Knowledge Clinics:

a virtual method for co-creating and codifying knowledge across organisations

Mike Klassen

November 2020

Citation

Klassen, M. (2020) *Knowledge Clinics: a virtual method for co-creating and codifying knowledge across organisations*, BEAM Exchange, accessed from www.beamexchange.org

Publisher

BEAM Exchange
editor@beamexchange.org
www.beamexchange.org

The BEAM Exchange - in partnership with the DCED - is a platform for knowledge exchange and learning about the role of markets in poverty reduction.

Knowledge Clinics: a virtual method for co-creating and codifying knowledge across organisations

Summary

This paper introduces knowledge clinics as a virtual method for capturing knowledge from MSD practitioners across various organisations. It explains the main features of the facilitation process, including new adjustments to the methodology from 2020, such as linking the group learning with published final outputs. It includes key lessons on how to facilitate clinics – from agenda-setting, to building relationships, to choices around which technology to host meetings with.

Definition

The Knowledge Clinics[1] method brings together practitioners to help each other grapple with practical ongoing challenges. Drawing on collective experiences and tacit knowledge, participants gain rich, contextualised insights. The process can also be used to codify knowledge into outputs that capture guiding principles and promising approaches.

> **Knowledge clinics:**
>
> We use the word clinic to signify a place to come to diagnose and reflect on key challenges in market systems development. It does not mean coming to an expert who will give you the solution, but rather a group process whereby participants share experiences and ideas, with support from a process facilitator.

Participants

The clinics target diverse groups of practitioners who share a similar problem or interest, but have limited time. The incentive to learn comes from the expectation of gaining insight on specific challenges for which they are responsible in their day jobs.

Initial Pilot

The clinics were first tested in 2016 by the SEEP Network and BEAM Exchange. Four groups of market systems practitioners worked on field-level challenges in MSD. This facilitation process is described in detail in the Clinics: how-to manual.

[1] Definition taken from Market Facilitation Clinics Manual (2016): beamexchange.org/resources/812/

Main features of a knowledge clinic

- Designated facilitator organises the overall process, recruits participants and facilitates each small group meeting.
- Facilitator meets participants via 30-minute introductory 'interviews' to understand participants' contexts, challenges and interests.
- Participants are organised into small groups (4 - 5 participants per group) framed around common challenges or interests.
- Each group meets 5 - 6 times over a 3 - 4-month period. Different sequences of meeting focus are possible, depending on the groups' preferences and the nature of the challenge. For example:

  Option A: 1 meeting for problem definition
  3 - 4 meetings focused on individual cases/examples (with embedded analysis)
  1 - 2 final meetings for synthesis and planning any written outputs

  Option B: 2 - 3 meetings focused on iterative problem definition & analysis
  2 - 3 meetings to generate principles and examples drawing on promising practices
- The main learning mechanisms are peer presentations, reflection and feedback (supported by existing reports and resources, and prior analysis).
- Summaries of each group's work is shared with other groups to clarify scope and framing and gather feedback.
- After group meetings conclude, there is a secondary process of collaborative writing to generate the final outputs.

Refinements of the method in 2020

The clinics methodology was used again by the BEAM Exchange to support four groups of senior MSD advisors and programme officers (from donors, implementers and consultancies) interested in tackling procurement and contracting challenges in MSD.

What was different about the procurement & contracting clinics in 2020?

1. **There was a pre-defined overarching topic**
   The clinics focused on procurement & contracting in MSD instead of 'any topic in MSD'. This drew a smaller pool of applications (20 vs 55+ in 2016) but led to a much higher acceptance rate based on commitment & relevance of challenge (95% vs ~40% in 2016). This bodes well for future application for common challenges that cut across multiple organisations or agencies.
2. **Type of participants**
   By drawing on donors, implementers and consultants, mostly at HQ level in advisor roles, this was a considerably more experienced group with more divergent perspectives on MSD. Unfortunately, the high proportion of implementers and low proportion of donors made it challenging to effectively 'allocate' the scarce donor participants. This meant one group had no donor participants and this

was reflected in some of the discussion topics and preliminary conclusions. In future, more targeted recruitment is needed to get a desired mix of participant types.

