A COMPARATIVE STUDY OF AFTER ACTION REVIEW (AAR) IN THE CONTEXT OF THE SOUTHERN AFRICA CRISIS

A CASE STUDY PAPER FOR
THE ACTIVE LEARNING NETWORK FOR ACCOUNTABILITY
AND PERFORMANCE IN HUMANITARIAN ACTION

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ABBREVIATIONS

AAR	After Action Review
ALNAP	Active Learning Network for Accountability and Performance in Humanitarian Action
BP	British Petroleum
BPWG	Best Practice Working Group, World Vision International
BRCS	British Red Cross Society
CRS	Catholic Relief Services
CU	Concern Universal
DC	District Commissioner
DFID	Department for International Development
DPDMA	Department for Poverty and Disaster Management Affairs, Malawi
EA	Emergency Appeal, British Red Cross Society
EAM	Evangelical Association of Malawi
EAT	EA Team, British Red Cross Society
EI	Emmanuel Information
EPRS	Emergency Preparedness and Response Standard, World Vision International
ERM	Emergency Response Mechanism, World Vision International
EWG	Emergency Working Group, British Red Cross Society
FAA	Food Aid Audit, World Vision International
FAS	Food Aid Standard, World Vision International
GM	Goal Malawi
GOM	Government of Malawi
IA	International Aid
IFRC	International Federation of the Red Cross
JEFAP	Joint Emergency Food Aid Programme, World Food Programme
KMS	ALNAP Key Messages Sheet
LBDA	Learning Before, During and After
LL	Lesson Learned
LR	Learning Review
LSO	Learning Support Office, Malawi
MNA	Malawi News Agency
MP	Member of Parliament
ND	National Director, World Vision International
NDPRC	National Disaster Preparedness and Relief Committee, Malawi
NGO	Non Governmental Organisation
OPSWG	Operations Working Group, World Vision International
OP	Operational Proposal, World Vision International
RC	Red Cross
RC	Relief Committee
RCS	Red Crescent Society
RF	Relief Forum, World Vision International
RR	Review Report, World Vision International
RRN	Relief Review Network, World Vision International
RT	Round Table, World Vision International

ABBREVIATIONS continued: -

RTE	Real Time Evaluation
SA	Salvation Army
SAFER	Southern Africa Famine Emergency Response, World Vision International
SAR	Specific Actionable Recommendation
SARO	Southern Africa Regional Office, World Vision International
SAVE	Save the Children Federation, US
SCF	Save the Children, UK
SHA	Senior Humanitarian Adviser, British Red Cross Society
TOR	Terms of Reference
VP	Vice President, World Vision International
WFP	World Food Programme
WVI	World Vision International

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Part One – BACKGROUND

1.1. Introduction

1.1.1. This paper provides background to the ALNAP Key Messages sheet (KMS) – *A Comparative study of After Action Reviews in the context of the Southern Africa Crisis*.[1] The aim of the KMS was to 'distil' out the essential elements of After Action Review (AAR) good practice as demonstrated by humanitarian agencies engaged in emergency response to the Southern Africa famine crisis. The KMS provides good practice guidance on the effective design and use of AAR processes. Much of this guidance has come from practitioners who were deeply involved in putting together AAR type events or actively engaged as facilitators. Their descriptions have been captured in this paper providing a set of three detailed case studies. Each is a 'standalone' example of an AAR-type activity, demonstrating considerable variation in approach and in the name by which these activities are known within each organisation. All form part of a learning review process directly related to some aspect of agency relief work in the famine disaster. The AAR-type events took place between October 2002 and February 2003.

1.1.2. The case studies provide a 'snap-shot' of current efforts by agencies to adopt learning principles and carry out reviews. The three case studies reflect the experiences of World Vision International (WVI), the British Red Cross Society (BRCS) and the consortium of Joint Emergency Food Aid Programme (JEFAP) implementing agencies. The challenge in each case has been to develop an approach that takes into account the uniqueness of a particular context or institutional arrangement, rather than simply replicating what others are doing. Plurality of approach is in most cases a strength and not a weakness. This study has tried to recognise that by not imposing rigidity or setting in place an 'orthodoxy' with regard to how AAR should be used. Agencies have at their disposal a variety of entry points for creating AAR-type processes, with tasks and objectives in AAR being conceived differently and outcomes used for different purposes.

1.2. How this Paper is Structured

1.2.1. This paper is structured into five parts. **Part One** identifies the principal components of an AAR-type process and explains how AAR works. It also contains a section on the assumptions underpinning the methodology used for this study. **Parts Two**, **Three** and **Four** each describe the experience of an individual agency or event. **Part Five** explores the comparative dimensions of the case studies. These are drawn out as a framework for viewing the entire AAR process. **Annex One** describes AAR good practice, as illustrated by the case studies (and described in greater detail in the KMS).

1.2.2. WVI's approach focuses on integrating learning across a global partnership of independent national offices and support offices. BRCS's approach has evolved because of the need for an adequate coordination-feedback mechanism at headquarters to allow for learning to take place between departments. The JEFAP Consortium approach used AAR on a one-off basis to bring together field workers from twelve different organisations and promote a mode of engagement based on inter-agency, multiple-stakeholder working.

[1] *A Comparative study of After Action Reviews in the context of the Southern Africa crisis*, Key Messages, ALNAP, April 2003 now available on the ALNAP website as: http://www.alnap.org/pubs/pdfs/aar_key_messages.pdf

1.3 What is After-Action Review?

1.3.1. After Action Review (AAR) is a review technique, for appraising ongoing or past operational activity, which originated with the US Army. It is increasingly being used by groups, teams and organisations within the Humanitarian Sector, to improve their performance by reflecting back on their activities and actions. This simple and straightforward technique can be described as:

> 'A professional discussion of an event or action, with a focus on performance, which enables participants to discover for themselves what happened and why, and how to sustain strengths and improve on weaknesses.'
>
> 'It captures and applies learning as quickly as possible back into action. It allows participants to get on with the tasks at hand and to learn as they go.'[1]

Various adaptations of the AAR method have been developed, termed variously 'lessons learned', 'post-operation review', 'learning review' or 'learning after the event'.

1.4. What does After-Action Review Entail?

1.4.1. Although a number of variants of the AAR process exist, all approaches are similar in asking a series of structured questions about the action under review:

- What was the objective or intent of the action?
- What went well?
- What went less well or what could have gone better?
- What would we do differently next time?

The sequencing of the questions allows a group of people involved in an action to: (a) reflect on what has happened; (b) identify the lessons they have learned; (c) capture learning that could improve on the action a second time around, and; (d) disseminate leaning to others who may be embarking on similar actions.

1.5. How does After-Action Review Work?

1.5.1. AAR works best when it involves the following elements:

i. *A focus on a small number of key issues.* An AAR examines a limited number of key issues agreed by the participants. A clear focus at the start of the process allows for greater clarity and a stronger result.

ii. *A non-judgemental, 'safe' environment.* AARs provide a 'safe' space, in which people have trust and feel free to discuss issues without attachment of blame or judgement. Being safe means knowing that there will be no retribution for being honest and expressing "unsafe" ideas. This ensures that the AAR is able to get to the root of an issue or problem without obstruction caused by defensive reasoning.

iii. *An inclusive process.* AARs involve everyone directly involved or closest to an action, whatever their decision-making authority or level in the organisation. It builds up a picture reliant on multiple perspectives based on every ones experience. It is therefore a fundamentally participatory process.

[1] Adapted from Solon, Jenny, *A Leader's Guide to After-Action Reviews*, TC 25-20, Headquarters, Department of the Army, DC, 30 September 1993 (revised 4 December 1998).

iv. *Builds a shared understanding.* AARs allow groups, teams and organisations to build a shared understanding, or mental map, of their activity. An AAR creates a 'helicopter' view of how a particular action unfolded, peoples' respective roles and responsibilities, and the nature of the constraints and complexities faced, both individually and collectively.

v. *Carried out as close to an action as possible.* An AAR is best carried out, either during or immediately after an action has finished. It is important to do it while memories are fresh and people can recall what happened.

vi. *Learning feeds directly back into action*. The outcome of an AAR is not simply a discussion, but a series of recommendations or action points that are acted on immediately after the AAR is finished.

vii. *A structured and facilitated process.* A facilitator – who is independent of the group but has familiarity with the subject matter - takes a group, team or organisation through the structured questions as identified in 1.4. above.

1.6. Method

1.6.1. The original aim of the study was to undertake real time observation of actual field level AAR events. An initial mapping of ALNAP members - although revealing a considerable level of interest in AAR - also showed that no agency had plans to conduct a Southern Africa based AAR event within the consulting period. However, of the agencies contacted, BRCS had a London headquarter based AAR on their Zimbabwe Emergency Appeal (EA) planned for February 2003; WVI had in October 2002 conducted a Southern Africa regional AAR of its Southern Africa Famine Emergency Response (SAFER); and the JEFAP Consortium, also in October 2002, had used an AAR type methodology as part of its guideline preparation exercise on community-based food distribution. Given the time constraints posed on the study, it was decided to conduct a desk study of AAR methods. The consultants' were invited to attend the BRCS AAR and were able to follow-up with face-to-face meetings. In the case of WVI and JEFAP, the bulk of the case study preparation was undertaken by telephone interview with key informants. Background papers were provided by informants for all three AAR events.

1.6.2. The study is reliant on drawing lessons on AAR from an extremely small sample of past AAR-type events. A question arises as to the appropriateness of trying to generalise observations from such a small sample group. We believe however that there is a richness of experience represented by such samples, which March, Sproul and Tamuz (1991) describe as examples of "small histories".[1] Since we do not have multiple occurrences of an event we aim to arrive at a set of multiple observations for each single event. It is the differences in interpretation between different observers engaged with each AAR that allows us to build a 'rich' picture of how AAR is conducted.

[1] James G. March, Lee S. Sproull and Michal Tamuz, "Learning from Samples of One or Fewer," *Organisation Science*, Vol. 2, No. 1, February 1991. Traditionally small samples have been used routinely to examine critical incidents. Critical incidents come in a variety of forms and can include events that bring change, events that change what is believed and events that evoke meaning, interest and attention. We legitimately engage in the construction of "small histories" of our experience through such critical incidents.

Part Two – CASE STUDY: WORLD VISION INTERNATIONAL (WVI)
Southern Africa Famine Emergency Response (SAFER) 15-16 October 2002

2.1. Introduction

2.1.1. After Action Review (AAR) in World Vision International (WVI) is known as Lessons Learned (LL) – and is understood as a 'real-time' lessons learned or review process. WV has so far conducted a total of fourteen LL exercises. In the period 2001-02, WVI conducted learning events in Gujarat, El Salvador, Central Asia/Afghanistan, Chad and in Southern Africa. The LL approach now forms an integral part of WVI's engagement in each complex emergency response.

2.1.2. In spite of its formidable track record, WVI would be the first to admit, that its adoption of LL has not come easily. For the most part it has 'tripped' and 'stumbled' into LL. The first learning events were of questionable quality and it was only by virtue of its steep organisational learning curve, that things became more sophisticated as time went on. Superficially, much of WVI's approach bears strong resemblance to the approaches used by the British Red Cross Society (BRCS) and Tearfund (which will be explored later). The same questions are asked – what did we do well, what did we do less well? Yet, the WVI approach is largely home grown. WVI was not aware of the US Army AAR experience and WVI's first learning events predate those carried out by other humanitarian agencies. It is only in the past two years – after having successfully built up its own experience - that WVI has begun to cast its net more broadly, incorporating aspects of the good practice from other learning models.

2.1.3. The uniqueness of the WVI approach is that it views LL as just one part of a much broader lessons learned relief review system. The focus is on the documentation of those critical aspects of WVI's emergency response experience that are most likely to be lost to institutional memory and recall. In the case of WV, it is very difficult in practice to disentangle AAR from the larger lesson-learning system in which it is embedded. The emphasis on documentation, allows WVI to create a historical record - from which it can identify emergent good practice and practices that are less than useful and challenges that invite focused attention. At the heart the WVI method are clear Terms of Reference (TOR), which provide a standard framework for conducting learning events and for documentation write-up. The TOR is supported by a comprehensive and detailed set of guide questions encompassing all aspects of WVI's operations. The questions identify issues around good practice routines, which should be prevalent in all of WVI's emergency response activities.

2.1.4. In key respects, the learning system developed by WVI represents a global, learning system with field level learning outcomes. It seeks to be adequately inclusive of all stakeholder perspectives. Its focus is on integrating learning across a global partnership of interdependent national and support offices. The lessons captured therefore tend to capture the imperatives of WVI as a whole and not the idiosyncratic experiences of individual field offices. However, it is also clear from the Southern African Emergency Response case study, that where lessons are captured at field level, these are acted on informally at the local level, quite independently of the more formal actions taken at the global level. WVI has adopted a system where learning goals are made global and explicit thus allowing for the identification of learning from across quite dissimilar contexts. The reasons why WVI chose to adopt this approach are outlined in the discussion below.

2.2. The Origins of the WVI's Lessons Learned Approach

A. Challenges

2.2.1. The WVI approach to LL evolved in response to a number of challenges faced by the organisation in the 1980s and 1990s. The challenges were various, but four critical challenges can be identified, which were highly influential in shaping WVI's adoption of LL as part of its emergency response activity. WVI has fashioned a learning system that is highly responsive to a set of institutional requirements. It illustrates that humanitarian organisations have at their disposal, a variety of entry points, for creating systems that promote learning. Learning systems can be seen to evolve from a range of unexpected directions.

2.2.2. *WVI's Partnership Structure* – The first challenge originated in the character of WVI's global structure, as a loosely affiliated, or federated Partnership, of independent national and support offices. World Vision International (WVI) is tasked with representing all members of the Partnership. The Partnership operates through a highly decentralised tripartite structure allowing for variable degrees of autonomy in operational decision-making. Some offices are affiliated national offices - managed and independent in their own right. Others are under the direct line management of WVI. This arrangement poses some quite critical challenges to WVI – the central problem being - how do you preserve the operational autonomy of national offices, whilst ensuring consistent operational standards, across all national offices in the Partnership?

