guidance? For CARE as an organization seeking to achieve greater consistency in program quality across all offices, it is the organization's responsibility to equip or enable staff to make those choices and find the relevant documentation.

⇨ Lack of 'upstream' and 'downstream' procedures

To develop an explicit knowledge library[2] that is a living, breathing, growing, and evolving system, two types of procedures, currently lacking in CARE, are the subject of this proposal:

1. **Upstream**: Routines, procedures, and staff responsibilities for actually developing, agreeing on and formalizing that which constitutes 'program policy' and 'good practice guidance;' and
2. **Downstream:** Routines, procedures, and staff responsibilities for 'retiring' outdated policies and practices.

Thus, the creation of an explicit knowledge library will require a clear set of routines, procedures, and responsibilities for agreement on the contents of that library on a continual basis. With that in place, staff and the general public will be aware of what CARE stands for and seeks to promote.

The Intended Audience

1. The primary audience for the library is CARE staff with program responsibilities, ranging from Project Managers and other field-based programmers, to CO and RMU program staff, to the Program Directors of CI members and others at the headquarters levels. In specifying this range, it is of paramount importance that core, explicit knowledge such as policies and good practices should be captured in simple and straightforward ways that are understandable by all staff within that wide range of experience, education levels, and language abilities.
2. The secondary audience for the library is CARE external relations and fundraising staff. For this audience, plain-language, direct statements of program policy and good practice will help fundraisers to better discuss, explain, and sell CARE's work.
3. The tertiary audience for the library is CARE's external stakeholders: the digital library will be open to the public and so accessible to partner organizations, donors, journalists, academics, social movements, lobby groups, and so on.

Overall Aim of the Program Quality and Learning Digital Library

The digital library will serve as an explicit knowledge database where any staff with Internet access can quickly find what constitutes a) program policy and b) organizationally-vetted good practices for implementing program policy. In order to achieve this, the process for establishing the digital library will identify upstream and downstream procedures, responsibilities, and resource needs in order to a) capture and make explicit good new ideas flowing through the CARE system, and b) retire ideas and keep the explicit knowledge library refreshed. In subsequent phases additional ways for sharing these documents will be developed for those who have limited access to the Internet (e.g. sending out CD ROMs, hard copies, as part of workshops, etc.).

[2] There are multiple ways that good ideas get shared and circulated in the organization, and many of these – quite rightly and quite effectively – occur through people-to-people processes and through social networks. The explicit knowledge library does not address this fact, nor does it have as its purpose making those kinds of social knowledge networks more effective. IMLT does believe, however, that a functioning explicit knowledge library will be a useful tool for those social knowledge networks and, eventually, once it proves its effectiveness, could become an important repository for the knowledge that gets crystallized out of such people-to-people knowledge sharing.

Process for Establishing the Library and Its Specifications

IMLT proposes an incremental approach to building the library. The time horizon is multi-year but the current proposal is for the next 6-12 months, with the initial system set up by the end of December 2005, and rollout and additional content during the last half of FY'06. In collaboration with an Advisory Group, IMLT will review and critique:

a) suggested upstream and downstream procedures as described above;
b) the initial set of documents; and
c) the architecture and platform for the library.

A prototype library will be up and running by January, which will initially include no more than 100 documents (explicit knowledge) that will be identified as needing to be in such a digital library with the purposes and for the audiences described above. Populating the prototype library will entail a trial review process of the initial candidate documents by IMLT with input from the Advisory Group, as well as drafting and completion of documents for which there are gaps.

II. CONTENT PARAMETERS

It should be made clear, first of all, that this first phase is about establishing a physical (electronic) space for CARE's program policies and practices that can be quickly and easily accessed by all intended audiences. Thus, creating the 'space' (in a conceptual rather than physical sense) and facilitating the processes for knowledge sharing and exchange on these and on programming topics more generally will come in a subsequent phase of this initiative, as the Advisory Group advances in its discussions around this.