3. **Cross-group interactions**
   The clinic's pilot in 2016 identified that cross-group interactions should be encouraged. This was implemented in 2020 in three main ways:

   a) **Mid-point synthesis review** shared across groups: by request, a detailed mid-point synthesis document captured the main points of each group after 3 - 4 meetings each, and this was shared with all participants. People appreciated seeing the different issues being discussed, as well as the broad trends and patterns that were common across groups.

   b) **Participants shifting groups part-way** (n=2): two individuals showed interest in topics that were different to that of their initially assigned clinic group. Following 1-on-1 consultation with the facilitator, they were reassigned – and were much happier with their final group assignment. This sort of flexibility is valuable and can be fine-tuned in future iterations.

   c) **Peer review of initial draft papers** by groups with similar topics: at the end of the process, groups were paired up to exchange their final paper for feedback. This helped to identify key terminology and assumptions that were unfamiliar, and also led to additional examples being added to the text, based on a wider set of experiences.

4. **Extended process of writing and revising outputs**
   For the 2016 clinics, the main outputs were a how-to manual, half-page summary case studies, and edited 'podcasts' consisting of key clips from the clinic meetings (which had been recorded). For the 2020 procurement & contracting clinics, the outputs were four substantial papers that provide in-depth framing of a problem, and ways forward based on the clinic discussions. The papers range from 12-20 pages in length each.

   There were numerous lessons about this process, given its high level of effort:

   a) Decide on structure early, to save time in revision and restructuring.

   b) Be clear on the expectations for participant input into the papers.
   This worked best when the facilitator developed key framing and bullet points of the overall paper and asked specific people to write (i) key aspects of problem analysis or principles/lessons; or (ii) short mini case studies from projects they worked on or supported, which made a particular point related to that part of the paper.

   c) And finally, set realistic expectations about the review process that reflect the range of reviewers required, and the time for each iteration. The writing process started in April, with an (unrealistic) initial target of completion of June. The papers were ultimately published in September.

Major lessons on how to facilitate knowledge clinics

1. **Build relationships & community**
    a. Encourage short personal/life updates at the beginning of every call: what's going on beyond the work? (hard for only a single session, but pays off over multiple sessions)
    b. Early on, ask people what they care most about, what they are interested in. This can inform breakout groups and sub-groups based on overlaps.
    c. Use energisers creatively to get people to move around, show things in their area.
2. **Drive engagement**
    a. Ensure groups are small and framed around common interests.
        - 3 - 4 active participants is the sweet spot. 5 is possible with very committed people, but 6 is too large.
        - Get people comfortable sharing current challenges and issues that they don't have answers to.
        - Help them share enough context for others to 'get it', but not so much that it's distracting.
    b. Encourage other people to share suggestions in response to stated challenges.
        - Experiences they have had that are similar/different.
        - Things they've tried that worked.
        - Other relevant examples, projects or initiatives they have heard or read about.
    c. Directly ask people to share their ideas
        - At regular intervals, ask each individual in a group to share their perspective or opinion.
        - Open or close a meeting by giving each person 1 or 2 minutes to summarise their thinking. This ‘democracy of time’ helps break up patterns of only one or two people doing most of the talking.
    d. Prepare a detailed agenda with preparatory work made clear in advance.
        - Identifying key individuals to share a ‘live’ case study including a short slide deck, or sharing a document in advance, can significantly deepen conversations.
        - For longer sessions (more than 1 hour), a detailed agenda can help people follow along and commit to participating for the full time.
3. **Build continuity across multiple meetings**
    a. Record meetings and make recording available for anyone who misses the meeting.
    b. Take notes, share summaries a week in advance of the upcoming meeting.
    c. Ask people at the beginning of a session to share insights from the previous session.
    d. Actively build connections between previous examples, discussions and the present session – don’t assume participants remember in detail the last meeting.

4. **Specific tools and technology to use**
    a. The 2016 clinics used WebEx with a dedicated admin support person for each session.
    b. The 2020 clinics used Skype, which was the best balance of functionality (screen sharing, ability to record) with access as all participants were familiar with Skype and could use it even while on remote travel assignments. It also offered the opportunity to call people's mobile numbers when they had no access to internet.
    c. Clinics (e.g. MRM clinics of the DCED) that engage larger numbers of participants (e.g. more than 10) have used Zoom and the breakout group functionality to balance inclusion with smaller group interactions. The main downside to Zoom is that some agencies have blocked access.

Conclusion

Knowledge clinics are a time-intensive process, but the investment reaps significant rewards. Participants leave meetings energised, with new ideas and new relationships to build on. Organisations can step back from day-to-day pressures to see and analyse broader patterns affecting their work, and together think about new ways forward.

Finally, with the new process adjustments documented here, knowledge clinics can also lead to concrete outputs that advance knowledge for the field as a whole.