2019 CLA CASE COMPETITION

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**Case Title:**

# Failing Forward: How CARE is focusing on what goes wrong to improve impact

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CARE staff launch a pre-mortem exercise to learn more from failure in a workshop about Water Smart Agriculture in Malawi.

**Summary:**

CARE's Failing Forward initiative is sparking opportunities to showcase the ideas that don't work so we can spend more time implementing the ones that do. It's changing the conversation inside the organization, and leading to changes in the way we design and implement programs. It's also allowing us to make connections across a global portfolio of more than 900 projects, and with new and different partners to learn from their experience.

Talking about what went wrong is still very difficult for most staff members. This happens at all levels, from high-level conversations about multi-million dollar grants to conversations about what went wrong during a specific project activity. Without that conversation, we lose critical chances to improve impact and development outcomes. The pressure for quick wins and high return on investment can make us risk averse and unable to innovate if we can't learn from our mistakes.

Unlocking these conversations started with focusing the topics on what we can learn and how we can improve our work. Tying learning from failure explicitly to development outcomes has been a motivating force for everyone. Failing Forward combines a number of light-touch approaches, like podcasts, coffee conversations, social media posts, and slight changes to meeting agendas. It also builds on the power of networks and collaboration to spark new ideas and conversations, and to showcase problems that we know we need to tackle differently. The project works with buy-in from high-level leaders, but more importantly, draws on the deep experience of implementing staff to talk to their peers about what they tried, and how they would do it differently.

**Think about which subcomponents of the Collaborating, Learning & Adapting (CLA) Framework are most reflected in your case so that you can reference them in your submission:**


- Internal Collaboration
- External Collaboration
- Technical Evidence Base
- Theories of Change
- Scenario Planning
- M&E for Learning
- Pause & Reflect
- Adaptive Management
- Openness
- Relationships & Networks
- Continuous Learning & Improvement
- Knowledge Management
- Institutional Memory
- Decision-Making
- Mission Resources
- CLA in Implementing Mechanisms

## 1. What is the general context in which the case takes place? What organizational or development challenge(s) prompted you to collaborate, learn, and/or adapt?

Every year, CARE operates about 900 projects in 94 countries around the world, and these projects generate a tremendous amount of information. Project reports, evaluations, datasets, photos, theories of change, learning briefs--all of these tools lift up valuable information and help turn it into knowledge, but it can be hard to make sense of global trends in systems that are primarily geared toward project-level measurement and implementation. Much of the learning happens informally at project level and with local staff, so the organization as a whole misses the opportunity to use that learning to improve programming.

The problem is especially acute when we are trying to avoid repeating mistakes. Many templates for learning products focus on success stories and documenting impact. There is enormous pressure in development to talk about what worked, and to show stories of hope. We are constantly trying to show responsible use of taxpayer dollars and public donations. There are trends in the industry to have failure fairs, to discuss more about failure, and to be more open, but pressure for quick wins, short-term exit strategies, and delivering low-cost, high return interventions counterbalances much of that rhetoric. Fundamentally, talking about what went wrong is still very difficult for most staff members. This happens at all levels, from high-level conversations about multi-million dollar grants to conversations about what went wrong during a specific project activity. Without that conversation, we lose critical chances to improve impact and development outcomes.

In our own programming, and in the broader sector, we see new projects repeating approaches and tools that another project or team tried and couldn't make work. This is often a result of the lack of information sharing about what went wrong, and it creates inefficiencies in development that threaten our broader impact.

## 2. Why did you decide to use a CLA approach? Why was CLA considered helpful for addressing your organizational or development challenge(s)?

In 2015, as CARE started publish impact summaries about what worked, there was a demand for learning more from other people's failures, but a lot of barriers to talking about failures from specific projects. Project teams wanted ownership over the story of what went wrong, but were  too busy to take the time to write up failure documents. There were no clear incentives to do so. The approach of having an independent reviewer didn't working, and project-owned failure stories didn't get off the ground, so we clearly needed a more collaborative approach. There was buy-in for the idea of talking about failure, but we hadn't found an approach that connected incentives and resources to doing it.

CLA provided some really useful tools to think about how to create space for this. Framing the Failing Forward conversations around continuous learning and improvement was the first key piece. Thinking not about "where did you fail" but "what would you do differently if you could do it again" helped project teams re-center their ideas. Having adaptive management meant that one incentive to speaking up about failure was the possibility of fixing it.