2.2.3. *The Changing Face of Emergency Response* -The second challenge was a significant evolution in WVI's approach to humanitarian assistance that took place during the 1980s. The shift was marked by a move away from relief assistance characterised by food aid to a much more integrated, multi-focus emergency response. As WVI attempted to make this shift, there was the dawning realisation that a new level of complexity and uncertainty had been injected into WVI's operations. Different country offices were adopting different approaches, and the lack of congruity between the approaches made it almost impossible to identify, how where and why, WVI was being successful, or less than successful, in conducting emergency responses.

2.2.4. The central problem was that the success of WVI's operational activities could no longer be identified using the type of quantitative indicators that had been used so successfully in the past. Food aid distribution had been a relatively straightforward affair. Monitoring and measurement primarily involved the physical measurement of quantities of food distributed, the timeliness of distribution and details of beneficiaries reached. WVI's shift to increasingly sophisticated concepts of emergency response, incorporating a rights-based agenda with strong links to development, advocacy and a focus on children, implied a qualitatively different paradigm for monitoring and measurement. Existing tools for monitoring qualitative aspects of performance proved inadequate for this new task. LL became a tool for self-assessment aimed at helping personnel to articulate what the more qualitative aspects of performance might comprise.

2.2.5. *An Audit Culture* – The third challenge was the central role played by audit in WVI. WVI had always believed that it handled accountability well. Traditionally there had always had a strong audit orientated and audit compliance centred culture. WVI undertakes an audit of national offices every three years and requires national offices

to conduct their own audits on a yearly basis. Audit was the agreed basis by which the Partnership as a whole was able to establish a common standard to underpin its operations. Audit proved relatively uncontroversial given that it represented a globally recognised and accepted practice and did not appear to impinge too much on national and support office operational autonomy. Other mechanisms for ensuring accountability, for example - evaluation, appeared to be far more intrusive: since there was no agreed standard that could capture the diversity of activity involved in WVI's new approach to emergency response.

2.2.6. As the complexity of WVI's operational activities grew, so did the elaboration of its audit processes. WVI was successful in developing its own specialist audits. WVI, as the largest food aid distributor outside the World Food Programme (WFP), was able to achieve the lowest ratio of food loss (less than 1%) to the Food Aid Standard (FAS) of any agency. Much of that success was due to its own Food Aid Audit (FAA). The audit approach was also extended to include risk analysis for projects and programmes. However, as the scope and quality of WVI's emergency response changed: audit proved increasingly inadequate as a means for harmonising standards across the Partnership. The frame of measurement had irreversibly changed, and audit was insufficiently flexible and sensitive to cope with this new situation.

B. Reaching for a Solution

2.2.7. The mid to late-1990s saw WVI in a triple bind. The organisation had adopted sophisticated emergency assistance interventions but lacked the tools to measure their effectiveness. The disparate nature of the interventions, and diversity of approach, threatened to weaken WVI's ability to uphold standards of operational consistency across the Partnership. In addition, other conventional accountability tools – audit or evaluation, either did not work, or threatened to impinge on one of the key founding principles of the WVI Partnership: namely the right of offices to engage in autonomous operations. These problems were further compounded by a number of inappropriate emergency response interventions. WVI's difficult and problematic performance in the 1999 Kosovo emergency was to give impetus to a new initiative.

2.2.8. WVI was to establish the Best Practices and Relief Standards Working Group (BPWG) - now known as the Relief Review Network (RRN)) - comprising a small team drawn from support offices across the Partnership. A set of Emergency Preparedness and Response Standards (EPRSs) were drawn up in 1999. The standards identified emergencies as being Category 1 (containable local emergencies) led by the National Office, or Category 2 (regional emergencies) led by the Regional Office, or Category 3 (complex emergencies) led by WVI. Initially it was proposed that a central evaluation department be established. The BPWG realised however, that the real issue was not evaluation per se (even with all the institutional baggage around evaluation), but that WVI had appeared to be incapable of learning from its past experience. A shift was required, away from an emphasis on accountability towards a stronger emphasis on learning, and a shift away from the mindset of compliance towards one of dialogue across the Partnership. It was realised that WVI's own corporate understanding of its new emergency response process was still evolving, and that it was important that this understanding was communicated broadly within the Partnership.

2.2.9. The BPWG had a number of breakthroughs during the very early stages of its work. It identified a lesson-learning tool that had been developed by Mark Janz of WVI California. Until BPWG's formation, there had been little 'buy-in' to the use of the tool by WVI's senior management. The tool comprising a proforma template of guide

questions, loosely coupled to a participatory review technique, had been developed in response to the Mozambique (2000) flood emergency. WVI carried out a review while the response was still ongoing: dissecting out and breaking down the response to its operational sub-components. A series of questions aimed at identifying good practice had resulted. The tool was enthusiastically adopted as a protocol by BPWG, and its use made compulsory for all Category 3 complex emergencies, with occasional use in Category 2 regional emergencies. There is at yet no requirement that the lesson learning be conducted for Category 1 national office fielded emergencies. A trial was also conducted of the tool in the context of the East Timor (2000) emergency and then again for Ethiopia (2000), which also benefited from the implementation of a new Emergency Response Mechanism (ERM). The full approach was then used for the Kenya drought relief programme towards the end of 2000.

2.3. Adopting the Lessons Learned Approach in WVI

2.3.1. The WVI LL approach is set out in a set of guidelines *Lessons Learned from Emergency Responses: A Tool for Developing Lessons Learned and Facilitating Documentation Workshops* last revised in October 2002. The guidelines set out the generic framework for the conduct of the LL exercise. Lesson learning begins sixty to ninety days into an initial operational response, so that institutional memory and recall remains fresh (a longer period is allowed for slow onset disasters in order to give time for response activities to gain momentum). The sequence of events in a LL exercise are described as follows:

2.3.1. Before the Lessons Learned Event

1. Identify all Participants for the Lessons Learned Process – everyone who was directly involved in the emergency response is identified. In circumstances where participants are physically dispersed, an LL may be conducted virtually, by video or teleconference.

2. The 'Tool Kit' Questionnaire - A standardised questionnaire has been developed which is sent out to all participants. It contains a set of trigger questions or prompts to draw out appropriate responses and inputs prior to the LL. The questionnaire is quite comprehensive, covering fourteen operational areas, all of which are likely to feature in each WVI emergency response. Those specialist areas are:[1]

- Communications Management;
- Donor Visit Management;
- Volunteer Management;
- Networking and Collaboration;
- Funding and Resource Management;
- Staffing Issues;
- Logistics;
- Relief Supplies Distribution and Gifts-in-Kind Management;
- Programme Development, Implementation and Management;
- Management of Information Systems;
- Preparedness and Rapid Response Strategy;
- Emergency Response Structure and Decision-Making;
- Security Issues;
- Advocacy and Ministry;
- Open Questions

[1] In order of listing by WVI.

Between six and ten questions are asked in each area of operations. Rather than constraining the LL, the questions aim to engage participants in a reflective and thorough process of analysis before, or at the start of the LL. This ensures that participants are not entirely unprepared when they participate in an LL event, and that the event is not entirely based around unstructured memory and random recall. The questionnaire also asks respondents to identify – "what did we do well, what did we do less well?" The questionnaire is continually updated and revised against each LL event.

3. How is the Questionnaire Used? The questionnaire is sent out to everyone, who has been engaged in the emergency response well in advance. It enables those who will not be able to attend the LL to feedback their responses in electronic written form. This feedback is later incorporated into the LL event. In circumstances where large LL events are planned, often involving more than one office, each office collates feedback into a working document before the LL. The questionnaire is used to ensure:

- a standardised approach - the trigger questions implicitly define the scope, consistency and depth of the LL for each emergency response. Each workshop follows a standard format, which allows for comparison between different emergencies;
- documentation, familiarisation with LL procedures, reflection and analysis before the LL event – Part of the work has already been done before the LL event is held. Participants have done some initial structuring of their thinking. The facilitator has received written feedback, for familiarisation, and for the planning and structuring of the event;
- documentation – the first stage of documenting lessons learned has commenced, providing a record of raw data. This is then the data that is later refined, recontextualised and given clarity through the parallel LL workshop discussion.

2.3.2. Facilitation

1. The Facilitator and Note Taker's Role – An experienced facilitator is recruited (either in-house or as an external facilitator) at a very early stage in the process. It is important that the facilitator is not directly involved in the response so they are a not biased and can probe alternative sides to any disagreement. It is also important that the facilitator has sufficient orientation and familiarity with the process (i.e. has seen questionnaire feedback or has been able to meet participants and organisers) before the actual event takes place. A note taker is also recruited separately from the facilitator.

The facilitator also has to create a non-threatening environment in order to have issues discussed without participants apportioning blame. Positive lessons have tended to outnumber negative lessons providing sufficient incentive for people to open up to the process. The most challenging aspect is for the facilitator to probe respondent stories and aid their translation into lessons.

2. Guidelines for Facilitation and Note Taking - WVI has produced several guidelines for facilitation and note taking:

- Competences. The facilitator should have assisted at least one other LL event;
- Building capacity. There should be a co-facilitator – somebody locally who is keen to move to a full LL facilitation role in the future. The concern here is to build capacity and sustainability for the LL process;

- Workshop aids. Facilitators are required to use the tool kit questionnaire as the basic approach for the LL workshop as well as a Power Point introduction to the process and to the desired outcomes.
- Note taking. The facilitator's role should be separate from that of the note taker. The note taker must capture dialogue in small group sessions as well as the discussion in the plenary session. Good note taking is critical to the success of the LL – the written record of the event needs to be comprehensive, detailed and accurate;
- Small groups and note taking. A written record should be made of all discussions – even those taking place in small working groups. Where it is not possible to have a formal note taker, somebody should be nominated to undertake note taking on behalf of the group. An LL workshop may therefore require more than one note-taker. All small group discussions should be documented by the group. Lessons documented are shared and probed in a wider discussion in a plenary session. Lessons are then rated as top 10 and top 5 by the entire group in the plenary.

At the end of the LL all aspects of the event are written up in document form. The facilitator, the note taker, or an event organiser or coordinator, might undertake this.

2.3.3. The Lessons Learned Event

1. How The Workshop Event Is Structured – WVI tries to allow two days for an LL workshop event around an emergency response. The workshop revolves around the following lead questions:

a. What did we do well, what did we do less well?
b. With reflection, what was missing from the prevailing perception of the response? What additional lessons did we learn?
c. So what? How will the major lessons inform our future response and preparedness for emergencies?

- Day One. The first day involves identifying lessons in small working groups with report back and discussion within a plenary session. The groups are sub-divided along the lines of the operational and specialist areas outlined in the Tool Kit questionnaire. The groups then report back and discuss the lessons identified in the plenary session.

- Day Two. The morning of the second day is used to prioritise the lessons generated during the first day and give clarity where required. By mid-day, a final plenary will have been conducted to work through a sizeable list of lessons learned, whittling them down no more than ten priority lessons. The afternoon is spent identifying how these ten lessons learned can be applied to future emergency responses.

A third day is now envisaged which aims to reduce the list of lessons learned still further and identify how just a few priority lessons can be integrated within the organisation from a management and leadership perspective. The intended objective is to narrow down and eliminate the largest number of lessons possible, in order to focus the energies of the group around the application of just a few lessons.

2. *Importance of Senior Management 'Buy-in'* – Considerable importance is attached to attendance by senior WVI management. Guidelines require that WVI's

senior regional relief leadership – Regional Vice-President (VP), sub regional directors and National Directors attend and participate in the workshop. This has proved important in ensuring senior management awareness and application of lessons at this level.

2.3.4. After the Lessons Learned Event

1. WVI's procedures for what happens following an LL workshop have evolved significantly over the past year. The sequences of steps, which are currently being evolved, are described below:

a. Validation of Lessons Learned – Following the workshop, a narrative of workshop proceedings is created. Workshop proceedings are then compiled into an edited and abridged account of the LL, which is then sent out to all workshop participants and their offices for comment. Once feedback is obtained, a consolidated document is then produced for circulation, within WVI. This document is then archived and placed for retrieval in an accessible location. Once the document has received management approval it is then available for public distribution.

b. Follow-up by National and Support Offices – The lessons learned and discussions over the course of the workshop form the basis for follow-up by management and personnel in both national and support offices. Prioritisation of lessons learned lead to the development of goals for follow-up with specified actions required of named individuals. There is at present no clearly defined procedure for monitoring whether follow-up actually takes place at this level.

c. Review of Lessons and Follow-up – The consolidated lessons-learned document is reviewed by two WVI working groups: the BPWG and the Operations Working Group (OPSWG). Recommended actions from both working groups go to the Relief Forum (RF). The RF meets every six months and comprises senior management who have responsibility for disaster response and disaster mitigation. The RF has the mandate and remit to make quite significant decisions with regard to WVI's emergency response. The only area, where changes cannot be made is with respect to policy, where the RF can make recommendations to the Board.

d. Looking for Trends in Lessons Learned – Once a lessons learned exercise has been completed, the BPWG undertakes a trend analysis to establish whether new lessons have emerged, old lessons re-emerge as the result of the lack of incorporation into practice and whether other lessons don't reappear, either because they are no longer relevant or because they have been successfully captured, learned and put into practice. To date, the BPWG has identified nine major trends and thirty-six minor trends. Trends are classified under four categories – standards, structure, staffing and practices. A fundamental review of trends is conducted every three years.

2.4. The Southern Africa Emergency Response – Lessons Learned Workshop

2.4.1. The lessons learned workshop on the 'Southern Africa Famine Emergency Response (SAFER)' was held on the 15 - 16 October 2002. The LL was one of WVI's most ambitious lessons learned exercises to date, involving six National Offices – Malawi, Zimbabwe, Zambia, Mozambique, Swaziland and Lesotho; four Support Offices – Canada, U.S., Germany and the U.K., the WVI Southern Africa Regional Office (SARO) and the Partnership's South Africa Famine Emergency Response

(SAFER) team.

