The power of participatory monitoring in making the Sustainable Development Goals a reality

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Contents

Executive summary

Before governments around the world begin implementing the Sustainable Development Goals (SDGs) on 1 January 2016, a robust monitoring system must be put in place to track progress in a consistent and rigorous manner. At CARE International, we believe that this system requires more than just better technology, more surveys and greater government capacities in collecting information and transparency in publishing data. This is only one side of the equation. Based on our successful experiences with the approach in a broad variety of countries, we believe that **incorporating participatory monitoring into the SDG process can provide much that was lacking in the MDG system.**

Participatory monitoring adds value in three distinct ways. One, it develops an indigenous accountability mechanism in the form of 'shadow reporting' to provide oversight of the data entering and passing through the official system.

Two, it introduces new, critically important contextual information on the quality of service-delivery inputs that has been lacking in previous monitoring systems. Responding only to outcomes leaves governments constantly behind the curve; understanding the link between inputs and outcomes gives both national and international communities more robust options for improving service-delivery in a timely fashion.

Three, it links local communities with an endeavour that has largely been the remit of the international community, thereby delivering a greater sense of ownership and potentially shifting incentives in a positive direction. If developed further and ultimately implemented, participatory monitoring will provide a necessary complement to any official UN/World Bank monitoring system established for January 2016.

Building on a **two-tiered approach to measuring progress against the SDGs**, this paper presents a potential six-step model for effectively incorporating participatory monitoring into the monitoring system for the post-2015 development goals. We have an opportunity now to create a monitoring system for the SDGs that **delivers the data required** for the international community and **changes the incentives of national governments** to respond to domestic as well as international priorities when setting development agendas. Progress on these complementary objectives will culminate in potentially stronger monitoring systems and better development outcomes for the world's population.

Background

What is participatory monitoring?

Participatory monitoring is much more than the use of participatory techniques within a conventional monitoring and evaluation setting. It involves substantially **rethinking who initiates** and undertakes the process, and **who benefits** from the findings (Guijit and Gaventa 1998). The concept has evolved over a series of decades into many different forms.

Essentially, however, participatory monitoring has **four broad principles**:

- *Participation* – which means opening up the design of the process to include those most directly affected, and agreeing to analyse data together;
- *Negotiation* – to reach agreement about what will be monitored or evaluated, how and when data will be collected and analysed, what the data actually means, and how findings will be shared, and action taken;
- *Learning* – which becomes the basis for subsequent improvement and corrective action;
- *Flexibility* – is essential, since the number, role, and skills of stakeholders, the external environment, and other factors change over time.

Participatory monitoring is now often subsumed under the more expansive term 'social accountability'. This approach seeks to build accountability by **relying on ordinary citizens and/or civil society organisations** participating directly or indirectly with officials to achieve accountability through a broad range of actions and mechanisms. These citizen-driven accountability measures complement and reinforce conventional mechanisms of accountability, such as political checks and balances, monitoring systems, administrative rules and legal procedures (World Bank 2004).

CARE believes that participatory monitoring and social accountability mechanisms more generally are crucial for **making the voices of the most marginalised heard**, increasing public awareness of global development goals, and by so doing, generating collective action and bottom-up demands against inadequate service-delivery. It has the **dual benefit** of allowing beneficiary communities themselves to assess the quality of service provision and provide accurate information about their own satisfaction, while also offering service-providers and district and national officials the opportunity to assess the perception of users in terms of quality of services, to track outcomes, and to take corrective measures to improve performance. This creates a potentially **virtuous circle of accountability and responsiveness** that could be applied to the measurement of the post-2015 Sustainable Development Goals (SDGs).

CARE's history with the concept

CARE International has significant experience working in social accountability with communities and government officials across the globe in a range of different contexts. Together with these stakeholders, **CARE has developed a variety of approaches and models,** including Community Score Cards (CSC), adapted models such as Community Health Score Boards (CHSB), and alternative citizen oversight mechanisms implemented through community monitors. The CSC methodology, developed by CARE Malawi in 2002 as part of a health services project, was an innovative approach to facilitating a participatory assessment of health service provision and developing a shared strategy for its improvement. Since its inception, the CSC has become an internationally recognised process for improving service delivery and has been a central component of many of CARE's governance programmes across a range of sectors in countries that include Rwanda, Tanzania, Malawi, Ethiopia and Egypt.