Another key piece was talking to other people in the KM community, including participating in a Failure panel with TOPS in 2016, and conversations with other organizations at Moving the Needle in 2018. Having key donors signal a willingness to learn from failure has been critical. Conversations with IADB about "Lessons unlearned" was a critical catalyst for defining the model. Modeling openness has also been really helpful, and came from NASA's suggestion at the 2016 Knowledge on a Mission event, where they talked about leaders needing to go first, and the importance of openness starting at the top. We also leveraged relationships & networks to build in critical feedback mechanisms so people got incentives and support from managers and colleagues when they stepped up to discuss failure.

## 3. Tell us the story of how you used a collaborating, learning and/or adapting approach to address the organizational or development challenge described in Question 2.

Since 2015, CARE has been conducting a rolling review of evaluations to look for evidence of impact in our programming to align with our global impact indicators (https://impact.care-international.org/impact) and to check evaluation quality. These reviews led to impact summaries for each product and an annual review of evaluation quality which highlighted wins and misses. Almost as soon as the impact statements started, people wrote to ask, "ok, but what went wrong? This can't be the whole story." Project teams were happy to have an independent person review their evaluations and write summaries of what went well so that everyone could learn from that, they didn't want an outsider highlighting failures in front the whole organization. Teams didn't have time or incentives to document their own failure stories. There was buy-in for the idea of talking about failure, but the attitude was very much "you first."

The annual evaluation report highlighting wins and misses took off pretty quickly. It allowed us to highlight what worked and what didn't in a more data-driven way that looked at trends, rather than putting any one project team in the hot seat. As the data set grew, it allowed us to make a compelling case to leaders about specific improvements we could make in our evaluation processes, and resulted in teams unlocking funds to invest in better capacity.

Talking about project failure was harder. We tried a quarterly failure panel, but it took a lot of energy to organize, and each panel was a one-off event that was hard to follow up on if you couldn't make it. We created a failure form that no one filled out because writing things down was daunting and time-consuming, with no obvious payoff to doing it. In the fall of 2018, we launched 2 key products: a Failing Forward podcast (https://careinternational.podbean.com/) where individual tell their own stories, and an annual Failure Report, where we look at trends across the whole CARE portfolio. This balances the individual stories and rich learning from having all the context with a more bird's eye view of trends and quantitative data.

We're still in the pilot phase, but data is promising. We've gotten more than 1,100 downloads in the first 7 months, and can see that the most popular examples are from project staff talking about ways to improve implementation. We're also identifying key trends in failures that will allow us to build action plans for the next year specific to country, regional, and global management teams. Teams are starting to apply tools and lessons from the Failing Forward podcasts to existing projects and when designing new projects.

Through this process, we've had 5 key lessons learned.
1) Openness starts at the top: we started working with top leaders in the organization talking about critical organizational misses and ways to improve. Having executives talk about high stakes issues in progress modeled the idea that staff could step up too. After the first few big conversations, it got easier to get volunteers from other parts of the organization. We got great buy in from senior leaders to participate.
2) Make it easy: instead of having to write up separate case studies, we launched podcasts with a few key framing questions that stayed consistent every time. Having a conversation with one other person at the time that was most convenient to the interviewee made it less intimidating and lower effort for people to share their stories. Recorded podcasts also mean the audience can listen any time it works for them.
3) Focus on learning and adaptive management: building from conversations with other organizations, we focused on 2 main themes: what was the context of the failure, and what would you do differently. That gives people a chance to offer solutions and apply learning instead of only focusing on the problem.
4) People own their own stories: by giving people a few prompts, and the chance to talk about their own behavior reduces a lot of the tendency to blame and provides a chance to see that anyone can address a failure. One criteria is that people must talk about something they personally were involved in.
5) Networks matter: we've used an approach of having people share recordings through their own networks, and deliberately building in feedback loops so that people hear from others who listened to the podcast. We get bosses to publicly recognize staff who did a good job. People who have listened to the stories write to the volunteer to thank them for sharing the experience. These networks then start their own conversations about what to do next to address failures, or share similar experiences and solutions.

## 4. Organizational Effectiveness: How has collaborating, learning and adapting affected your team and/or organization? If it's too early to tell, what effects do you expect to see in the future?

The first big change is that there is more appetite for talking about failure in the organization. We're starting to get volunteers from the project staff implementing in the field, who are offering incredible insights into programming and changing the way we work that we can't get any other way. It's also opening a channel to put project staff and senior executives into the same platform, so learning can happen at all levels.