It is envisioned that the initial space for this explicit knowledge library will be organized in two areas:

The **'core'**
The **'practice**

The core, being defined as:

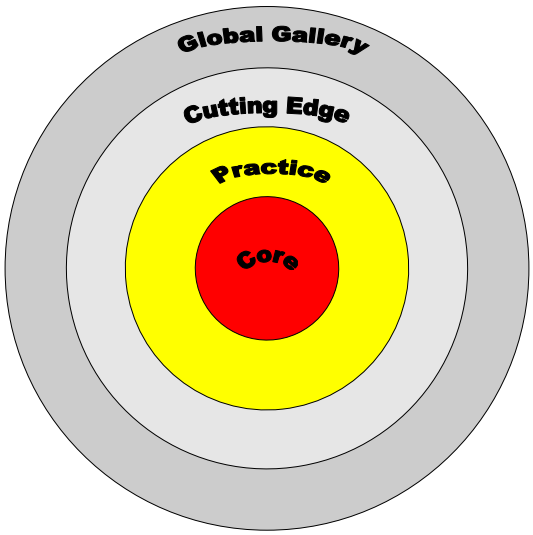
> minimum threshold of what anyone should know about CARE -- what the organization stands for, agreed upon principles, standards and policies as they relate to programming, and how CARE evolved to the present stage of its approach to development. The core piece is the CI Program Framework as the 'jumping off' point. The core represents what is non-negotiable in our programming work. And it will be central to an orientation to the newcomer on CARE's conceptualization of program quality.

The practice, being defined as:

> guidelines, tools, methods or approaches on how to *put into practice* CARE's principles, standards, and policies. They represent CARE's good practices that are being promoted by the organization.

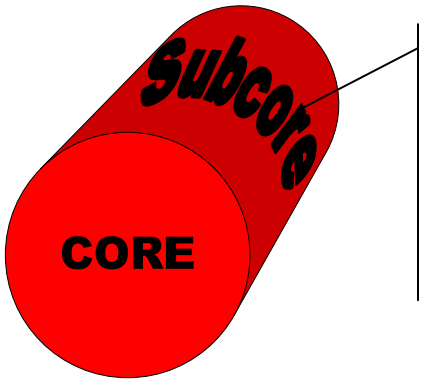
Beyond this, a defined space will need to broaden out to accommodate other aspects of a knowledge management system, for instance, the space or the capacity for '**cutting edge**' knowledge that promotes the flow of ideas on current debates and innovations in CARE; and a space or capacity for what could be called '**the global gallery**' that promote the free flow of ideas on any topic relating to program quality. These spaces or capacities will not be pre-defined or pre-designed in their structure or specifications. As mentioned, these will be the subject of the next phase, while keeping them in mind during this first phase.

The following diagram is intended to help visualize the conceptualization of the whole picture:



THE CORE

The ‘core’ will be further subdivided to include a ‘subcore,’ as defined below:



The **'sub core'**: the cross-cutting frameworks and lenses that compose CARE’s conceptual backdrop and influence the entire cycle of programming (rather than any one particular phase). This is the normative material that drives programmatic inquiry and design and is what any staff person needs to know before engaging in program work. The 'sub core' dimension takes each approach or framework individually and elaborates in 5 pages or less, giving it definition and some history. The user will be able to click on terms that are hyperlinked to definitions.

Having a ‘subcore’ allows for an expanded yet still tight set of agreed upon policies, standards and principles that apply across the organization.[3]

An illustrative list of documents for the Core:

- A brief description of the Core
- The CI Program Framework (Vision, Mission, Principles and Standards)
- What does program quality mean to us?
- The DME cycle in context (graphically represented)
- CI Evaluation Policy

[3] Whether the agreement is amongst all CI members (e.g., via the Program Working Group) or just C-USA at this stage will be determined at an early stage in discussion with all relevant stakeholders. Importantly, the aim is to be as inclusive as possible to achieve an organization-wide (international) buy-in. If a point is reached at which this does not seem practicable, the idea for the library will still proceed.