CARE is also a partner in the World Bank's Global Partnership for Social Accountability (GPSA). In **Malawi**, CARE is one of two organisations that were awarded grants to address teachers' absenteeism and corruption in schools, using mobile technology (cell phone and IT platform) and Community Score Cards as the means to improve accountability. In **Bangladesh**, CARE is also one of just two organisations that were awarded grants to support the capacity of citizens to participate at the local level in participatory budgeting and to monitor the use of decentralised government funds.

In **Egypt**, in October 2010 and in partnership with the World Bank, CARE organised the first regional workshop on social accountability in the Arab world. Since March 2012, when the GPSA was officially launched in the region, **CARE has been managing the ANSA network for the Arab world (Morocco, Tunisia, Egypt, Palestine, Jordan, Lebanon, and Yemen)**. Beyond the CSC approach CARE has also used other methods of social accountability in contexts as diverse as **Nepal** and **Peru**, as discussed below.

CARE has also supported participatory monitoring efforts in conflict and post-conflict contexts, linking local to national and global-level recovery, peacebuilding and transitional governance processes. In contexts as diverse as **Afghanistan**, **Burundi**, **Sierra Leone** and **Yemen**, CARE has undertaken research and supported civil society engagement with the UN Peacebuilding Commission's Strategic Peacebuilding Frameworks, Mutual Accountability Frameworks and the New Deal on Peacebuilding and Statebuilding.[1]

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1. Consolidating the Peace? Views from Sierra Leone and Burundi on the UN Peacebuilding Commission (2007); Women and Transition in Afghanistan (2012); Arab Spring or Arab Autumn? Women's political participation in the uprisings and beyond: Implications for international donor policy (2013); Aid Reform: Addressing situations of conflict and state fragility (2008).

CARE International's current engagement with participatory monitoring

This paper draws upon CARE's experience with **two specific forms of participatory monitoring: Community Score Cards and social monitoring**. While broadly similar in theory, they involve different methodologies for achieving their objectives and lead to different experiences of implementation.

CSCs – methodology and application

The Community Score Card is a citizen-driven accountability mechanism that brings together service users, service providers and local authorities, first to identify the underlying obstacles to effective service delivery (expressed in indicators), then to score the services against the identified indicators, and finally to generate and implement a community action plan to address identified problems and issues. The CSC is a flexible process that can be adapted to any service-delivery sector and context.

The CSC should form part of an ongoing assessment process, and is commonly repeated on a biannual basis. It can form part of a government institution's monitoring and evaluation system; for example, health assistants at a health centre can lead a CSC process in which various groups are given an opportunity to discuss the quality (availability, access and use) of health centre services. The health centre can then use the information to identify gaps and improve services where necessary.

Given the wide range of contexts within which it is used, the CSC process varies according to what is appropriate within different settings as a means of facilitating good governance and improved service delivery. Broadly speaking, however, the **CSC application consists of five phases** (see diagram on page 8):

1. PREPARATORY WORK AND PLANNING
This can include identification and training of facilitating staff, community research, introductory engagement with the community, and development. At this stage, it is best to identify the sectoral and geographical scope of the CSC process to make efficient use of resources. CSC's broad applicability is its strength but if the process is not sufficiently focused, it will dilute its effectiveness. In **Rwanda**, for instance, CARE has limited its application of the CSC to **water and sanitation, infrastructure, and agriculture sectors**.

2. COMMUNITY SCORING OF PERFORMANCE BY COMMUNITY MEMBERS AND SERVICE PROVIDERS
In this phase, facilitators should divide the **participants into focus groups** and develop performance indicators and a scoring system. Agreeing the issues is a critical phase in the CSC process. CARE's experience suggests that questions such as, "How are things going with this service? What are your main concerns with this service? What does not work well?" are effective at drawing out participant engagement.

Having established the main issues, the facilitators reconvene and compare issues across focus groups to determine the common areas of concern. For these, indicators are created in order to measure progress. These indicators are then presented to the community and scoring commences. Where scores for certain indicators are rated poorly, community members are encouraged to offer potential solutions for improvement that can be passed on to service providers. This is both **an empowering step and a practical one in generating grassroots solutions to grassroots problems**.

