Decades of KM-enabled records put to use in South Sudan

- Describe the KM initiative

Summary: AMREF, an Africa-based international NGO, has improved health services for remote African populations for over 50 years. Using KM, AMREF has linked its archived documentation to present health initiatives. AMREF's health programmes in South Sudan now draw on records from over forty years ago, providing data about South Sudan health trends before strong M&E systems had been established, illustrating the evolution of health programming in South Sudan's conflict-ridden context, and demonstrating the depth of relationships and engagement with local communities, government and partners. None of that information is remembered by current staff, and this knowledge would have been lost without KM. Especially in South Sudan, where public records were non-existent or destroyed due to the civil war, this knowledge is essential in filling in a lost history and creating a platform for health planning and programming.

Background: the African Medical & Research Foundation – AMREF – is Africa's oldest and largest international health development NGO. Founded in 1957 as the Flying Doctors of East Africa, AMREF has over half a century of experience in delivering health care and building health systems across Africa. With decades of engagement with Africa's most remote and impoverished populations, AMREF's credibility with local communities and African governments stems from the tacit understanding and appreciation built over the past five decades. Documentation of its 50-year history of health programming does exist in AMREF's Heritage archives, and this half-century trove of data about the development of Africa's health systems is now being used to translate programming experience into best practices and health policies appropriate to the African context.

Knowledge Management Initiative: KM techniques were not yet developed in the 1960's, when AMREF first began working in Southern Sudan. Consequently, AMREF's documents from its early years (1960's – 1980's) were stored, but not indexed or linked to each other. Applying modern KM techniques, AMFEF has now linked its current health programming to relevant documents from a half-century of history. An immediate result is a database of health programming history in South Sudan, describing the construction and rehabilitation of health centres and hospitals, training of South Sudanese as health workers and engagement of South Sudanese communities.

AMREF has worked alongside UN agencies in South Sudan, and has shared its project documentation with UN staff. In November 2010, UNFPA requested AMREF to expand its maternal health outreach to cover all states of South Sudan, based on AMREF's records of its history in East Africa.

Further, given the importance of relationships in African culture as a foundation for collaboration and engagement, this new access to AMREF's own history in improving health for marginalized people has allowed AMREF to demonstrate its past work with institutions and communities even after the individuals involved have left the scene, and thereby to strengthen its ties to African decision-makers, both at local and national levels. In South Sudan, AMREF uses KM to expand on government coordination with its current health interventions, by relying on past documentation of AMREF's health programmes. Decades-old MOU and correspondence expressing gratitude from past South Sudanese leaders reinforce the tacit appreciation that exists today, and results in AMREF being able to use its

experience to improve policy formulation by the South Sudanese government. This level of trust between NGO and government would have been very difficult without KM.

- Describe the approaches utilized to measure / assess this KM initiative

Both qualitative and quantitative methods are employed.

Qualitatively, AMREF assesses the types of uses of KM-enabled data, including areas as disease trend analysis, community support, policy contributions and government/donor relations. A record of queries for KM-enabled data is also maintained, so that AMREF can map which archival records are most in demand.

Simple quantitative measures include the following:

- # of closed health projects with information on best practices;
- # and types of project documentation (evaluations, annual reports, etc.);
- # of non-project documentation (correspondence, MOU's, etc.);
- # of dramatis personae identified (local leaders, AMREF staff, UN);
- # of South Sudanese community health workers trained, by cadre and year.

As further reports from South Sudan are retrieved from archives, estimates will also be made of populations covered and served through past health interventions.

- What was the purpose or motivation for assessing this KM initiative?

As an international NGO with African roots, AMREF understands the importance of cultivating and maintaining positive relationships with local communities, governments and other stakeholders. Investing in these long-term partnerships has been part of the AMREF approach for some time, and drawing on past experiences can be a tremendous advantage. Fifty years' worth of documents, however, are a lot to sort through and compile in a KM database, unless the benefits are clear. Thus, AMREF is assessing how its past records can help current health programmes. Moreover, by showing the value today of archived reports, KM helps to reinforce AMREF's current emphasis on high-quality documentation.

- What were the most important lessons learned from the assessment process?

Knowledge management for AMREF has yielded benefits beyond the expected areas of improved quality, efficiency and effectiveness. With KM, AMREF is better able to build on its greatest strength – its rapport and reputation with African communities and leadership and also with outside donors – by incorporating the depth of its past efforts into current relationships and future engagements. In this case, AMREF's current health interventions in Southern Sudan access and rely on forty years of health documentation, through the period of political strife and civil war. In support of its health programmes, AMREF can also point out to donors their own history of support, even when the current staff have no direct memory of that work. In a recent visit by a CEO from a multinational corporation that provides pharmaceuticals to East Africa, AMREF drew on its archives to show the CEO that his company was supporting AMREF's work in the early 1970's. That history of involvement surprised and pleased the CEO, and reinforced his on-going commitment to AMREF's work as part of corporate social responsibility.

- What would you do differently next time?

AMREF continues to analyze documents from its 50-year archives and to link its past records with current health programming. For the future, AMREF is designing an intranet system that incorporates best practices in KM, including open linkages of documents to projects, somewhat borrowing from a wiki approach, in which staff can collaboratively add to each other's work. New project evaluations will also have searchable abstracts published on-line. AMREF will not repeat its past of storing documents for decades without enabling their contents to be used.

- What advice would you give to others based on your experience?

Two recommendations stand out. First, make your information accessible to everyone. Too often our project reports are seen by donors and no one else. Posting them on-line and using KM techniques to create new linkages can help staff and partners use the information they created. Second, broaden ownership of information by developing participatory techniques (communities of practice, wiki-editing) based on in-house knowledge. Those will motivate staff to incorporate and build on tacit and formal knowledge.

- What do you think are the main unanswered questions or challenges related to this field of work?

Based on unlocking the power of a half century of information on health development in Africa, the push is to make records more accessible. What is unclear are the limits that might be appropriate: are there organization risks, or individual incentives and disincentives, that are not addressed?