An illustrative list of documents for the Subcore (written as 5-page summaries, with links to fuller descriptions):

- The Household Livelihood Security framework
- The Unifying Framework For Social Justice And Poverty Eradication
- CARE's conceptualization of RBA
- Gender equity and diversity in CARE
- Partnership and constituency building
- Advocacy
- Humanitarian Aid

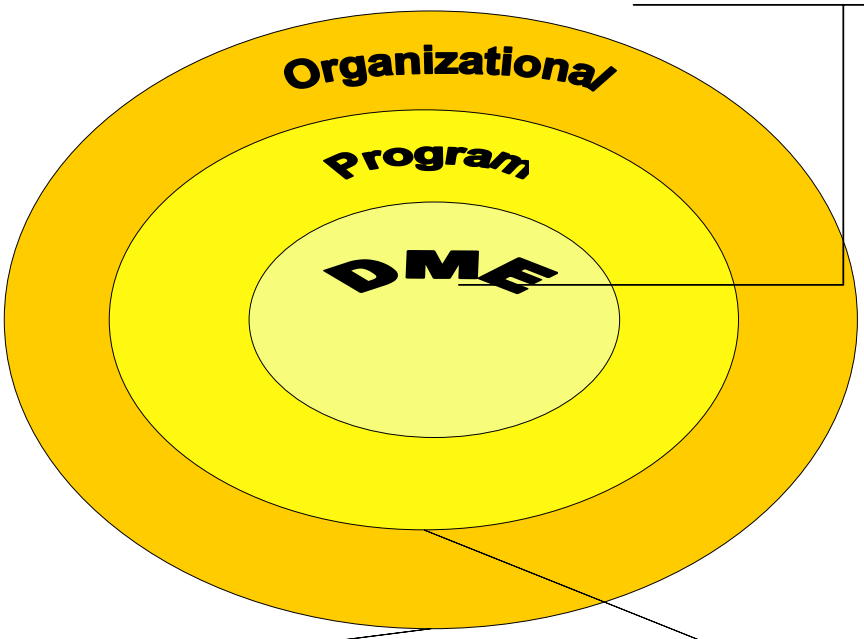
THE PRACTICE

The 'practice' space will also be subdivided to present programming contextually - in the context of organizational culture/ environment (typically the Country Office). The rationale for this is as follows:

1. Though most of CARE's programming is, and will continue to be, through the implementation of "projects," an exclusive focus on the project is not sufficient to create the conditions for good practice. Aspects of the overall program and the organizational context must be aligned with and supportive of the practices being promoted at project level (e.g., systematizing a rights-based approach).
2. The three levels of project DME, program and organization are highly inter-related and taking steps to improve program quality may begin at any of the three levels; in fact, good programming *should* begin at the level of the organization. Staff will be interested in actions or practices being made at all three levels.

An explanation of the levels (or 'arenas') is illustrated in the diagram on the next page.

DME – generic tools, approaches, methods associated with design (inc. holistic appraisal and analysis), monitoring and evaluation that can pertain to program or project



The organizational level has to do with institutional aspects that may constrain or promote learning and accountability within the CO context (or other office). These may relate to:
(1) the learning culture (inclusive of innovation, creativity, reflection, evaluative thinking);
(2) the capacity, attitudes, behaviors and skills of staff and partners in DME practices and the principles;
(3) the organizational drivers and incentives for a learning culture;
(4) relationships with partners and downward accountability;
(5) mechanisms for institutionalizing good practices;
(6) mechanisms for accountability;
(7) how up-to-date and informed is its approach to to the wisdom and best practices that exist in CARE (and generally in development)

Program level has to do with the particularities and challenges associated with seeking cohesion at this level as well as with defining strategies, addressing and incorporating cross-cutting themes, and other aspects of a program approach

Organizational Arena:

The categories to be included in the organizational arena will be the subject for discussion with the Advisory Group.

The organizational arena, as defined in the diagram above, is the space reserved for **the means and approaches** to promote support, and institutionalize the program policies and good practices that exist and are continually being updated. Thus, this touches on the internal dynamics of the workplace such as learning culture and diversity; on relationships with partners and other players; on the incentives and forms of accountability for influencing staff behaviors; and on steps to keep current with good practices, not only in CARE but in relief and development work in general.