PUBLIC POLICY INFORMATION, MONITORING AND ADVOCACY (PPIMA) PROGRAMME – RWANDA

An external evaluation of the PPIMA programme in Rwanda argued that the choice to focus engagement quite narrowly on key services was a strategic asset. The CSC process **builds the citizens' relationship with the state, and not just the capacity of a narrow band of civil society organisations**. Ensuring that citizens understand their

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right to information and where to gain access to it means they are less likely to become dependent on outside organisations, making the intervention more sustainable. The CSC process was judged to have the **following strengths in the Rwandan statebuilding context**:

- It is based on **evidence**, a key advantage in an environment where an avowed aim is to make policy-making as evidence-based as possible;

- It provides a **fulcrum for engagement** in which citizens have a chance to express opinions collectively, clarifying and gaining confidence in their position before engaging government actors;

- It **avoids a potentially sterile debate** between CSOs and government actors in which the latter dispute the legitimacy of the former.

Source: Delta Partnership, PPIMA Mid-term Review, October 2011

3. SELF-EVALUATION BY SERVICE PROVIDERS

A service-provider Score Card can be conducted **after** the Community Score Card has been completed or it can be conducted **concurrently**. The process for the providers is essentially the same as that for the users. The pace, however, for generating issues of concern and indicators with service providers is often much quicker because of the literacy levels of service providers. The indicators generated by the providers are usually similar to those of the community because the service providers often identify the same issues but from a different angle. It is important to explain clearly to the service providers that the Score Card process is **not to point fingers at individuals but to improve service-delivery problems**. This requires a shift or change in attitude of the staff to be open-minded and critical thinkers while taking part in the scoring process.

EXAMPLES OF INDICATORS FROM CARE CSCs

Water and Sanitation		
Access to clean water	# of households with tap water	Citizens have access to clean and drinkable water
Quality of source of water	Existence and application of safety and security protocols for each of the water sources	Villages are connected to a source of water with safe network supply to households

Infrastructure		
Access to electricity	# of households at cell level connected to a source of electricity – ratio # of ...	Citizens' access to electricity
Availability of market places/spaces	# of developed and organised market places at village/cell level – ratio # of markets per village	Farmers and cash-crop middle-men have access to organised and structured market places

Farming – agriculture + livestock		
Size of farming land for cash crops	# of farmers' households with ownership or lease of arable lands engaged in cash-crop farming – ratio acres of arable land allocated to cash-crop production per household	
Type and quality of facilities for distribution of fertilisers and inputs	# of selling points for fertilisers within the vicinity and easy reach for farmers – organised cooperatives that ease access to fertilisers and extension services	Citizen have rights, and are supported to organise in cooperatives to better access fertilisers and improved inputs

4. INTERFACE MEETING BETWEEN SERVICE USERS AND PROVIDERS, AND ACTION PLANNING

The interface meeting is where the service users and providers **share and discuss their scores and the reasons for the scores**. This is also where a **joint action plan will be developed**. The interface meeting brings service users, service providers and other interested/relevant parties together. It is important that key decision-makers (chiefs, group/village headmen, district officials, ministry officials, local politicians, etc) are present to ensure instant feedback on the issues and responsibility to take issues and the plan of action forward.

The interface meeting might become confrontational if not handled carefully and correctly. Community participants should always be reminded that **this is not a finger-pointing exercise** and should be encouraged to think about services and not to have unrealistic demands on service-delivery staff, who very often face significant challenges in fulfilling their mandates.

COMMUNITY SCORE CARDS IN TANZANIA

"The process influenced the improvement of health services in our communities because community members now know the health centres are their property and it is their responsibility to monitor their performance." – Government Representative