2.4.2. Given the ambitious nature of the exercise, the process of run-up to the workshop began in August 2002, when the LL Tool Kit questionnaire was distributed to National Offices and Support Offices. Two months were allowed for responses, and National Offices and Support Offices were encouraged to do their own LL exercise. National Offices were asked to allow at least one-day for this LL exercise bringing together a review group of staff directly involved in SAFER operational activities. In the case of Support Offices the LL exercise was optional, but both types of office were requested to submit documents, based on staff feedback, at the end of September 2002. The facilitator – a WVI Australia staff member, who had no previous involvement in SAFER, was given two weeks to familiarise himself with the exercise and undertake a provisional review of materials. During the workshop the facilitator worked with two note takers and an editor, who took responsibility for the final narrative of the workshop report.

2.4.3. The main LL event was originally scheduled to have taken place over three days, although in the end, this did not prove possible. The compact nature of a two-day event (given its unprecedented regional scope) forced the facilitator to focus on the prioritisation of learning points drawn from the questionnaire responses In total, twenty-five potential lessons were highlighted and reduced down to ten key learning points. Prioritisation focused on identifying those learning points, which represented reoccurring issues for all offices involved in the emergency response. The key points were distilled down, triangulated and represented on flipchart sheets during the workshop.

2.4.4. The first day of the event saw the 35 participants split up according to their respective offices, in order to make initial presentations. The workshop group as a whole was able to gain some understanding of the constraints and issues facing different offices in the region. Participants were then reorganised into working groups. Each working group was responsible for reporting back on a selected number of operational areas identified in the LL Tool Kit questionnaire. Members of the groups were carefully selected, subdivided by expertise, and operational responsibility. An effort was made to ensure that each group had sufficient diversity. Internal and external stakeholders were balanced proportionately across the five groups. Different levels of WVI management were also balanced out across each of the groups. The groups were then asked to rank six lessons learned, according to priority, and arrive at a consensus on the top three priority lessons learned. Each group then reported their findings back in plenary session during the afternoon of the first day.

2.4.5. The second day of the event saw the participants reviewing the top twelve prioritised lessons learned (these were then whittled down to ten lessons learned over the course of the day). The facilitator used the classic ‘hallmark’ AAR process questions: ‘What did we do well, what did we do less well?’ etc placing great emphasis on working with the group to try to understand what really did happen and why it happened. Getting the whole group to agree and reach consensus was the key aspect of this exercise. The exercise of building consensus had a number of distinct stages.

2.4.6. The initial presentation by the various offices demonstrated considerable consensus across office teams. Even greater consensus was achieved when the participants were subdivided into specialist operational areas. The main differences

and divergences emerged during the plenary session during the second half of the first day. A pre-meeting was organised on the second day, to iron out any differences, and to enable the facilitator to respond to any changes. This allowed the facilitator to keep the agenda on course and provide the necessary degree of focus for the second day.

2.5. Observations and Reflections

2.5.1. A number observations and reflections were made by WVI staff who participated in the event. Their feedback provides important insight into the dynamic and emotional quality of an LL event.

2.5.2. National offices had been asked to conduct their own mini LL exercises. The results and the processes used proved highly uneven. In one case, a dedicated team spent two days sifting out their lessons. In the case of another office, the whole exercise was reduced to half a day of activity, working through the Tool Kit Questionnaire. The conclusion reached was that a greater effort needs to be made, to ensure a consistency of approach, across the different national offices. Despite this issue, it did not seem to impair the overall quality of the main LL event. The task for the facilitator was to get all the issues on the table quickly. The event was very concentrated. Everybody needed to be heard, respected, trusted and his or her contributions explored. Pulling together the main leanings was hard on time. Each specialist operational group had their own style. The ND and senior management group genuinely believed they knew all the answers. Other groups were a little more exploratory.

2.5.3. In key respects the process was very challenging for NDs. Although much of the event was a process of visiting 'old ground,' NDs were now being required to field questions in a quite different context. In a number of cases this resulted in NDs having to change their view of a particular experience and having to re-evaluate what was being done by the office. Some NDs were required to answer very difficult questions that could not have been asked by their own staff. Contributions were circumspect but also candid. Overall, there was a considerable degree of commitment to the process. Participants were genuinely looking for support and ideas, and there was recognition that a number of offices had made mistakes. Issues related to failure, error and shortcomings were generally handled well.

2.5.4. Overall, a number of concluding comments can be made. The event generated a number of unexpected 'ground truths'. For example, it was not generally realised by expatriate staff that their arrival in country during the first days of the emergency, generated acute fear among local staff that they were about to loose their jobs. The perception was that the expatriate staff had come to replace them and that they were not up to the task. The event also brought into focus, the 'lived' experience of the emergency. The emergency was still ongoing and 'close'. This allowed for a very real 'dynamic' to the event with everybody contributing. An open forum was created, where opinions and views were freely expressed, allowing people to get issues off their chests. It was also guided by a conviction that the field could take action - there and then - to implement the changes being surfaced through the event. It also proved useful as a cathartic closure process, marking the end of a very fraught, and intensive period of activity for many of those involved in the engagement.

2.6. Strengths and Weaknesses of WVI's Lessons Learned Approach

2.6.1. The global and integrated character of WVI's LL, marks it out as a highly sophisticated response to a complex set of challenges, many of which are not unique to WVI. At first sight, much of the pioneering work undertaken by WVI suggests a potentially productive approach, ripe for adaptation by other organisations. A second sighting, however, might reveal the approach to be too much a product of the particular institutional circumstances of WVI to have broader application within the Humanitarian Sector. Only through case-by-case comparison, looking at the particular circumstances of individual agencies, would it possible to determine whether the approach has broader applicability. This section aims to map out some of the strengths and weakness of the WVI lessons learned approach, to help inform those who might be considering moves in such a direction.

2.6.A. Strengths of the WVI's AAR Approach

2.6.2. *Embedded in More Ways than One!* – One of the key strengths of WVI's lesson-learning system is that it not only harmonises practice across a partnership, but also has the potential to harmonise practices of a single agency across a variety of emergency contexts and different programmes or projects within the same emergency context. For WVI, however, its particular importance lies in its ability to harmonise operational activities across a partnership of autonomous offices. More overt types of intervention – even if institutionally possible – would threaten the delicate balance of co-dependency and autonomy within the Partnership. LL is important because it is embedded as a non-intrusive and novel form of 'control', able to span the different component parts of the Partnership without imposing excessive demands. The BPWG coordinators of the lessons learned process are drawn from across the Partnership so that no one 'member' is privileged. LL is very much a necessary part of how WVI works. It cannot easily be substituted, because WVI has yet to find a better alternative for harmonising operations across the Partnership.

2.6.3. These observations suggest that when learning initiatives are central to the systems and processes of an organisation they are more likely to be successful as well as more sustainable. Initiatives tend to fail when they are treated as 'add-ons' to existing activity. They then become superfluous, when the champion or promoter leaves, when work builds up and other priorities become overwhelming, or when discouragement sets in after the first few experimentation attempts. LL in WVI is a sustainable process because it has managed to respond to a number of institutional needs simultaneously. It holds a pivotal position in an evolving Partnership structure and meets other needs ranging from cross-office communication and knowledge sharing to monitoring and evaluation.

2.6.4. *An Adaptive Tool for Coping with the Future* – WVI places great stress on LL as a means of looking for emergent innovative trends, which could be adopted more broadly within the organisation. Not only are successes and weaknesses identified where corrective action can be taken immediately: trends over-time can be used to identify longer term, deeper and more systemic issues where corrective action takes longer to organise and where successes take time to disseminate. Through this longer term incremental process of discerning trends and taking corrective actions – LL has the potential to shape the overall profile of WVI's emergency response.

2.6.5. *Structuring and 'Framing' the AAR* – WVI is quite unique in setting an LL off against a series of written pre-structured guide or 'trigger' questions. For example:

> "Within the context of this event (i.e., location, scope, needs, population

> affected, etc), what specific and deliberate approaches were used to incorporate SPHERE in our emergency response program design and delivery?"

And:

> "What specific steps were taken to debrief and update staff on security conditions in the field, particularly inexperienced, newly seconded, or other staff working with partnering agencies?

In contrast, most classic LL processes are very vague in defining what sorts of issues should be addressed. It is assumed that participant memory and recall is sufficient in itself to identify what issues are important for the organisation and that participants carry some sort of coherent cognitive map that will inform their responses. In practice, due to the high degrees of complexity and uncertainty involved in emergencies, it is often difficult for participants to put their thoughts together and prioritise what is important, either individually or collectively. The pre-structured questions provide a means for shortcutting this problem by providing a more focused and directed process of memory recall and reflection. Pre-structured questions thus create a sort of meta-structure for the LL, defining boundaries and establishing a focus for the proceedings. By asking the same questions each time and by creating iterations of response around the same questions through successive learning events, it then becomes possible to establish sets of good practices that can inform subsequent emergency responses.

2.6.B. Weaknesses of WVI's AAR Approach

2.6.6. *Issues with the Pre-structured Question Approach* – However, there are a number of risks inherent with the pre-structured question approach. The first is, to what extent are the questions truly reflective of a real emergency response? Do they adequately reflect what people really do (or should be doing) when engaged in an emergency response? The pre-structured questions are in a sense an attempt to model an archetypal emergency. But if the modelling does not correspond with reality, then the lessons inferred, are unlikely to produce a match with the type of operational changes and applications needed. Similarly, there is a risk that through a filtering process – pre-selecting what might constitute good practices – the focus then becomes "are we doing things right?" according to the good practice generated, as opposed to "are we doing the right things?" based on the specific reality and needs of an emergency. The organisation may end up being 'good' at carrying out a set of good practice routines but not so 'good' at producing the outcomes needed for mitigating the effects of an emergency. The final risk element is that a method based on pre-selected questions can become routinised if done on a recurrent basis. The questions take on a 'checklist' quality, which may well give rise to another layer of unthinking 'ritualised' practice, rather than genuine learning.

2.6.7. *How Inclusive is the Process?* – From the start WVI did not set out to design a fully inclusive LL process. WVI staff participate unevenly in learning events around emergency response. This is primarily because WVI envisaged a global process of lessons learned from one large emergency to another: there is at yet no requirement that lessons learned process be conducted for smaller Category 1 national office fielded emergencies. The lessons learned process therefore does not capture the rich band of field level experience that arises around emergency responses generally.

Similarly, while WVI emergency staff are engaged continuously in learning events, from one emergency to another (allowing incremental learning to take place, which can be applied and adapted on an ongoing basis), for individual field offices the experience of an emergency may happen only once. It is therefore difficult for field level staff to apply their lessons once learned, unless the emergency is ongoing or there is a reoccurrence of the emergency. This constraint is also reflected in the format of the pre-structured questions, which takes an HQ focused perspective on an emergency (looking at the integration of specialist emergency functions), rather than trying to grapple with an alternate reality as seen and experienced by the field.

2.6.8. Other aspects of WVI's experience show that field staff gain much from the LL experience. Much of the learning captured during this event, was considered relevant and appropriate, and could be taken back and applied within national offices. But it is arguable that this was almost an extra-curricula type of outcome. The lessons-learned system has no means of monitoring, or recording, to what extent lessons captured are successfully applied in the field. This can only be captured indirectly by the broader lessons learned system – ie, where a lesson is subsequently learned and applied in another emergency response context or later in that same context. Here, the lesson is subsequently revealed, paradoxically by the absence of a problem (a lesson successfully learned), or through the reoccurrence of a problem (a lesson not learned) in new emergencies. In this context, it is the centre, rather than the field, that is engaged in a formal process of identifying and applying lessons learned. It is the centre that ultimately detects the underlying shifts in lessons captured from one emergency to next. The centre then has responsibility for diagnosing corrective action and identifying and disseminating best practice. Yet, WVI has also found that where National Offices take lessons to heart and address the issues around them, they are also able to move forward in their capacity to respond.

2.7. Ways Forward for WVI

2.7.1. Much can be learned from the WVI experience. The uniqueness of the WVI approach has been to embed an LL process inside a lesson learned relief review system, which can meet a range of WVI organisational requirements. It is therefore not simply about lesson learning. The system is a hybrid – and as with all hybrids - strengths can be perceived as weaknesses and vice versa. The issue then becomes one of trade-offs. To what extent should WVI work to mitigate weaknesses - if this leads to ever increasing degrees of complexity in basic design? Can such changes justify the associated difficulties in managing the system? To what extent has WVI the resources - or indeed the 'buy-in' or mandate from various national offices - to develop field-level lessons learned systems. Indeed it is true, that most things tend to work better and become more sustainable when they are kept simple! Yet WVI's approach is very much a work-in-progress. Certain issues that we have identified above are being addressed only through quite radical modifications in the lessons-learned approach. We will conclude with a brief summary of one of these modifications.

2.7.2. One of the problems that WVI has struggled with is: 'When is the best time to conduct an LL?' and 'How many LLs should be executed over the course of an emergency?' It has never been clear what represents the best 'trigger' for an LL – eg, a specified timeframe, or perhaps an event - to capture fully the learning arising from an emergency. WVI has moved partially towards the method devised by British Petroleum (BP) based on 'Learning Before, During and After' (LBDA). A 'Learning Before' stage is now envisaged which will complement the existing learning 'During'

stage. The 'Learning Before' stage will focus on previous events of a similar type to be reviewed jointly with new emergency response programme planners and implementers. These past lessons should help inform current and future planning for the emergency response. From a learning perspective, this establishes an initial benchmark, where assumptions, expectations and goals are made explicit, providing a 'frame' for subsequent activity. This will better enable WVI to phase its learning during the early stages of an emergency response, allowing it to have several stabs, or intervention points to contextualise what is happening as the emergency unfolds.