Key leaders have also adopted these models and are rolling them out in their own contexts. The USAID-funded SHOUHARDO project team has adopted failing forward conversations in their regular reflection sessions, which is allowing them to improve their implementation model.

We are also starting to document failures well enough that we can avoid them in future. Framing the issue as "something you wish people had told you before you started" is getting people to articulate broader learning to share so new project teams can avoid repeating previous mistakes. External collaboration with other organizations has helped us identify specific project tools like pre-mortems to build into regular practice.

Highlighting common failures across a series of evaluations allowed us to move from focusing on one specific project or team to looking at larger systemic challenges we need to fix. As a result, we've re-vamped our MEL training materials and are investing in much more user-centered capacity building on evaluations. We're also building new tools to support teams through areas the report highlighted as weak. We have also raised more resources to invest in these areas. We expect the failure report will result in similar systemic changes on a project implementation level. Highlighting global trends and gaps in our support systems and help us set priorities for where to invest resources. Combining global data with context-specific stories will show us not just gaps, but also possible solutions.

## 5. Development Results: How has using a CLA approach contributed to your development outcomes? What evidence can you provide? If it's too early to tell, what effects do you expect to see in the future?

It's still very early to see specific development impacts. However, our expectation is that our projects will get more efficient and deliver better results faster because they are able to apply lessons from elsewhere and adapt to challenges faster. We are also starting to see projects adopt tools and methods that they have learned from other people's failure stories--especially in the project design phase. That leads to better projects, and consequently better impacts. For example, projects are conducting pre-mortems in design phase to brainstorm possible failure points and create action plans around them. Teams are also asking for the specific data from their sector so that they can create action plans to address common failure points.

We also expect that these conversations will help us get better evidence and ability to scale. We are already seeing a cluster of conversations and actions around MEAL that will help us more effectively measure development impacts, and make the case around ROI that helps us select the most effective and scaleable options in programming.

## 6. What factors enabled your CLA approach and what obstacles did you encounter? How would you advise others to navigate the challenges you faced?

Some factors that enabled this approach include:
* Leadership buy in: The highest levels of the organization have gotten involved in promoting the idea and talking about serious issues in their conversations around failure. Perhaps more importantly, mid-level managers and people with large staffs are starting to host conversations and build the ideas into their own teams.
* Focus on practicalities: People who have participated are focusing on what works to fix something, and on problems that show up for many staff in many places. By articulating practical solutions for program staff, they are attracting a bigger audience.
* Making it light touch: The project has tried to find easy, quick ways to participate rather than building a large and complex process on top of an already overloaded staff. It also means we have not had to find large budgets to facilitate conversations.
* Outside audience: having other organizations talk about failure, participate in conversations, and even message the importance of learning and adaptive management gives us a way to convince people that this is not only safe, but desirable.
Obstacles for failing forward include:
* Fear: this is easily the biggest issue. People are afraid they will get in trouble with their bosses or their donors if they talk about things that went wrong. In some contexts, very hierarchical management styles mean that staff don't feel that they have permission to talk about something that went wrong, especially if they have tried to raise it before.
* Delicate donor relations: There is still a very compliance focused mindset in many donor relationships and projects, so exposing problems can risk funding and livelihoods. This depends as much on the individual we are working with (either inside CARE or outside) as it does on the broader institution.
* Time and resource constraints: project teams especially are often overwhelmed with implementation and compliance demands and find it hard to make space for these reflections.

## 7. Did your CLA approach contribute to self-reliance? If so, how?

This has not yet directly contributed to self-reliance, but we expect it to. One of the key recurring themes we see in our failure conversations is the need to involve local stakeholders and really listen to their needs and expectations at all steps in the process. As that pushes us to build in local stakeholder approaches more universally, and make the case to donors that they need to do the same, it will contribute to self-reliance for country teams.

The other contribution that we expect this to make to self reliance is supporting critical thinking and adaptive management behaviors that are so critical in all levels of programming. As teams spend time thinking through what went wrong and how to fix it, they will be able to direct their own development more completely.

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As the USAID Policy Framework states, USAID's operations and work force will be re-oriented to realize the goals of the Journey to Self-Reliance. This case is an operations-oriented example of CLA, so there is an indirect link to programming for self-reliance.

The case authors explain their view of the connection between self-reliance and the work described in this example.