Participants in the CSC process in Tanzania remarked on its ability to cut through the 'bureaucracy' of traditional government systems and provide almost immediate and real-time feedback loops between service users and public service providers. The process elucidated the inherent challenge of making decisions about public service provision against a backdrop of limited resources and resource constraints. Through this process, participants realised the value of analysis and evidence in setting priorities for decision-making. Resulting action plans were rooted in systematic analyses of which services require immediate attention and align with community needs and preferences.
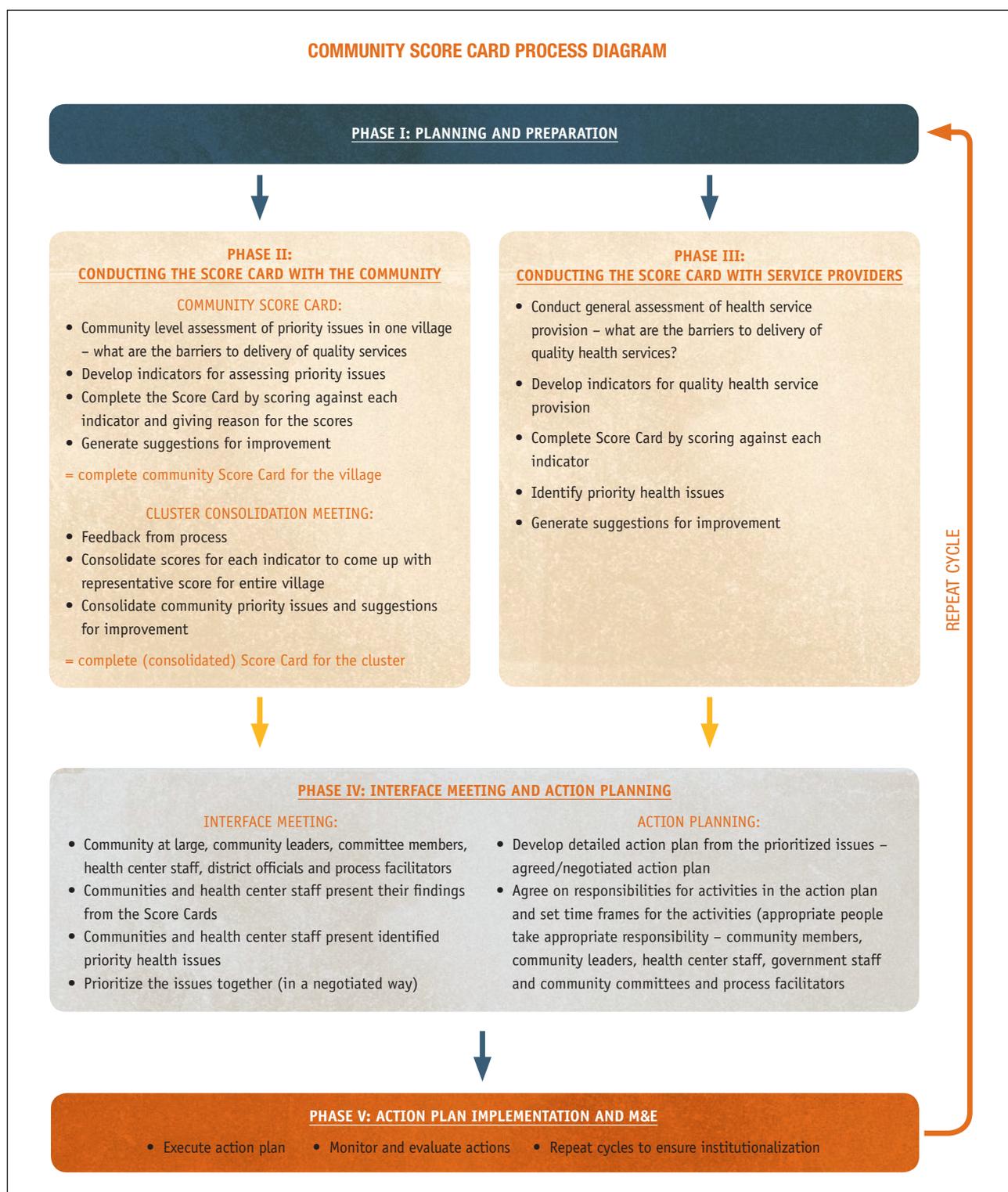
Source: CARE, The Community Score Card in Tanzania, 2011

5. POST-IMPLEMENTATION ACTIVITIES

It is important to recognise that the **Score Card process does not stop immediately after generating a first round of scores and joint action plan**. Follow-up steps are required to jointly ensure implementation of plans and collectively monitor the outcomes. Repeated cycles of the Score Card are needed to institutionalise the practice – the information collected needs to be used on a sustained basis, ie, to be fed back into the service providers current decision-making processes as well as its M&E system. The Score Card process generates issues which can be used in advocacy efforts to raise awareness of the problems and push for solutions. These advocacy efforts can also help integrate the solutions into local policies and systems for the sustainability of results.