Some overlap between the three arenas is to be expected. The DME arena, for example, pertains to generic tools and approaches but it will appear in the organizational arena from the perspective of improving our institutionalizing capacity.

The following set of categories and corresponding documents is illustrative only:

Capacity, attitudes, behaviors, skills in DME and principles	**Institutionalizing DME capacity**	**Accountability mechanisms**
➢ Rights and Social Justice - Desk-based appraisal tool ➢ RBA Rating Scale ➢ DME Capacity Assessment Toolkit (DME CAT)	➢ Action plans based on results of DME CAT and/or PSMI ➢ Institutionalizing DME capacity	➢ CARE Impact Guidelines Part 4: Project Summary Design Review and Approval Form (see Profound format) ➢ Use of PSMI at time of project design, mid-term review and final evaluations ➢ CO Organizational Performance Assessment (COOPA) Tool ➢ Management Assessment for Country Offices (MACO)
Downward accountability and relationship with partners	**Learning culture**	**Organizational drivers and incentives**
None yet	None yet	➢ CO Organizational Performance Assessment (COOPA) Tool ➢ Management Assessment for Country Offices (MACO) ➢ Report of the 2002 Bangkok Workshop (Leading Change) on Aligning our Work with the Vision ➢ GED Gap Analysis Summary Report
Other	**Other**	**Other**

Program Arena:

The program arena, as explained in the diagram above, are the **means and approaches to creating a cohesive program that is able to operationalize** the cross-cutting themes, such as partnership, and the conceptual frameworks that appear in the subcore.

An illustrative list of documents for the Program Arena:

- Program Strategy Paper (tool) (by Ambler)
- LRSP guidelines
- Gender Equity Building Blocks as checklists
- Governance mapping exercise
- Chapter A, Building Organizational Capacity and Strengthening Institutions
- The RBA Risk Assessment Filter Tool: A Facilitator's Guide

Design, Monitoring and Evaluation Arena:

This arena pertains to tools, guides, and approaches that apply broadly across all sectors and program areas to attain quality in design, monitoring and evaluation for accountability and learning.

Design	Monitoring
➢ Chapter 2 of the Project Design Handbook: Holistic Appraisal ➢ Vulnerability Assessment Tool ➢ *In search of* documents related to: ▪ PRA manual ▪ participatory livelihood assessment tools ▪ needs assessment ▪ stakeholder analysis ▪ environmental assessment ▪ gender analysis ▪ power analysis ▪ institutional assessment ▪ policy analysis ➢ Chapter 3 of the Project Design Handbook: Analysis and Synthesis ➢ Chapter 4 of the Project Design Handbook: Focused Strategy ➢ Causal Responsibility Analysis Tool ➢ Benefits-Harms Handbook ➢ Checklist for Reviewing Project Proposal for M&E Resource Requirements	➢ Chapter 5 of the Project Design Handbook: Coherent Information Systems ➢ How Are We Doing? M&E Guidelines for CARE (initially CARE Uganda) ➢ Guides to Logical Framework Development or Logic Models ➢ DM&E Workshop Series - 1997. Volume I: Handout Manual ➢ DM&E Workshop Series - 1997. Volume II: Facilitators' Manual ➢ Course Materials for the Design, Monitoring and Evaluation Course ➢ Project Management Information Systems: Guidelines for Planning, Implementing, and Managing a Project DME Information System ➢ Quantitative Methods Workshop ➢ M&E Planning Training Course ➢ CARE Impact Guidelines Part 2: Menu of Indicators for HLS Impact ➢ Participatory Monitoring and Accountability Tool Checklists Related to Quality of Monitoring Information ➢ Exercise to Assess and Compare Quantitative and Qualitative Methods
Evaluation	
➢ CI Evaluation Policy (in core) ➢ Guidelines for Evaluation ToRs (in development) ➢ Guidelines to CARE Malawi for the Design of Future Baseline and Evaluation Studies ➢ Chapter 6 of the Project Design Handbook: Reflective Practice ➢ Some of the guidance coming out of the SII on Women's Empowerment	

Each of the arenas above, the categories and parameters of each will be finalized in consultation with the advisory group.