Part Three – CASE STUDY: BRITISH RED CROSS SOCIETY (BRCS)
Southern Africa Food Crisis – Zimbabwe - 6 February 2003

3.1. Introduction

3.1.1. After Action Review (AAR) in the British Red Cross Society (BRCS) is known as a Learning Review (LR). To date, the BRCS has conducted an LR event for six emergency responses. It is now an established part of BRCS's 'way of doing things.' It involves getting departmental heads, desk officers, advisors and those that would not normally have an opportunity to have a say (accounts, personnel, media etc) around the table for a three-hour review of BRCS's most recent emergency response. Discussion is guided by the questions – 'what went well?' 'What went less well?' 'What should we, do differently next time?' 'What action points did we take forward from the previous LR?' and ' what actions should we now take in the light of the latest LR?' The BRCS approach is highly informal: little preparation is undertaken prior to the review and staff are left largely to their own devises on how to structure their responses. The results of the review are written up as a two-to-four page summary. Because BRCS is not a large organisation it does not require an elaborate process for organising its LR activities.

3.1.2. The simplicity of BRCS's approach to LR stems largely from the needs of its organisational culture. The culture is built on a tradition of consensual and collegial working where relationships are highly personalised. The organisation as a whole tends to shy away from overt conflict and personal criticism. The work approach is one of relaxed engagement as opposed to one of 'working to task'. Rather than using LR as a means for identifying gaps in performance, it is used to create a neutral space, in which different departments within BRCS engage in dialogue. No formal mechanism exists within BRCS for such inter-departmental interaction. The non-judgemental character of LR, makes it amenable for dealing with issues, which in other circumstances might be passed over. There is also recognition that within a busy and quite frenetic environment, there are few mechanisms that enable staff to take time out and reflect back on past experience. LR provides an opportunity to set time aside for structured reflection. BRCS has yet to discover an alternative approach that is able to draw together staff from across the organisation to reflect back on past experience. Most importantly, LR has become embedded in the culture, having survived a potential succession crisis when its 'champion' and originator left BRCS.

3.1.3. The BRCS LR approach is headquarter focused. BRCS is not operational, in the sense of delivering humanitarian assistance on the ground, but acts as an interlocutor between donor and public, who donate to Emergency Appeals (EA), and national Red Cross (RC) or Red Crescent Societies (RCS), who are directly involved in the delivery of emergency services in-country. BRCS would not claim that its LR

process represents an example of field level learning practice. However much of BRCS's experience in the design and delivery of an LR process is directly applicable to any organisation that wishes to establish an LR process in the field. The main aspects of the process used by BRCS to conduct LR are illustrated here with reference to the LR conducted in February 2003 for the Southern Africa 2002 EA, which focused on Zimbabwe.

3.2. The Origins of BRCS's Learning Review Approach

3.2.1. Initial ideas on knowledge sharing and organisational learning stemmed from a BRCS concept paper circulated internally in 2000. The paper gave recognition to an understanding, already current within the Humanitarian Sector, that humanitarian agencies – BRCS amongst them – were not particularly good at learning from past experiences. Off-the-shelf and standardised approaches to disaster responses, despite repeated application, appeared not to work. Similarly, standardised management practices, comprising pre-defined goals, objectives and best practice, appeared only to work in stable and predictable environments. Emergency response situations, characterised by unpredictability and 'discontinuous change', required somewhat different approaches. The need was to - "'anticipate surprise' in order to act in a way that was faster, more adaptive and more focused". The issue was not only to find the right answers, but also to ask the right questions - to unlearn, in order to learn. The paper anticipated BRCS taking two steps. First, BRCS needed to anticipate surprise by managing, utilising and sharing knowledge. Second, it could only learn to do this successfully if it became a 'learning organisation'.

3.2.2. In practice there is often a gap between knowing what you want and knowing where to get started. It was not evident to BRCS that it would adopt LR as its primary learning approach for emergency response. LR represented something entirely new for the organisation. BRCS's thinking about learning plans followed an approach originally developed by British Petroleum (BP) and adopted by Tearfund, a UK development and relief agency. The model envisaged learning-reviews before an activity, during an activity and after an activity – Learning Before, During and After - LBDA for short. BRCS had initially contacted Tearfund to review its experience in setting up a knowledge bank. However, BRCS staff, were also impressed by the simple and straightforward way in which Tearfund carried out the LR component of the LBDA model. It was an approach that BRCS believed it could sell to its own staff. LR then became the entry point for developing learning around its EA.

3.3. The Adoption of the Learning Review Approach in BRCS

3.3.1. The adoption and adaptation of LR in BRCS owed much to John Mitchell, the former Senior Humanitarian Adviser (SHA). It required an enthusiastic 'champion' - convinced of the importance of improving learning - willing to put the learning organisation concept into practice. The approach adopted was one of stealth: recruiting and cajoling staff, by convincing them of the efficacy, the time-bound nature and straight-forwardness of the LR process, bringing them on board one staff member at a time. Once a critical mass of staff members (moderately receptive to the idea) had been established, it was then possible to pilot an LR event with a full quorum of emergency staff, along with other staff in BRCS.

3.3.2. The adoption of LR can also be attributed to a number of other factors. Senior management 'buy-in' was a necessary pre requisite for the acceptance of LR, as was the agreement of BRCS Advisers. This required a process of consultation. The paper described earlier – which also passed through several draft stages - provided support

for the concept. This was then circulated within BRCS. The learning organisation concept was profiled in presentations, both internally within the organisation, as well as externally to forums such as International Aid (IA). Potential supporters were thus engaged from within a constituency that extended well beyond BRCS. Other circumstantial factors also played a role. The fact that BRCS was not adequately learning from past experience was widely recognised within the organisation. There was clear recognition that something had to be done about it and that somebody should play a lead role. Critically, at an institutional level, BRCS lacked clear formal mechanisms for achieving operational coordination between its component departments. LR represented a 'soft' and relatively 'safe' solution for filling this gap. Other factors also undoubtedly played a role. A knowledge management initiative was underway within the International Federation of the Red Cross (IFRC) and BRCS must have felt some form of institutional imperative to ensure that it was aligned with the efforts of the Federation. Similar efforts by other humanitarian agencies – such as Tearfund - indicated that the rationale for knowledge sharing had also gained currency within the Humanitarian Sector.

3.3.3. BRCS's approach to learning review can be briefly summarised as follows. Past learning reviews conducted by BRCS indicate that they all tend to follow the same format. Participants are drawn from representatives of the various departments involved in the emergency. They are then asked to identify the three priority objectives of their departments. Each participant is then asked in turn to identify three points concerning what went well for their department, and what went less well. Actions and issues for future consideration, along with action points arising, are then listed. Some reviews also ask 'what would we do differently next time?' This last question was not a consistent feature of the BRCS LR process. The case study used to illustrate the main aspects of this LR process – the Southern Africa 2002 EA – identifies these elements in more detail below.

3.4. The Zimbabwe Emergency Appeal – Learning Review

3.4.1. The Learning Review on the BRCS response to the Southern Africa Food Crisis was held on the 6 February 2003. The critical elements of the Review were as follows:

i. *Timing of the Review* – The timing of the Review aimed to ensure that the largest number of BRCS staff members who participated in the EA (along with support staff) attended the Review. In practice this meant that it had to be delayed and postponed several times before the full complement of staff could be attained. The Review took place several months after the EA had formally closed.

ii. *Participants in the Review* - Twelve staff members, drawn from different sections of BRCS (including support departments), attended. All staff members were either departmental heads or were there to represent their departments. A vital core of staff members attending the LR had been involved, either for the full duration, or at critical points in the EA. Despite strenuous efforts to have everyone involved, two staff members who had played a significant role in the EA were unfortunately absent from the Review due to prior engagements. Critically the Review made provision for an in-house facilitator and a note-taker.

iii. *Creating a 'Safe' Environment* – A LR aims to provide a non-judgemental and 'safe' environment, which will enable participants to talk candidly about their experience. The BRCS Review was conducted with a high degree of informality and humour. It was evident that all participants had worked closely together and respected each other's views. This allowed for an open and engaged discussion.

iv. *Setting the Agenda* – The Desk Officer for Southern Africa identified six key points that identified the main challenges presented by the EA. The preamble provided a useful summary, set the agenda and provided the context for much of the later discussion.

v. *Departmental Review of Objectives* – Each participating staff member was asked to identify three key departmental objectives that had informed their participation in the EA. Given the number of people attending it took some time to complete. Objectives were presented in broad terms.

vi. *What Three Things Worked Well? What Three Things Worked Less Well?* – Participants were required to prioritise what had worked well and what had worked less well. Each had to identify three points for each question. Participants identified both outward-facing factors (factors external to the organisation) for things working well or not working well, as well as inward-facing factors (internal organisational factors) such as communication, clarity over roles, handover arrangements, logistics, financial procedures etc.

vii. *What Would We Do Differently Next Time?* – In the case of this particular review, participants were not asked what they would do differently next time. Instead the Southern Africa Desk Officer was asked to summarise the main strengths and weaknesses of the EA. The summary was done in a positive upbeat manner since BRCS had achieved some quite notable successes. The question – 'What would be done differently next time?' was introduced very briefly by one of the participants in the final closing exchanges of the Review.

viii. *Intervention By the Facilitator* – Once the earlier steps had been completed the facilitator gave the participants a number of options on how the review could move forward. The facilitator indicated that participants would have five minutes to review specific actionable recommendations (SARs) arising from the previous Learning Review covering the Goma EA. The Review could then either go into open session or participants could formulate SARs for points arising from the Southern Africa EA.

ix. *Review of Specific Actionable Recommendations (SARs) from the Goma Learning Review* – Recommendations were read out by the facilitator. It was clear that most participants were not able to identify the recommendations on the basis of recall from the past LR. There was a sense of delight when it was realised that many of the recommendations had been followed up and acted upon.

x. *Specific Actionable Recommendations (SARs)* – This was not carried out. Participants decided to go for open session to discuss the broader ramifications of the Southern Africa Crisis for (a) ongoing emergency assistance; (b) the linkage between humanitarian assistance and longer-term

development assistance; (c) the linkage between the HIV Aids crisis and the food crisis. Participants made the point on several occasions that they rarely had the opportunity to discuss the deeper, more exploratory aspects of their work. The opportunity to arrive at SARs through a structured process of investigation was lost. SARs were reconstructed retrospectively from notes taken during the Review.

3.5. Observations and Reflections

3.5.1. A number of observations and reflections can be made on the BRCS LR process illustrating the inherent complexity that informs even the simplest type of learning review process. The analysis presented here moves through some of the more critical elements of the LR, identifying the issues and problems that afflict LR processes. Its purpose is to provide pointers on how to design a strong learning process through LR. It explains what is important to the LR method and what was similar or different in the way that BRCS used the method. In many areas there are no easy solutions. Much is reliant on the judgement of those involved and the institutional context in which LR takes place. The issues and dilemmas discussed here, in the context of BRCS, are likely to be faced by any organisation trying to implement an AAR-type process.

1. Timing and Participation in the Review

3.5.2. BRCS were extremely conscious of the fact that the LR needed to include staff across the organisation. A judgement call was made – should the LR be undertaken when events were fresh in participants' minds, or should the review be delayed, so that it would be inclusive of the largest number of participants? BRCS decided for the latter. The LR was postponed several times and despite efforts to bring everyone together: two key staff members were not able to attend. It was agreed that these absences weakened the overall LR experience.

3.5.3. *Why is timing Important?* – Memory degrades quickly following the completion of action or activity. Recall is lost, diminishing the richness of participants' contributions and understandings. As memory fades, critical events are reinterpreted introducing large elements of hindsight bias. Within a relatively short period of time the interpretation given to an event can be entirely transformed giving a different meaning to the experience. Effective capture of learning requires the capture of experience when it is fresh.

3.5.4. *Why should all participants be included?* – First, LR aims to put the 'whole system' in the same room. By tracing out the contributions of all participants, it becomes possible for every individual to see the contributions of others and, correspondingly, their own role within a broader context. Gaps in understanding are greatly reduced as individual contributions build a more complete picture of what happened. The aim is to build-up a composite picture or a collective 'mental map' of the event. The picture or map thus forms the basis of a commonly agreed understanding as to what happened. Second, LR works by recognising a diversity of view. LR explores the divergent understandings of individual participants, identifying differences, before creating a convergence around a common understanding. LR does not allow any participant to 'second-guess' the interpretations held by other participants, nor is any participant allowed to represent a view on behalf of another.

3.5.5. *What is to be done?* - There are no clear rules that can help mitigate the trade-

off between achieving a timely event and a fully participatory event. Tentative rules might be:

- if the worst happens – it is always better to hold an LR rather than none at all;
- if the organisation chooses to conduct LR following an event, it should fix a date well in advance – some organisations go as far to make attendance mandatory with long lead times are built-in to ensure that everyone attends;
- on the other hand, it does not matter if timetabling leads to an LR being held while an activity is still being completed. LR is best conducted when actions and activities are still underway. It can, in many cases, lead to greater commitment by staff to an LR process, since staff are still fully engaged in the activity under review.

2. Agenda Setting

3.5.6. The Desk Officer for Southern Africa identified six issues to set the scene for the LR. In addition, the purpose of the Review was identified, by asking staff to articulate their departmental objectives. Successful LR processes require the identification of 'handles' or 'triggers' that provide focus and direction as a Review unfolds. These usually involve clearly defined objectives, in which the scope and purpose of the review activity are agreed and communicated. Given the infinite number of possibilities for scoping and framing a Review, the question then arises – did BRCS choose the right goals and objectives for maximising its learning from the LR? Were these goals and objectives manageable and achievable within the context of a three-hour LR?

3.5.7. *A focus on issues, which staff can 'fix', or influence* - Ostensibly the purpose of the LR is to review experience and identify potential areas of improvement with each EA. At a more pragmatic level, learning that leads to improved performance has to deal with practical, at 'hand' issues, which staff can either influence or deal with directly through their work. Goals and objectives must allow staff to 'drill down' to those issues amenable to change. In the context of the Southern Africa LR, the six issues initially identified were very broad in their scope. It was notable that the facilitator rarely made explicit reference back to these issues. Participants touched upon them in many different ways, though the issues never really had central position in the proceedings.