While the CSC process is not a solution to all problems in the development of local and community service-delivery, it does offer access to a wealth of community knowledge and information important in service planning and monitoring. The process allows different social groups to be **aware of each other's problems** regarding access and enjoyment of government services. Both the outputs and the process itself are ideal for **evidence-based advocacy**. The CSC process **empowers service users and service providers to start discussing issues** affecting service-delivery, working from the bottom to the top through sectoral structures to effect change.

COMMUNITY SCORE CARD PROCESS DIAGRAM

PHASE I: PLANNING AND PREPARATION

PHASE II:
CONDUCTING THE SCORE CARD WITH THE COMMUNITY

COMMUNITY SCORE CARD:
- Community level assessment of priority issues in one village – what are the barriers to delivery of quality services
- Develop indicators for assessing priority issues
- Complete the Score Card by scoring against each indicator and giving reason for the scores
- Generate suggestions for improvement

= complete community Score Card for the village

CLUSTER CONSOLIDATION MEETING:
- Feedback from process
- Consolidate scores for each indicator to come up with representative score for entire village
- Consolidate community priority issues and suggestions for improvement

= complete (consolidated) Score Card for the cluster

PHASE III:
CONDUCTING THE SCORE CARD WITH SERVICE PROVIDERS

- Conduct general assessment of health service provision – what are the barriers to delivery of quality health services?
- Develop indicators for quality health service provision
- Complete Score Card by scoring against each indicator
- Identify priority health issues
- Generate suggestions for improvement

PHASE IV: INTERFACE MEETING AND ACTION PLANNING

INTERFACE MEETING:
- Community at large, community leaders, committee members, health center staff, district officials and process facilitators
- Communities and health center staff present their findings from the Score Cards
- Communities and health center staff present identified priority health issues
- Prioritize the issues together (in a negotiated way)

ACTION PLANNING:
- Develop detailed action plan from the prioritized issues – agreed/negotiated action plan
- Agree on responsibilities for activities in the action plan and set time frames for the activities (appropriate people take appropriate responsibility – community members, community leaders, health center staff, government staff and community committees and process facilitators

PHASE V: ACTION PLAN IMPLEMENTATION AND M&E

- Execute action plan
- Monitor and evaluate actions
- Repeat cycles to ensure institutionalization

REPEAT CYCLE

Source: CARE Malawi, The Community Score Card (CSC): A generic guide for implementing CARE's CSC process to improve quality of services, 2013

Social monitoring – methodology and application

CARE has also piloted the monitoring of health services in the **remote Peruvian highlands** through community health monitors (*vigilantes*) which allowed citizens to voice their concerns, hold service-providers to account, and promote constructive dialogue to improve the quality of services. Monitors have been chosen, trained and deployed to visit health centres throughout the targeted areas, assessing the quality of the services provided. This information is fed into a series of dialogues with government officials and health administrators and practitioners, highlighting the strengths and weaknesses of various facilities' performance. CARE's decade-long experience with Peruvian community health monitors' oversight of maternal and infant health services has been hailed as an **example of best practice by the UN Commission for Information and Accountability for Women's and Children's Health** in September 2012.

In Peru, the methodology consisted of **four broad phases** (see diagram on next page):

1. PLANNING AND OPERATION

From the outset, CARE Peru partnered with ForoSalud (the country's largest civil society health network) and the government Ombudsman's Office. Together, they defined what training was required for monitors and the support that public agencies required. Roles and responsibilities for each body were also defined in the monitoring process.

EARNING RESPECT AS A SOCIAL MONITOR – PERU

A total of 150 women were trained and accredited to monitor health facilities and services. The majority of monitors were previously community leaders who had completed either primary or secondary education and had some prior training in sexual and reproductive health rights and family planning. Quechua was their native language, but most understood Spanish. Sometimes getting in the door of the local health facility meant getting respect:

"When I went to the doctor at the hospital, he said: 'What is all this about monitoring? We work hard here. Would you like me to come to monitor you at home?' I told him, 'Excuse me, doctor, we are health-care promoters and have been trained by the Ombudsman and ForoSalud in monitoring. We know our rights. You cannot go to monitor my house, because it is private, but I can come to monitor the hospital, because it is a public institution, it is state-run. And here are my credentials.' 'OK, come right in ...,' he told me."