III. DECISIONS AND DECISION MAKING PROCESS

A number of key decisions will need to be taken within the six months of this initial phase that will result in a prototype explicit knowledge library. These decisions will draw heavily on an ongoing consultation process with the advisory group. These are:

1. **Involvement of other CI members in the discussion process and mutual agreement on their participation.** Buy-in from all CI members is highly desirable. The eventual outcome – what role and level of involvement they wish to have – will depend on their expectations and negotiations over which can and cannot be addressed without impeding progress on this initiative.

2. **The proposed model for organizing documents, as described above**. A first draft of this proposal solicited feedback from Advisory Group members, IMLT staff, and others. Aside from the resonating caveat to define a clear business rationale for this first phase, none of the feedback challenged the overall model, only specific details of it. Some revisions have consequently been made to the original version and the proposed organization of documents will be reviewed one more time.

3. **The platform and technology that will support this explicit knowledge library**. It is understood that some program staff in CARE offices around the globe do not have easy access to the Internet. While this library will make use of the Internet, it will have to supplemented by other forms of storing and making available this database of explicit knowledge.

4. **The downstream and upstream procedures, routines and responsibilities for developing, agreeing, formalizing what constitutes the policies and good practices in the 'core' and in the 'practice.'** As mentioned earlier on, this is a key outcome of this first phase. Proposed procedures and processes for accomplishing this will be drafted and ready to submit.[4]

5. **The pool of candidate documents (in addition to the illustrative ones above) to be reviewed for inclusion in the 'core' and the 'practice.'** Efforts will be made to keep this pool from which documents will be drawn for review fairly limited to allow sufficient time for agreement on and completion of documents that will constitute a prototype library only.

6. **Further work on existing documents and, to a very limited extent, creation of new documents.** Some documents will need to be updated, edited, reduced in page length, or modified in some way. Where there are critical gaps in documentation, it may be necessary for a document to be written in its entirety but this should be avoided as much as possible, given time limitations during this initial phase.

7. **Persons responsible for drafting, editing, or writing documents.** This will be decided and agreed upon with the respective individuals who are viewed as the most appropriate authors, i.e., who have the expertise or information base to write a specific piece. These individuals will not necessarily be part of the advisory group.

The decision-making process will involve regular consultation (by conference call or email and face-to-face in some cases) with the Advisory Group and relevant IMLT staff but will also involve occasional consultation with the CI Program Working Group to solicit their perspectives and relevant 'resource persons' in CARE who may be called upon to write or advise this initiative. A tentative plan and work schedule for the next six months will be prepared by Mary Picard, the consultant for this initiative, who will lead the process with close support from Jim Rugh and Kent Glenzer in IMLT.

[4] See "PQDL Procedures" document.

IV. SOME KEY PRINCIPLES ON THE BROADER VISION FOR A KNOWLEDGE MANAGEMENT SYSTEM

With this initiative, looking beyond Phase I, certain principles of a knowledge management system would be expected to guide the longer term effort. These would include:

1. Threads that link the concentric rings – global gallery, cutting edge, practice and core – and allow for the migration of ideas from the outer to inner rings to contribute to the refreshing / updating of policies and practices. This is also a means for field staff to have greater influence and input into what constitutes program quality.

2. Search capability that is both user-defined and menu-driven.

3. Connecting to all relevant websites and repositories in CARE that relate to program quality and avoiding any unneeded duplication.

4. The use of technology that adapts to people and their situations.

5. Responsive to the level of demand of all potential users in CARE in terms of the types and categories of knowledge they wish to locate on a regular basis (e.g., sector-specific good practices).

6. Promoting an organic, user-driven knowledge management system that does not overlay a structure. This will be guided by the conventional wisdom on how to create communities of practice.

7. Creative and practical in terms of the solutions for promoting exchange, feedback, and learning that will keep alive the explicit knowledge library.