3.5.8. *Doing the right thing as opposed to doing things right* - Much of the LR was framed against departmental objectives, but was this useful? Defining departmental objectives has been a fairly consistent feature of the BRCS approach since the first LR experience. Looking back at past LR records, departmental objectives have not changed significantly over the course of a large number of EAs. Interestingly, participants found it difficult to identify three priority objectives for their departments and objectives were often tacit and unclear. Participants tended to describe their activities rather than their objectives. Why? The answer may relate back to why BRCS initially became interested in becoming a learning organisation. An emergency response is characterised by unpredictability and 'discontinuous change.' The need was initially to have learning in order to 'anticipate surprise'. Departments work responsively and reactively, thus departmental objectives are unlikely to remain static – changing tactically – as the life cycle of an emergency changes although overall department. Perhaps a more appropriate question might have been to ask 'how did your department objectives change over the life cycle of the emergency?' 'were you successful in identifying when a change in objectives was required?'

3.5.9. *What is to be done?* There are no clear rules that can automatically make an LR a productive learning experience. The primary question always has to be – what do we really want to achieve by doing an LR? This follows into the next question - what is achievable and manageable within the time you have? The final question then becomes: what can you influence, or deal with directly, by changing something in the way that you work? If these three questions can be answered, then it becomes possible to move closer to formulating productive objectives for the LR activity. Once that is decided, 'handles' or 'triggers' can be identified, to provide focus and direction as the Review unfolds.

3. Things that worked well, things that worked less well, what would we do differently?

3.5.10. BRCS follows a set of structured questions originally devised by BP. The questions ask participants to identify – what worked well? what worked less well? what would we do differently now? The questions represent a significant departure from the approach originally conceived by the US military, which asked participants to identify – what was supposed to happen? what actually happened? why did it happen? The BRCS approach goes right to the nub of the issue. It is not so interested in trying to reconstruct an event but wants to know what was successful and can therefore be repeated. What was less successful and should not be repeated. The US military approach is more reliant on observing what took place and the reasons why certain things took place. Its focus is on why events unfolded in the way that they did in order to understand why things worked out differently from how they were supposed to.

3.5.11. *Identifying causes for why things happen* - The BRCS use of structured questions, with its focus on 'what worked well and what worked less well', allows the LR process to move along quite quickly in identifying bottlenecks and areas where things appeared to work well. This 'shorthand' approach appears entirely logical. What is missing though is the ability to identify why something worked well or less well. What was the 'cause' that resulted in something working well? The approach thus allows participants to reach agreement on what worked well and what worked less well, but it does not allow participants to understand why something worked well or less well.

3.5.12. *Importance of asking - what would we do differently?* – The US Army approach, by asking – why something happened? – is concerned with understanding the nature of the sequencing the decision-making steps and the type of decisions taken, which resulted in the achievement of a desired outcome, or the gap between a desired outcome and what was actually achieved. Decisions give rise to actions that have implications in terms of cause-and-effect. The Tearfund approach also does this but from a somewhat different direction. By asking – what would we do differently next time? – the method is constructing a 'hypothetical' history; it is identifying alternative plausible actions, which might have resulted in more favourable outcomes. This would require reflecting back on what is known about events to understand the reasons for past actions and the reliability of their consequences. We noted earlier that BRCS has not always been consistent in asking the third question – what would we do differently?

4. Specific Actionable Recommendations (SARs)

3.5.13. *Points Arising from the Goma Appeal* **-** The action points arising from the previous Goma EA represented something of a highpoint for all participants. Most

participants could not recall exactly what had been agreed at the end of the Goma EA LR. What was surprising for everybody, was that when the action points were read out, a large number of the issues had already been resolved. It was an affirming moment for all LR participants who recognised that BRCS was not only capable of responding to issues, it was also taking corrective action to ameliorate them. The question was – how much of this had to do with the LR?

3.5.14. The action points for the Goma Appeal demonstrated that issues arising from LRs were being taken up within BRCS. However action points were recorded unevenly: some were just general observations, for example: 'more discipline over file notes', 'consider institutionalising knowledge sharing'. Others dealt with specific points arising that needed to be followed-up. In such cases tasks were assigned to nominated individuals with dates for completion. In other cases, the issues were expressed very generally: 'need mechanism to pick up on issues in the field earlier on and not just at debrief', with no indication as to how the point could be made actionable and nobody assigned overall responsibility for ensuring that the action points were followed-up. Thus, while issues arising from the LR were evidently being followed up within the organisation, follow-up was because of things happening elsewhere in the organisation rather because the LR acted as a trigger. The action points therefore tended to reflect what was already taking place. However the LR action points were not entirely without their use. They provided a basis for the ex-post monitoring, or assessment of whether activities had been undertaken, regardless of whether actions were initiated as a direct result of LR. LR action points became useful as a 'trigger' when important actions were overlooked.

3.5.15. *Action points arising from the Southern Africa Emergency Appeal* – It was noted earlier that the LR was brought to a halt prematurely as discussants moved into open session to look at some of the broader ramifications of the Southern Africa crisis. As we also noted participants were not asked what they would do differently next time. Instead the Southern Africa Desk Officer was asked to summarise the main strengths and weaknesses of the EA. Given that the LR had not asked the question – what would we do differently? – the ability to identify an appropriate set of SARs was greatly diminished. The action points, which subsequently emerged in the LR document, identified that further work was required around certain issues. However there was no identification of what was required? Why? How? By whom? For whom? and When? The action points represented a series of outstanding tasks, rather than a series of recommendations, which aimed to increase learning on how to do things differently next time.

3.5.16. *What is to be done?* - Although the subsequent open session proved useful for participants (it was noted that only when LRs were taking place did participants get a chance to debate an emergency) the LR process was never allowed to develop where it could produce useful learning. Although participants gave recognition to a series of shortcomings, which were expressed as follows:-

> "… a problem with feedback."
>
> "… difficult to see where decisions being made."
>
> "… little clarity about what to make a decision on, and this creates confusion with regard to who makes a decision."

> "… desk not always a focal decision-making point …not clear where decisions were coming from"

Shortcomings never made it into the 'action points arising'. On these types of issues one can legitimately ask the question – what should we do differently next time?

3.5.17. It is possible to suggest the following course of action that might have made the LR a more productive experience. About half way through the LR the facilitator might have asked participants to identify three priority issues. The issues would be targeted with the question – what would we do differently next time? The question opens up an opportunity for envisioning how things might have been done differently. Case examples of the issue could have been explored in some depth and alternative course of action identified for each case. The most plausible alternative courses of action – assuming that they are generalisable – come to constitute the substantive element of the learning arising from the LR. SARs are then used as a means for ensuring that these plausible alternative courses of action are trialed, or experimented with, during the next EA. Somebody is then mandated with responsibility for ensuring that the SARs are followed-up. In the subsequent EA – the SARs as implemented, are investigated to establish whether there has been any improvement in performance as a result. Where improvements can be attributed directly to a set of SARs this indicates that a lesson has been applied and learned.

3.6. Strengths and Weaknesses of the BRCS Learning Review Process

A. Strengths of the BRCS Learning Review Process

3.6.1. The BRCS LR approach illustrates a number of key strengths. The number one strength is that it represents an "opportunity for every part of the organisation involved in an EA to contribute and to understand the contribution of others." It is a voluntary process, participants are not required to attend, but there is nearly full attendance for each LR. This suggests that staff believe that there is some value in holding a discussion around a recently completed EA. For a number of staff the LR represented an act of 'closure.' It represents a natural point for reflection back and moving-on. It also establishes a vital underpinning for cross-departmental collaboration. The LR holds no unexpected surprises because coordination at this level is now quite tight. From a desk officer perspective LR holds additional importance. It is an opportunity for debriefing – creating an opportunity for feedback from others – which would otherwise not exist. Desk officers are often quite exposed in terms of their responsibilities. Peer feedback is important, as a means for ensuring that there is also a common experience, which reflects back to the individual experience of a desk officer. As such, it can be confirming and empowering – a form of validation for this unique and extremely stressful type of experience. However, as it was also pointed out, desk officers are only involved in an emergency "once in a blue moon", the real learning is for those who have a continued involvement in the management of EAs. A further area where LRs have contributed significantly is that they have generated much more questioning around "corridor decision making." However, the LR process has yet to be used as a tool for addressing this issue centrally.

B. Weaknesses of the BRCS Learning Review Approach

3.6.2. The BRCS approach appears to have outlived what it was originally set up to achieve. Its original aim was to create a forum for cross-departmental collaborative

working where each department could delineate a set of departmental objectives against their performance in an EA. While this process has created clarity as to how departments interface with each other and the desk, it has also created a very static process. Although departments still have problems articulating objectives this does not imply that departments do not know what they are to do. Rather, it implies that departmental objectives are so engrained that they sit tacitly and there may be no real reason for their explicit articulation. Since each LR always has the same starting point – it is an agenda 'replicated time and time again' – this may account for why one participant described the LR process as "jaded, insular and tired". In addition, the agenda may now be working against genuine collaboration in EAs. The focus on departmental objectives tends to emphasise the separateness of each department, while a genuine team-working approach would cut across each department, making such distinctions irrelevant. A team-working approach would place greater emphasis on meeting EA objectives (rather than departmental objectives). An EA Team (EAT) would have a separate identity from the departmental team. Departments would be viewed as pools of resources which could be made available to the EAT as a whole. Inter-departmental distinctions would play a lesser role as the focus became more centrally directed on the EA. This approach may well resolve some of the decision-making issues identified earlier. Few of these issues appeared to be related to formal cross-departmental decision-making. Most appeared to be related to on-the-spot decision-making on operational matters which did not connect directly with areas of departmental concern. A refocusing away from this departmental emphasis would inject a very different dynamic into the LR process.

3.6.3. A second area of weakness appears to lie – as one participant put it – in the "plethora of reporting mechanisms" now available to BRCS. This suggests that LR is viewed as yet another form of reporting mechanism. This was clearly evident in the number of times 'debriefing' was mentioned in connection with the LR. Yet, 'debriefing' is quite a passive process - as is reporting - and does not capture the more dynamic elements of LR as a means of feeding learning directly back into performance. The perception of LR as yet another reporting mechanism means that it is no longer clear where LR 'sits' within BRCS management system. It is therefore not surprising that staff are ambivalent as to its merits given that there is no clear rationale as to what LR is supposed to achieve. The corollary to this is that the LR is a weakly managed process – very little preparation takes place before hand, the actual event is weakly structured giving rise to inconclusive outcomes; post-event write-up is unable to identify clear actionable points; nobody is allocated responsibility - or has the authority - to ensure appropriate follow-up. Moreover, the Emergency Working Group (EWG), which used to play a role in feeding LR SAR's to management, but is currently inactive, could be resurrected to perform this function. The issue is not that LR could be done better – the issue is the lack of clarity about what LR is supposed to achieve. Once this is sorted out then the incentives become clearer for establishing a stronger LR process.

3.7. Ways Forward for BRCS

3.7.1. BRCS has reached a cross roads in its use of LR. What BRCS has managed to do is to institutionalise LR having ensured that the LR review process continued following the departure of its mentor and champion. This is no mean achievement. What BRCS is also recognising is that it has to rejuvenate the process: to keep it relevant to changing organisational needs. The questions are: how much does BRCS wish to invest in this process? and What does it wish to achieve by doing so? One

approach may be gear LR more centrally around the objectives of each EA. The EA document (along with the protocols of engagement for each emergency and the actual negotiation process with sister Red Cross and Red Crescent societies) might provide a firmer basis for establishing the objectives of each LR. This would generate a set of overarching objectives that could cut across departmental objectives. Another approach may be to have an LR nestling within a broader LBDA process. This would allow for a stronger reflection and feedback process during different stages of an EA. It would also enable BRCS to integrate LR more closely within it decision-making processes, thus providing greater clarity as to how this works. A third approach may be to use LR in a more focused and directed manner, diagnosing specific problems which recur across emergency responses: LR could then be used as a tool for orchestrating collaborative action around the problem.

3.7.2. There is much merit in what BRCS is doing at the moment. The issue may simply be one of overly high aspirations about what LR is able to achieve. All organisations need to identify: what they do well? what they do less well? The LR benefits may appear to diminish over time but it represents an important means for triangulating understandings. Ultimately, whatever BRCS decides to do, it can be done most productively by focusing on desired outcomes. It takes time to structure a set of SARs. It takes some effort to envision how things can be done differently. The LR process 'needs' to be engineered backwards. Greater time and attention needs to be given to the final stages of the LR than to the earlier stages. This will in turn determine what is manageable in terms of the scope for an LR. BRCS may decide, that with three hours to spare for the process, it is better to start and end with just one or two issues arising from an EA rather than to take the whole Emergency Appeal in its totality. The end point may be a richer and more directed learning experience with greater clarity around action.

Part Four - CASE STUDY: JOINT EMERGENCY FOOD AID PROGRAMME (JEFAP) CONSORTIUM

Formulation of JEFAP Guidelines for Community-based Food Distribution Workshops – Malawi 4, 21-22 and 30-31 October 2002

4.1. Introduction

4.1.1. An After Action Review (AAR) approach was used by the Joint Emergency Food Aid Programme (JEFAP) Consortium to develop a comprehensive set of guidelines on Community-based Food Distribution, drawing on the experiences of field-level workers in Malawi. As with the other case studies, the process was never formally constituted as an AAR, although it also used an AAR-type questioning format. It involved a series of workshops conducted in various parts of Malawi to discover how food was being distributed, a process used only once by the JEFAP implementing agencies (this grouping had a relatively short life, linked to the JEFAP's one year workplan). Three workshops were conducted. Each workshop asked three basic questions about the guidelines formulated for the JEFAP: what is supposed to happen? (with reference to the existing guidelines); what is actually happening? (current practice); and what should be done differently? (recommendations for revised guidelines). The learning events were conducted as a 'quick and dirty' process, with very little initial planning. A considerable amount of learning in terms of procedure had to be done during the first AAR event, which fed into the subsequent learning events with considerable success. Despite its ad hoc nature, outcomes were very tangible

and resulted in the development of a comprehensive set of guidelines, acculturalised to the Malawi context and informed by those who would use them on a day to day basis.