Source: CARE, Social monitoring to defend maternal health rights in Peru, forthcoming

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2. MONITORING VISITS TO HEALTH FACILITIES

Two provinces were chosen, Azángaro and Melgar, where there were extremely high rates of poverty, maternal and child mortality and a history of user complaints regarding the treatment of poor indigenous women in health facilities. The project made an open call for participants through the radio. Rather than starting from scratch, CARE reached out to health promoters in the department of Puno which formed part of ForoSalud and local women's organisations, as they had previously received some training in reproductive health and family planning. Monitors were chosen based on their time availability, proximity to health facilities, knowledge, interest and level of commitment. Monitors were then shown how best to introduce themselves and address patients and service providers, and were given an ID and accreditation by the government Ombudsman.

3. DIALOGUE WITH SERVICE PROVIDERS AND COMMITMENT

The monitors visited health centres in pairs and generally carried out two to three visits per week, each roughly five hours long. They discussed issues with female patients in their native language about how they were treated, how long they had to wait to be attended, whether personnel complied with working schedules and whether they were provided with information in their own language. The monitors documented this information in a register and they produced regular reports including both positive and negative findings. These were analysed monthly with the regional Ombudsman's Office, CARE Peru and ForoSalud members. At the end of the visit, monitors asked the staff who were present to sign a monitoring form as proof of their visit and to help corroborate or challenge their findings.

FROM LOCAL TO NATIONAL – ADVOCACY IN PERU

"Change does not happen overnight. I think that some doctors, nurses and midwives have begun to understand why we are doing this volunteer work... Little by little, they will see that their work also improves this way." – Social Monitor

One of the greatest achievements of this participatory monitoring model in influencing policy is the fact that **it has become a national reference point for the issue of citizen monitoring of the quality of health-care services**. During a visit to Azángaro in May 2008, the Minister of Health met the monitors and saw their work in person. As a result, and due to the technical assistance activities of CARE Peru nationally, **the first Ministerial Resolution was issued** in recognition and support of the Citizen Health Monitoring Committees (R.M. 422-2008/MINSA, DA 133-2008-MINSA/DEST-V01).

Since then, CARE Peru has continued with the activities of policy/advocacy and technical assistance to the Ministry of Health. Together with other cooperation agencies, and on the basis of the experience in Puno, in January 2011 the **National Policy Guidelines for the Promotion of Citizen Health Monitoring** (R.M. 040-2011/MINSA, 14 January 2011) were promulgated.

Source: CARE, Social monitoring to defend maternal health rights in Peru, forthcoming