4.1.2. There are a number of important lessons to be drawn from the JEFAP experience. The first is that AAR does not have to be undertaken in a systematic fashion in order to draw benefit. A standalone AAR can achieve some remarkable outcomes if objectives are clearly defined at the outset and the AAR is designed to meet some clearly felt needs. The LSO facilitated workshops were, was not only clearly defined in terms of what it wanted to achieve, it also met the essential needs of a number of stakeholders. These needs were quite disparate in a number of instances, but proved sufficiently overlapping and convergent, to be incorporated into the AAR process. The second lesson is that the AAR model proved beneficial for inter-agency, multiple-stakeholder engagement. The AAR model therefore need not be restricted to a team, group or organisation; it can be used across organisations with a considerable degree of success. The key ingredient here is to ensure that there is 'buy-in' from each of the agencies involved, around some common purpose or goal. The third lesson is that an AAR can be a highly productive tool when it is focused on a job-of-work to be done. The task at hand had immediacy and relevance and all those involved had a material interest in seeing the task completed successfully. The final lesson is that the Learning events were highly successful in drawing together large groups of field-based staff, most of whom were neither consulted nor able to participate in events hosted by their organisations. In the Malawi context, a considerable number of field workers had no access to e-mail or telephone, and would often have very little direct engagement with a central field office. Much of their work was conducted in isolation, with very little organisational support or backup.

4.2. The Context

4.2.1. AAR represented the right solution, arriving at the right time, dealing with an issue lying at the heart of a combined NGO food distribution effort. The NGOs found themselves dealing with a highly complex emergency relief situation. The severity of the problem involved the arduous task of scaling-up food distribution efforts at a most extraordinary rate (i.e. having to double the number of beneficiaries in September 2002 and again in January 2003). The net effect was to overstretch the organisational capacity, of most, if not all, NGOs. The success of the effort was also largely dependent on the degree to which NGOs could coordinate and synchronise their efforts. This implied an additional, burden – though a necessary one - of developing collaborative links with other agencies and stakeholders. Much of this coordination and liaison work was done within the framework of an NGO Consortium, hurriedly put together in anticipation of the JEFAP. The Consortium was formed in May 2002 and the first distributions using food aid supplied by the WFP began in July 2002. The NGO Consortium members who became JEFAP implementing partners faced a new level of complexity involving them in a complex array of stakeholder relations that had to be managed and negotiated.

4.2.2. JEFAP was a programme of the World Food Programme (WFP) overseen by the government of Malawi. The NGO Consortium, formed to support JEFAP, comprised twelve NGOs – CARE, Malawi Red Cross, Catholic Relief Services (CRS), Oxfam, World Vision International (WVI), AFRICARE, Save the Children UK (SCUK), Save the Children US (SAVE), Salvation Army (SA), Emmanuel Information (EI), GOAL Malawi (GM) and Concern Universal (CU). JEFAP programme formed part of the overall emergency response programme of the Government of Malawi (GOM) that

was coordinated by the Joint Task Force of GOM, donor organisations, UN agencies and NGOs. JEFAP reported to the Task Force via the Humanitarian Response Sub-Committee (HRSC) that was chaired by the Department for Poverty and Disaster Management Affairs (DPDMA). From January 2003 onwards, JEFAP was additionally overseen by a Parliamentary Overseer Committee, appointed by the President. CARE represented the NGOs on the HRSC and also acted as Chair for the NGO Consortium. NGOs were tasked with responsibility for implementing JEFAP at the district level. In practice this meant that NGOs were allocated geographical areas for which they had responsibility - either as District Coordinating NGOs (as the nominated lead agency for the district) or as Implementing NGOs (which in most cases comprised local NGO partners). At district level, NGOs had to liase very closely with the Government, as represented by the District Commissioner (DC) for the area. Further down the chain at field level, both NGOs and DCs worked with Relief Committees (RCs) drawn from the Group Village Headmen and Village Headmen of each district. Within this quite complex configuration, NGOs also had responsibility for working according to guidelines, setting out standard operation procedures for targeting, distribution, monitoring and reporting, in order to harmonise the effort between organisations and across districts.

4.2.3. At a practical level, clear guidelines were hard to come by. Events were moving so fast that the magnitude of the relief effort only became clearer day-by-day, and few international agencies had any practical experience of having worked in Malawi before. Some 'quick and dirty' guidelines had been prepared initially by WFP in conjunction with CARE. Other NGOs continued to operate using their own standard procedures until the guidance framework became clearer. Additional points for guidelines were beginning to emerge in minutes of meetings, in memoranda, status reports, circulated emails etc. There was no concerted effort to pin these various elements down. Individual NGO managers found it hard enough to manage the deluge of Email related to day-to-day operational matters, let alone the particular Emails that might relate to developing standard operational practices. Where such details could be found there was no clear means for getting this information out to the field. In addition, the initial guidelines that were provided had been developed in other parts of the world or were drawn from very generalised global operating procedures. There was no specific guidance tailored to the Malawi context. Against this background, NGOs were extremely vulnerable to allegations of malpractice around food aid targeting. Such allegations were beginning to surface within Malawi's political elite leaving the overall JEFAP initiative politically exposed.

4.3. Adopting the AAR-Type Workshop Approach

4.3.1. What JEFAP required was an initiative, which could codify practices around the JEFAP community-based food distribution experience to date. Ideally, the guidelines would reflect quite squarely the Malawi context and cover the whole cycle from community sensitisation to post-distribution monitoring. The outcome would be a practical manual geared to the needs of fieldworkers. It was also hoped that a spin-off of this work, would be a manual, comprehensive enough to be used in emergencies in other parts of the world. Again, at a very practical level there was also a strong sense of limitation. A number of NGOs had attempted to create awareness around food distribution guidelines. In a number of cases this had resulted in the wrong people being trained. Elsewhere rapid staff turnover had severely depleted the numbers that had held knowledge of the initial guidelines. In such cases there was insufficient capacity for repeat trainings. Other NGOs, simply did not have the organisational capacity to enable field level managers to translate policy guidelines to staff at an

operational level. There was a further problem of reaching out to staff internally within these agencies. A proposal was floated, that NGOs with well-established guideline procedures, would train-up the staff of other NGOs. Again the fundamental obstacle was that of organisational capacity and there was no follow-up. Other proposals included the idea that a manual could be developed on the basis of individual interviews with field staff. This proposal was rejected as being much too cumbersome. A final proposal, also rejected, was that feedback could be obtained electronically through the circulation of a series of structured questions via Email. This was dismissed, partly because of the problem of Email overload, but also because Email was not accessible for all the respondents that needed to be engaged in the exercise.

4.3.2. The issue became a priority during a JEFAP Discussion Forum meeting in late September 2002. It was agreed that the development of a set comprehensive guidelines was long overdue. The question was how to do it? An initial workshop was held at the start of October 2002, where it was quickly realised that the wrong people were attending the wrong workshop. The managers and technical staff, who attended, had neither the immediate field experience, to inform the guideline formulation process, nor were they the same people that would actually be using the manual once completed. On both counts, the critical group absent were the fieldworkers, who had both the knowledge of existing practice and would be required to adopt any revised operating practice. It was quickly resolved that JEFAP would need to conduct a series of three regional workshops, in which NGOs would endeavour to 'bring their fieldworkers in' to identify the problems encountered in the field, and to use their experience as the basis for developing the guidelines.

4.4. The AAR-Type Workshop Experience

4.4.1. The workshops were hurriedly arranged. The first workshop was convened within two days of the managers meeting, in Blantyre in the Southern Region. The objective was to get the fullest participation of fieldworkers, from as many NGOs as possible, including local implementing NGOs. The managers had agreed that the best way to do this was to take the workshops out to where the fieldworkers were located, rather than have fieldworkers make the trek into some central location. The staging of the workshops in the southern, central and northern areas, aimed to achieve as broad a geographical coverage as possible, encompassing all districts in the country.

4.4.2. *The Structuring of the Workshops* – The idea of conducting the workshops using an AAR format originated with the ALNAP Learning Support Office (LSO). Initial familiarity with the AAR approach stemmed from a presentation made by LSO to the NGO Consortium. LSO indicated their willingness to handle some of the facilitation and process elements of the workshops as well as workshop logistics. The NGO consortium was receptive to the proposal given that it had very little capacity to undertake the task itself. The relative neutrality of the LSO – no involvement on the operational side, and its ability to play an 'honest broker' role – positioned it well to carry out this task.

4.4.3. *Evolution of the Workshop Concept* - The workshop concept went through several iterations – the first workshop represented the most critical formative experience for the whole workshop sequence. The areas of refinement and evolution in the workshop process can be identified as follows:

- o <u>The manager and technical staff workshop</u> – the original workshop held in late September was originally conceived as one of three regional workshop

meetings to be held by managers and technical staff. The use of the AAR method, by that time, had already been established and accepted. The manager workshop concept broke down at the very first event, when the managers realised that they had incorrectly selected themselves as the key participants for the event. The original aim was to have in-depth technical discussions on different aspects of the guidelines – each workshop was to cover a different subject area – the first workshop, community sensitisation and targeting, the second – food distribution, and the third – monitoring, reporting and evaluation.

- The basic workshop format - what is supposed to happen? What is actually happening? And what should be done differently? – was originally proposed as a set of guide questions to be sent out by Email to all offices. Once the email proposal was dropped, it was a relative short step, to reinserting the AAR guide questions back into the workshop framework as the LSO presentation and AAR method originally intended. The first workshop proved relatively unstructured. Initially, the three guide questions were downplayed. The proceedings were also nearly derailed as fieldworkers gave 'voice' to the issues and frustrations of initial implementation that concerned them most. Later workshops had a tighter structure and the guide questions were used in a more overt manner.

- A change in objectives for the workshops - Once the realisation had set in that the people required for the workshops were fieldworkers rather than managers and technical staff, it was realised that logistically the original technical discussion focus would not work. Work constraints meant that fieldworkers would not be able to attend all three events and it was unfeasible that such large groups of attendees should be asked to transport themselves around the country in order to attend all three events. If the workshops were to work, all aspects of the guidelines had to be covered, in each workshop. Once this was agreed, the focus was then able to shift to securing the maximum possible attendance of fieldworkers, from each of the three regions, in each regional workshop.

- The first workshop experience – The first workshop was initially guided by a set of very practical considerations – the first was the lack of time for preparation. Critical organisational details, such as agenda, the structuring of the days workshop process, the identification of facilitator roles was only decided the day before. Decisions about who should attend, was largely a numbers issue – a combination of the size of the meeting room, the number of NGOs involved and the proportion of fieldworkers who could take 'time-out' from organising and supervising food distributions. Short notice in contacting people, and a set of ambitious expectations about what could be achieved, meant that the workshop was planned as a one-day affair. Greater effort in ensuring that fieldworkers had advance notice of the event and that as many could come as possible (along with an additional workshop day) was planned into subsequent workshop events.

- Refinement of the workshop concept – The second and third workshops were carried out with a much tighter structure. The AAR guide questions became positioned much more centrally in the overall event. There was an appreciation, that for the majority of fieldworkers, the event provided one of the

only few points of contact with fellow colleagues and workers in other organisations; time was needed to enable this to happen. Additional time was also required for fieldworkers to air grievances. Facilitators became more adept at handling grievances: these were noted by the organisations concerned and a formula established for taking grievances out of the main proceedings. Thus, important issues – though not central to the development of guidelines – could be handled in a minimally disruptive and time-consuming fashion. As a consequence, workshops were developed for a two-day period. This suggests that the AAR experience was having an impact on NGO managers, who were now prepared to release staff for two days rather than one.

- Workshop Programme – the workshop programme evolved over the three workshops. The two-day programme – in its most mature form - fell broadly into five parts:
  - *Opening Address* – followed by an exploration of the guideline revision process. Outcomes and principal messages from previous workshops were feedback to participants using a power-point presentation and digital photos in order to convey a sense of the workshop process ;
  - *Key Messages for the agency country offices in Lilongwe* – fieldworkers feeding back their organisations experience, in terms of 'what was going well' and 'challenges' for each district;
  - *Small-group Working* – a 'carousel' type method was used where fieldworkers from the different NGOs were mingled and split into three groups. Each group was rotated between three discussion 'stations' where the group reviewed a particular aspect of the guidelines. Each station had a facilitator and recorder who remained at post for the duration of the small group working session;
  - *Plenary* – The plenary allowed for report back from each of the three stations. Key points, questions, suggestions were recorded on flip charts and were later typed up and appended to the report for each workshop;
  - *Evaluation and Close* – Evaluation forms were developed for the second and third workshops for written feedback. Oral feedback from the first workshop allowed for a series of adjustments for the second and third workshops.

- Facilitation – Additional facilitators were drawn into the process at a fairly late stage. LSO relied on NGO staff members among JEFAP implementing agencies to provide facilitation - on a voluntary basis - and did not seek to find external facilitators to do the job. The reliance on 'in house' facilitators probably gave the proceedings an initial 'edge' since an external facilitator would have found it very difficult to 'come up to speed' given that some knowledge was required of the guidelines and the operational context. However, this was a problem resulting from the lack of time allowed for facilitator orientation and probably did not stem from any conscious decision on part of the workshop organisers. Each facilitator had a different style of working - though this did not seem to impede the final result – the main differences stemmed more from organisational differences with regard to familiarity with guidelines – than with the quality or style of facilitation. Results from each of the workshops were broadly similar whatever the organisational affiliation of the participants or facilitation method used. The principal issue for

the facilitators was the uneven pace at which they were able to move through the issues. The workshops were time constrained. Each part of the workshop was capable of generating a veritable overload of new information and there was not much time to deal with any of the issues. Facilitators admitted that they went in with a bit of an agenda – each had their own 'roadmap' to follow in their heads. This was probably a positive element given the lack of initial structure and preparedness preceding the event. Throughout the workshop, the note taking function was kept separate from the facilitation function, with the note takers drawn from the JEFAP implementing agencies.

- Post Workshop Evaluation – On completion of each workshop a further review was carried out. Issues identified by the evaluation feedback indicated that could have been a further stage of fine-tuning for the workshops. Most of the issues involved very basic elements of workshop good practice. The main points raised were:
    - Make sure that representatives of all key stakeholders are invited.
    - Provide participants with the agenda and background documents well in advance.
    - Allow sufficient time for the task and the discussion;
    - Allocate a timekeeper so that sessions do not run over time.
    - Allocate time for regular breaks and energisers.
    - Provide meals at the venue (time is lost when people have to go out).
    - Schedule a variety of methods to enable maximum participation and a balance between plenary and group work.
    - Be focused and realistic about what can be achieved in plenary sessions.
    - Summarise the key points from each group session and at the end of the plenary discussion.
    - Organise the set up of the room well before the start of the meeting.

4.5. Observations and Reflections

4.5.1. A number of observations and reflections were made by participants involved with the workshops. The purpose of this section is to identify something of the dynamics that informed the workshop process.

4.5.2. *Participation* – The workshops added value because they brought frontline workers face-to-face. Many of those who attended, had never met before, despite being engaged in similar work for the preceding 2-3 months. From an inter-agency perspective, there was the full participation of fieldworkers from all agencies that made up the NGO consortium. Fieldworkers that had initially missed the first workshop held in the southern area were able to join the second and third workshops. There was also a broader involvement from those not directly involved in the consortium. Participants in the second workshop included the DC for Karonga, Malawi News Agency (MNA) and staff from three parastatal agencies. The third workshop in the central area included the participation of organisations that were not JEFAP implementing agencies – Concern Worldwide (CW), Evangelical Association of Malawi (EAM) and the Government of Malawi's (GOM) Department for Poverty and Disaster Management Affairs (DPDMA). In a number of cases however, the

involvement of external stakeholders resulted in a more subdued and less forthcoming dynamic. However, a significant group of participants were missing. Representatives from the Traditional Authority (TA) and from Group Village Heads (GVH) appear to have been missed out altogether. A vital voice from the community itself was absent.

4.5.3. Though diverse stakeholder engagement was important, the point to be made is that the workshops were primarily about the fieldworkers and their experience. Although the guidelines were important: the workshops also created the opportunity for the sharing of experience amongst workers carrying out similar tasks in different organisations. Collectively, the workshops gave fieldworkers a 'voice', which had previously been missing. Fieldworkers, who had only previously been able to relate in a limited fashion to direct line-managers, now had access to other fieldworkers, who could collaborate their 'stories' and to managers – from their own organisations and other organisations – to whom they could now speak to directly and publicly. In this sense, the workshops gave 'permission' for fieldworkers to speak their own truth - uninhibited and without fear of recrimination.

4.5.4. During the initial stages of each workshop – fieldworkers voiced criticism and frustration, with regard to the logistical bulk conveyance, handling and transportation of food aid – particularly with regard to timeliness and reliability of delivery. Fieldworkers also gave voice to problems engendered by inter-agency rivalries, inconsistent communication to communities and the frustrations created by the often-poor working relationships between District Coordinating NGOs and Implementing NGOs. For a limited period of time the workshops were able to transform the lines of communication running across the emergency response. For some of those present, the fervency of the criticism must have appeared quite threatening: many of the issues emerging arose from the accumulation of misunderstandings and miscommunications that inevitably occur when operating in an unpredictable environment. The workshops created space, where such issues could be surfaced, explored, explanations offered and solutions sought. The workshops highlighted the paucity - the limited nature of communication – within the emergency context, along with the rigidity and lack of imagination that underpins more conventionally defined systems of managerial communication.

4.5.5. *Ownership* – One of the paradoxical features of participation is that, while it can generate conditions for dissent and opposition, it can also give rise to a strong sense of ownership and commitment to a joint process. The LSO facilitated JEFAP workshops combined elements of both – the ownership dimension being critical for workshop outcomes. The fact that dissent was allowed to occur possibly strengthened, rather than diminished, the sense of ownership that came into being. From an inter-agency perspective, the workshop created a neutral space, in which all agencies could work towards a common purpose, uninterrupted by institutional rivalry. The feelings of ownership were even stronger for Malawi national staff. Not only were the workshops important in generating a manual that belonged to no particular agency, constituting a form of 'common' property, but the end product was also marked or 'branded' with the unmistakable 'signature' of Malawi. Malawian staff engaged in the Manual drafting process had previously found it very difficult to draft on the basis of other organisations' manuals, or on the basis of materials produced for emergencies in other parts of the world.

4.5.6. The opportunity to take an in-depth look at what was happening in Malawi permitted one of the drafters to observe:

> "suddenly our work became easier …… I could see the document evolving in front of me. Given the approaches presented in other manuals, I had the information needed for an informed selection and to make a 'fit' with Malawi.…. It was a Malawi document!"

It was this ability to inject collective ownership and participation into the drafting process that allowed for the emergence of a simpler and more directed document, which spoke directly to the Malawi experience. This was subsequently confirmed by the commitment of fieldworkers to integrate learnings directly into their work without having to wait for a final manual product. In Karonga, for example, Red Cross workers who had previously had very little training initiated their own improvements, in the way that they organised food distributions. One participant noted that there was an appreciation and excitement around the use of the guidelines and the importance of working with a methodology. It was noted that:

> "…rather than proving a burden [the guidelines] created a framework …. which could protect you. Taking care of most of our problems and concerns."

Favourable responses included:

> "It was user-friendly and simple"

And by including a directory of staff and other fieldworkers, it elicited responses, which included:

> "it opened communication channels – [about] who [we] should …contact. It opened
> doors about whom we should see. We didn't know this before."

4.5.7. *Understanding* – Prior to the workshop, the 'received' understanding of NGO managers - was that while guidelines existed in elemental form - the issue was primarily about the inexperience of fieldworkers (most of whom had only been recruited to work on the JEFAP programme) in providing a consistent application of what already existed. The aim of the workshop was to build a more elaborate understanding, based on what was already there, and to position it within a more comprehensive framework. It quickly emerged during the workshop – that the issue was not simply a matter of the unevenness of experience – it was more a matter of the simple basics - of guidelines not having been communicated outwards from NGOs to fieldworker staff. This was clearly reflected in the response to the question – what was supposed to happen? The extreme divergence in answers indicated some quite fundamental differences in understanding, which proved quite frustrating for some of the more knowledgeable participants. These cross-miscommunications were only cleared-up, when it became evident, that many participants simply had no knowledge of the guideline framework that was supposed to inform their work. The most appropriate question then became did you know that guidelines existed? If so, were you ever briefed on what the guidelines entailed?

4.5.8. This opened the way to a more fundamental learning process, where those who did have some knowledge of working against guidelines, were able to inform others - entirely ignorant of the guidelines - of their own experience. Those that were implementing guidelines – but with difficulty – would have also gained much from this

exercise. The group as a whole was then able to build a common understanding of the appropriateness and relevance of the guidelines - the opportunities presented and the trials and pitfalls to be overcome – by listening to the experience of others. However, the underlying issue was not so much the unevenness of experience in the use of the guidelines but the fact that quite large numbers of participants had no prior knowledge of the existence of guidelines. This poses some quite interesting insights on the AAR questioning process. The question – what was supposed to happen? – forms a fundamental part of the US army repertoire of AAR questioning, but does not seem to form part of the vocabulary for AAR techniques developed by BP (and used for example by Tearfund, WVI and BRCS). The question forms part of a 'reality check' on any event. It tries to establish at the earliest opportunity, whether in fact, everyone has the same perspective with regard to the action or event that they are reflecting on. Differences in perspective can indicate quite fundamental differences in understandings between different participants that need to be disentangled and acknowledged. The question establishes a 'ground truth,' requiring further diagnosis before things can move forward. In the case of the JEFAP experience, the answers created a certain amount of bafflement and confusion. Good facilitation becomes important at this point, in explaining the purpose of the question and the meaning of the divergences in the answer.

4.6. Strengths and Weaknesses of the AAR-Type Workshop Approach

4.6.1. The JEFAP experience illustrates a number of important strengths and weaknesses in the use of the AAR approach on an ad hoc basis. Much was gained by the sheer novelty of the event. Neither the NGO Consortium nor the JEFAP implementing agencies among them had previously committed to conducting large-scale, participatory workshop events with fieldworkers drawn from across their number, largely because it was only recently established and expected to have only a limited life. It was not geared up to do this type of activity. The individual agencies had neither the resources nor, it appears, a tradition of practice in Malawi which engaged fieldworkers in participatory workshop events. The experience was new to the agencies and fieldworkers. The JEFAP workshop process was thus able to 'throw-up' the novel and unexpected, departing from all previous norms of staff engagement. It is therefore very difficult to determine, whether the success of the process was due to the use of AAR type questions, or whether it was due to the overall workshop approach. This leads us to a number of conclusions with regard to the successes and weakness of the process.

4.6.A. <u>Strengths of the AAR-Type Workshop Approach</u>

4.6.1. The JEFAP approach achieved some important successes in three key areas: (1) the novelty of the process; (2) the workshops as a convention breaking process, and; (3) the workshops as an empowering process.

4.6.2. *The Novelty of the Workshop Process* - the workshops were significantly different than anything that had been done in the Malawi context before. Conventionally, workshops in Malawi had taken three forms. They were either conceived of as training events – participants brought together – with a trainer standing at the front imparting some of knowledge. Such events had the participants in a passive role - simple recipients of some sort of superior knowledge. Another type of workshop event was where discussion took place at the more abstracted policy level (i.e. the managers workshops initially devised for the guideline process would have fallen into this category) with no connection back to the operational level. Participants would resolve to translate policy into operations, but nothing would ever

materialise. Finally, where workshops were conducted at the operational level – these would invariably disintegrate into chaotic events, where different stakeholders would pull in different directions. The success of the JEFAP process was that it was reliant on bottom-up experiential learning – fieldworkers were deemed to have valid experiences - important and legitimate in their own right – which could thus constitute their own recognised body of knowledge. There was then the sheer practical nature of the event – with a clearly defined output – that provided a steer away from the policy focus so symptomatic of many other Malawian workshop events. It really was a case of learning by doing. Lastly, despite the fraught nature of stakeholder interaction, the guideline issue represented a clear area of consensus. Interests in this area converged to such a degree that the more conflictual elements of the process were subsumed beneath the common interest in 'seeing the process through.' This was aided in no small part by the neutral mediation role played by the LSO. It ensured that the 'flag' of no one particular organisation was able to predominate in the proceedings.

4.6.3. *The Workshops as a Convention-Breaking Process* - The workshops acted to break a number of conventions. New insights and understandings were created because the conventionally conceived and rule-governed ways of deciding, delegating and setting boundaries of membership had been subverted, albeit for a brief period. Lines of communication were no longer solely governed by the decision-making prerogative of management. Communication had been opened up, with staffs of organisations talking directly with each other and with their managements, establishing new priorities, perspectives and issues of concern. It was disruptive but also very pragmatic and practical. The face-to-face nature of the event uncoupled the connection between communication and decision-making authority, which had previously impeded 'bottom up' communication and lateral transference of knowledge. Communication no longer needed to be mediated and filtered by overworked managers. Both knowledge transference and feedback was immediate. It was possible therefore for very large numbers of people to convey and receive large volumes of 'rich' information in extremely short periods of time. The process heightened understanding and communication and more to the point did not detract from it. The process was therefore of a higher quality, more efficient and possibly more cost-effective than the sum of the efforts made by NGOs individually to engage in guideline dissemination.

4.6.4. *An Empowering Process* – The process produced a number of spin-offs all of which can be attributed back to the empowering effects of the workshop process. The workshop built confidence. It enabled fieldworkers - on the basis of their own understanding - to begin to apply what they had learned in their work, without reference back to the central office or their line manager. Facilitated by the LSO, the JEFAP implementing agencies had gained sufficiently from the experience to launch a series of one-day training events based on the JEFAP Manual that had been prepared using the material generated by the three individual workshops. In all, 250 fieldworkers, over eleven days in eight locations around the country. Prior to the workshops there had been issues revolving around resources and capacity to handle such a process. It appears that the workshops led to a much stronger consensus and commitment among the implementing agencies involved, which enabled engagement at this level. With the support of the LSO, capacity was developed to undertake the training activity. The process also contributed significantly to simplifying some very cumbersome tools used for building beneficiary household profiles, identifying food usage and undertaking post distribution monitoring, in response to demands from the

field staff. Furthermore, the draft Manual proved its value in demonstrating to Malawi MPs that targeting and distribution procedures were standardised. With the President of Malawi and MPs receiving complaints from their constituents, the JEFAP programme and in particular the targeting process had become politically contentious. The existence of a draft manual helped to diffuse some of the political tension.

4.6.B. Weaknesses of the Workshop Approach

4.6.5. A number of weaknesses are evident although it is difficult to know how much store to set on reflections around issues related to weakness. Had JEFAP done the workshops a second time around – based on the learnings gained from the first round - the approach might have taken a very different form. A quite fundamental issue was the absence of participation by the Malawi community. The Traditional Authority (TA) and the Group Village Heads (GVH) played a major role in JEFAP in every respect of the programme's implementation. Their involvement was critical to JEFAP's success. Yet, their absence from the workshop probably reduced the diversity of view that was so important for the formulation of what was a community-based approach. The need to ensure the broadest possible representation in an AAR event is critical to its success.

Part Five – COMPARATIVE ANALYSIS

5.1.1. The case studies collectively build a 'rich' picture of the dilemmas and constraints, the opportunities (and some of the possibilities presented) by using a technique such as AAR for review. The most telling observation is that even the simplest types of learning approach can be difficult to orchestrate. This is not because people are incompetent or ill-informed, it is because work environments themselves are extremely complex arrangements - the task of getting people together, getting 'consent' to engage in collaborative working and ensuring that the basic logistics of an event are catered for, often leaves little room for the pre-event preparation and post-event follow-up. Much of the reflective, deeper probing work around identifying 'burning issues,' seeking to give clarity to objectives, shaping areas of significant meaning for both the organisation and individuals – core to a successful AAR experience - all tend to get overlooked. Similarly, however insightful the learning that takes place, unless there is follow-up which shows the direct relevance of the learning to the work context, commitment to the process will diminish over time. What is clear, is that when AARs are constructed as 'mission critical' exercises dealing with issues central to organisation(s), they can achieve amazing results, as was so evident in the JEFAP case study experience.

5.1.2. Both WVI and BRCS lend important insight into what its takes to sustain and institutionalise an AAR-type process. In each case there appears to be a gap in formal management and organisational arrangements that cannot easily be filled. AAR is 'embedded' by fulfilling a clear institutional need that cannot be met in any other way. This suggests that more sophisticated approaches to AAR cannot simply be 'grafted' into organisations, or treated as an 'add-on' to what the organisation already does. It has to be positioned quite centrally to a 'gap' in an organisation's internal processes and systems. We would also expect this to ensure that the learning likely to emerge is central to the main imperatives of the organisation. Finding the gap and then filling it is not going to be easy and patience will be required to see AAR evolve, more or less organically, into a form compatible with an organisation's culture and imperatives. For this reason, it should be something of an anomaly to find AAR follows a fixed set of

conventions (or can be taken as an 'orthodoxy' to be adopted in one-form only) in the various organisational settings where it is used. In this vein, we felt that the most productive way of representing the comparative aspect of AAR was to set it out as a series of design problems to be solved. **Table One** overleaf provides a distillation from the case studies, the most essential questions that need to be answered in order to design an AAR process.

Table One - AREAS OF INQUIRY: AN INDICATIVE FRAMEWORK FOR AFTER-ACTION REVIEW DESIGN (1)

Area	Summary	Observations
1. Identifying The Purpose and Focus for Learning	What needs to be learned and why? (What counts as a lesson learned? Is effort focused in areas where the potential for developing learning and expertise has maximum payoff?)	The purpose of AAR is not to discuss everything or to conduct a post-mortem. The aim is to focus on a few critical issues. ▪ How are issues identified? Who selects the issues to be examined through AAR? How is the scope of the issue under examination decided? How are issues structured? Are issues always related to ongoing actions? Are clear purposes decided for the AAR before its implementation? ▪ Can AAR processes become unmanageable thus impairing the quality of learning – for example: Too many issues? Issues that are too broad in scope? AAR events planned with open-ended or competing objectives? ▪ What was supposed to happen? Were intentions or purposes ever defined in relation to the issues under investigation? ▪ Are past AAR lessons, action plans and results used as a basis for subsequent AARs? ▪ Are issues amenable to solutions by those directly engaged in the AAR? ▪ What triggers an AAR? What is the frequency of the AAR? ▪ Does the nature of the trigger and the frequency of AARs determine whether AARs produce useful learning? Or, do these factors limit the types of issues open to productive examination using AAR techniques?
2. Ensuring The Capture Of learning	What happened? (The longer one waits, the more the lessons learned decay)	The key to AAR is to be systematic and capture lessons as events unfold and not to wait until they are done. AAR is about recreating the reality of events, in other words, deciding what happened. ▪ Does the AAR involve all those who were closest to the event regardless of their level? ▪ Are participants solely reliant on their memories, or are other details made available in the form of logs, records of observations, minutes, documents, personal notes, visual material etc? ▪ Is the AAR sufficiently timely and immediate to the event, to allow individual participants to actively learn about the causes of their actions, to enable self-discovery and to take ownership of any resulting solutions? ▪ Is sufficient information available for all participants to understand the “big picture”? Do participants understand the experience, roles, responsibilities and intent of their colleagues? ▪ Are sufficient inputs elicited from all participants to ensure that everyone can see the ‘collectivity’ of their experience - bringing sufficient detail, clarity and understanding to what did or did not occur? Have individuals actively sought to understand the positions of other participants?

Table One - AREAS OF INQUIRY: AN INDICATIVE FRAMEWORK FOR AFTER-ACTION REVIEW DESIGN (2)

Area	Summary	Observations
3. The Group Learning Process	What happens as a group learns together? (How does team learning contribute to cohesion and performance?)	A successful AAR is a social process in which participants come together to make collective decisions about their performance ▪ Group size. Is there an optimum size for the conduct of AAR? ▪ Is AAR meaningful for functional groups where members are geographically dispersed or separated and may not normally meet? Can AAR work as a distance collaboration technique? ▪ Does group cohesiveness play a role in ensuring the effectiveness of AAR events? Is it further enhanced by active interaction among participants? Does AAR lead to greater group cohesiveness – trust, ownership of problems and solutions, common goals, worldview etc? ▪ Does the AAR structured, facilitated, reflective and non-judgemental approach result in better member participation, more information being shared, with interdependencies among team members being better illustrated and understood? Greater reflection on what is being done? ▪ What role does leadership and facilitation play in ensuring the success of the AAR? Does leadership and facilitation create an atmosphere conducive to maximum participation? ▪ What other benefits/costs accrue through AAR social processes in terms of organisational cohesion and performance?
4. Interpreting Learning	Why did it happen? (In order to determine how to improve)	A successful AAR requires all participants to arrive at a common understanding – a shared mental model - of the effects (of what happened). This understanding of effect must then be linked to a cause (why it happened), as a basis for problem-solving. ▪ How are participants encouraged to make inferences about the causes and outcomes of their actions? Is this achieved through an identification of key events, which are analysed further, or by a reconstruction of events, which are organised chronologically, or by some other means? ▪ Does the AAR look beyond surface issues and keep 'digging' to discover the real root cause of a problem? Do participants identify their own causes? Is cause and effect used to identify what is being done well, as well as for identifying problems that need fixing? ▪ Is the analysis disciplined and bordered? Focusing on cause and effect, in relation to those successes and failures which are amenable to action and solution by AAR participants? ▪ Can the analysis be re-interpreted in terms of what would be done differently next time? The demonstration of the application of learning. ▪ Is a walk-through conducted to ensure that everyone is in agreement about the nature of the link between cause and effect?

Table One - AREAS OF INQUIRY: AN INDICATIVE FRAMEWORK FOR AFTER-ACTION REVIEW DESIGN (3)

Area	Summary	Observations
5. Articulating Lessons Learned	What has been learned? (how do we understand learning?)	The learning points from an AAR may appear in a number of forms. In some cases it is difficult to decipher what represents useful learning. Issues which might be related to learning points and their representation are as follows: ▪ Does the AAR set out to achieve learning points, which are primarily the learning of the team? ▪ Are learnings unique to the situation: not simply renditions of what should constitute good practice or some other type of universal solution. ▪ In what form are learnings constituted: Do they represent new understanding about what was tried (intent) and what actually happened? Or, what is known now that was not known before an action was started? Or, if others were to start down the same path, what advice would be given? ▪ Are learnings achieved with regard to successful practice as well as failed practice? ▪ How are learning points translated into 'lessons learned' (good work practices or innovative approaches that are captured and shared to promote repeat application; or adverse work practices or experiences that are captured and shared to avoid recurrence)? ▪ Are learnings identified because of their significance to other areas of work outside the immediate AAR team?
6. Application of Learning	Who, What and When? (the importance of the learning lies in its application)	A successful AAR allows new learning to be quickly translated back into action and improved performance. A lesson is not learned unless something changes: ▪ How is learning targeted to affect specific operational problems and procedures? ▪ How are action-plans formulated, decisions taken and responsibilities mandated on the basis of AAR learning? ▪ Are the action implications of learning appropriately structured – for example, into: short-term actions – actions which can be taken quickly with immediate benefits; mid-term actions – those that affect systems, policies, practices and the organisation; long-term actions – those related to basic strategies, goals and values? ▪ Over what time-scales and what magnitude of change might we expect from the learning generated through AAR? ▪ Do frequent iterations of an AAR cycle, lead to greater learning proficiency, thus resulting in even greater improvements in performance? ▪ What happens when the capacity for action lies outside the immediate AAR team? ▪ How is AAR monitoring and follow-up conducted to ensure that learnings are applied in practice?

Table One - AREAS OF INQUIRY: AN INDICATIVE FRAMEWORK FOR AFTER-ACTION REVIEW DESIGN (4)

Area	Summary	Observations
7. Sharing of Learning	Who needs to know what AAR participants have learned? (What one group knows is more likely to impact if others also know)	Institutionalising and embedding the AAR lessons learned process within the organisation. Getting the right lesson learned to the right place at the right time represents the key to successful knowledge transfer: ▪ Can the lesson learned be transferred and replicated elsewhere? Does the AAR method limit the value of a lesson learn to the specific team and particular context being reviewed? What makes an AAR lesson learned amenable to broader sharing? ▪ What specific mechanisms exist for the contexturalisation of lessons learned, in order to ensure that they are useful for others doing comparable projects, others doing different projects, others who follow and the same team in the future? ▪ Are the results of the AARs documented and archived? Are they presented in an accessible manner using a common language and format? ▪ Is there a filtering and screening system to ensure the relevance and appropriateness of the lesson learned for broader dissemination; ▪ Are efforts to collate, analyse and disseminate lessons learned centralised? What types of dissemination method are used for this purpose? How are potential audiences targeted? ▪ Is there a system to identify mistakes and “relearned” lessons? Does the system address the status of “lessons learned” from previous AARs? ▪ How are lessons learned integrated with other systems, for work planning, training, resource allocation, operational activity and programme and project design? ▪ Do adequate feedback loops exist to identify effective corrective action in response to lessons learned?

Annex One – AFTER-ACTION REVIEW GOOD PRACTICE

BOX 1. Checklist of Good Practice for AAR

Before the AAR event

- ❑ Schedule the AAR as close as possible to the event**.**
- ❑ Ensure that everybody who was involved in the event can attend**.**
- ❑ Recruit a facilitator **as early as possible. The facilitator should be an independent and neutral party but with some familiarity of the issues.**
- ❑ **Check through results of past AARs to identify any lessons that might be useful to the current AAR.**
- ❑ Identify objectives for the AAR **in a participatory manner, to ensure participant buy-in and commitment to the AAR process.**
- ❑ **Prepare 'guide' or 'trigger' questions to stimulate discussion and reflection. Disseminate to participants before start of AAR.**
- ❑ Identify, and appoint a note taker **to record the proceedings.**

During and After the AAR event

- ❑ Record recommendations and action points **in sufficient detail to enable follow-up. Identify who is responsible for what. Give clarity to expected outcomes. Set deadlines for completion.**
- ❑ Create a written record of the AAR. **A short and concise 3-page summary. Use a standard format so that results can be compared across different AAR events.**
- ❑ Ensure the names, titles (areas of responsibility or involvement) and contact details of all participants are fully recorded**. Other interested parties may wish to get in contact.**
- ❑ Elicit feedback from participants. **Make sure that the AAR record represents a true and accurate reflection of the AAR.**

Disseminating AAR Event findings

- ❑ Archive the AAR record as a permanent and accessible document **– both electronic and hardcopy. Make sure that everyone has access to the document on an ongoing basis.**
- ❑ Ensure that decision-makers have been informed.
- ❑ Publicise the results **via internal staff distribution lists, bulletin boards, discussion lists, staff notice boards, newsletters, website and staff meetings etc.**
- ❑ Disseminate AAR outcomes **to external stakeholders who have an interest in the findings.**

AAR Monitoring and follow-up

- ❑ Monitor follow-up on recommendations and action points. **Report back to participants and stakeholders on progress made in follow-up.**
- ❑ Conduct periodic review and analysis **of the historic record left by previous AAR exercises. Identify significant trends, lessons not learned, recurring issues and lessons truly learned (ie, when issues no longer appear in subsequent AAR exercises).**

AAR Development Activities

- ❑ User analysis **– find out who uses the results of the AAR? How often? For what purpose? What types of benefits are achieved? Use the analysis to make AAR more productive.**
- ❑ Build awareness, promotion and advocacy for the AAR process. **Support other people in achieving the widespread adoption and adaptation of AAR methods.**

Annex Two – RESOURCES ON AFTER-ACTION REVIEW

A.1. The following is a list of resources that the authors have found useful on AAR. The list is not exhaustive and the authors would be interested to hear from others of resources they have used.

Baird, Lloyd, Philip Holland Sandra Deacon "Learning from Action: Imbedding More Learning Into The Performance Fast Enough to Make a Difference," *Organizational Dynamics*, Spring 99, Vol. 27, Issue 4, p.19.

Baird, Lloyd, John Henderson, and Stephanie Watts', "Learning From Action: An Analysis of the Center for Army Lessons Learned (CALL)" *Human Resource Management*, Winter 1997, pp. 385-395.

Collison, Chris and Geoff Parcell, *Learning to Fly: Practical Lessons from one of the World's Leading Knowledge Companies*, Capstone: Oxford, 2001.

Darling, Marilyn J. and Charles S. Parry, *From Post-Mortem to Living Practice: An In-depth Study of the Evolution of the After Action Review*, Signet Consulting: Boston, 2001

Garvin, David A, *Putting the Learning Organization to Work: Learning After Doing,* Harvard Business School Publications, 5/10/96 [video: Length 20 min: Prod No. 7099A. VHS/NTSC. $595-00 which shows AAR in Practice].

Johnson, Fred W, "Getting it Right Quickly," *Military Review*, March-April 2000.

Keene, S. Delane, *Suggestions for After Action Review Facilitators,* U.S. Army Research Institute for the Behavioral and Social Sciences, Alexandria, VA, ARI-RN-94-18, April 1994.

Marcus, Kevin B, *The After-Action Review (AAR): Standards and Execution TTP*, Mechanized Infantry Team (Scorpions), (draft document) 1994.

Mission-Centred Solutions, *Guidelines for the After Action Review,* [a targeted AAR process developed for fire fighting crews]. Found at: http://www.mcsolutions.com/Public/Library/AAR_Wildland_Fire.PDF#

Morrison, John. E and Larry L. Meliza*, Foundations of the After Action Review Process*, US Army Research Institute for the Behavioral and Social Sciences, Special Report 42, July 1999.

Townsend, Patrick L. and Joan E Gebhardt, *How Organizations Learn: Investigate, Identify, Institutionalise*, Financial World Publishing: Kent, 2001.

Whiffen, Paul, *The After Action Review (AAR) Tool-kit*, (adapted by Allison Hewlitt of Bellanet) found at: http://www.dgroups.org/groups/leap/evag/docs/AAR.doc?ois=no

Annex Three – ABOUT THE AUTHORS

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