4. MONITORING COMMITMENTS AND PLANNING NEXT STEPS

Every three to four months, monitors met with CARE Peru, ForoSalud facilitators, the Ombudsman's Office and the Departmental Officer for Integral Health Insurance (ODESIS) to discuss and analyse findings from the monthly reports and to identify trends of good and bad practices and performance at the visited facilities. Based on this information, a 'dialogue agenda' was proposed for a meeting with the directors of health micro-networks, provincial hospitals, the heads of the health establishments and their teams. In these meetings the monitors expressed their concerns and issues that needed to be addressed locally.
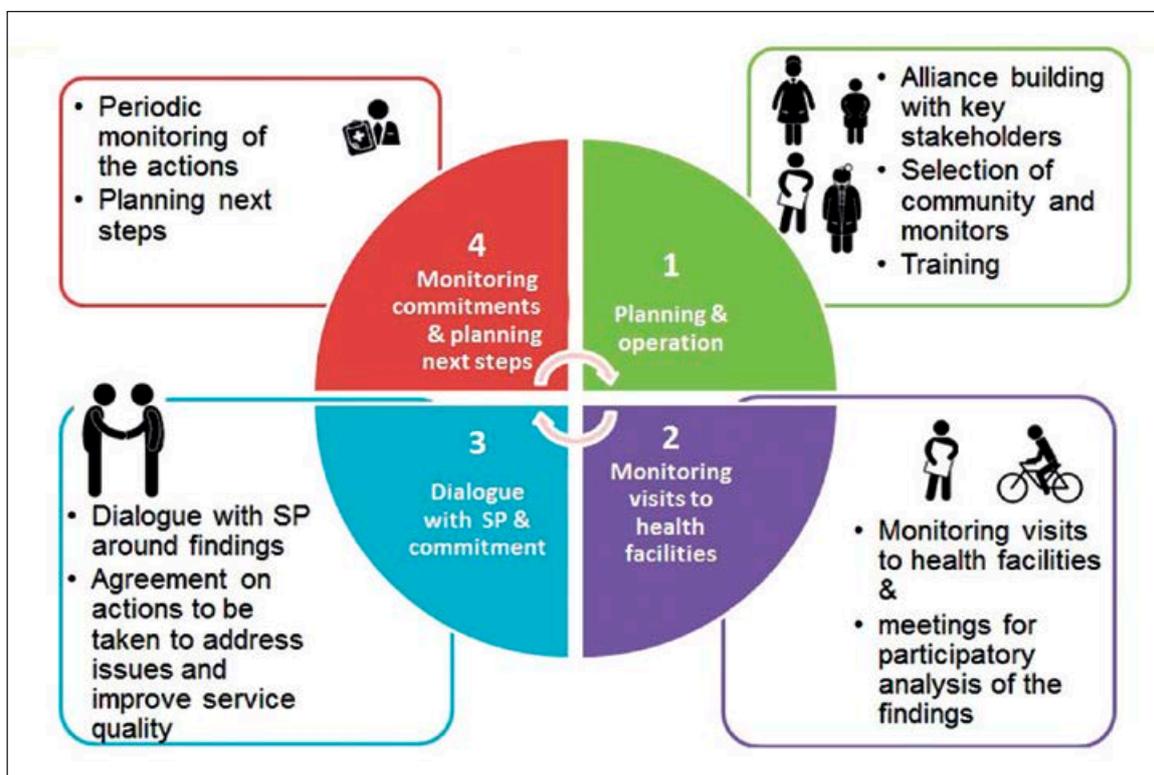
Outcomes of participatory monitoring

This report reflects **two sets of research findings of CARE's work: joint research by the UK Overseas Development Institute (ODI) and CARE of CSC use** in four **African** countries and **CARE's internal evaluations** of its social monitoring work in these countries, **Peru**, and **Nepal.** We have classified the **outcomes** according to **six broad categories**, three of which relate to specific service-delivery improvements (availability, access, and utilisation) and three to more intangible governance outcomes (citizen empowerment, accountability, responsiveness and effectiveness of service providers; and improved relations between service providers and users).

Citizen empowerment

Citizens become better informed about their rights and entitlements, as well as the responsibilities that local authorities and service providers have towards them.

- In **Tanzania**, community volunteers and service providers indicated that in some areas, service users were now better informed about their rights, national standards and initiatives, and that they were now more assertive and willing to criticise and engage with authorities and service providers. It was also emphasised that communities were now more willing and able to engage with participatory opportunities presented by national initiatives. CARE staff noted that communities which had originally been happy with only two health workers per facility changed their attitudes when they realised they should have seven.

- In **Ethiopia**, the CSC process acted as a convening venue for solving what was identified as essentially a local collective-action problem in terms of citizens failing to demand accountability for better services. Interviews conducted through the research highlighted that communities now have a greater sense of ownership and are assuming greater responsibility over service provision, whereas before they reportedly believed the government held the full responsibility for provision.

- In **Rwanda**, survivors of gender-based violence (GBV) were previously encouraged by other women to remain silent, including those on the National Women's Council who were ostensibly responsible for supporting GBV victims. Respondents claim that this 'culture of silence' has now been challenged locally, largely due to the training that community members have received on women's rights and GBV through the CSC process.

- In rural **Peru**, users of health centres where social monitoring was introduced have a *four times higher awareness* of complaint mechanisms and submit complaints twice as often. This has driven both a rise in expectations and an improvement in the quality of services.

Improved relations between communities and service providers

Improved relations also result in increased mutual understanding between the two groups.

- In **Tanzania**, the provision of information to the community about national standards for health services revealed in many places that health facilities were under-staffed and under-equipped, fostering an understanding of the difficult circumstances under which their staff were working.

- In **Malawi**, the CSC process brought the issue of community/service provider relations out into the open, and encouraged greater mutual understanding between community members and health workers. Anecdotal evidence suggests that health workers, in particular, are realising the impacts of their behaviour, which is contributing to changes in that behaviour.

- In **Peru**, the social monitoring process has contributed to greater respect and cultural sensitivity in service delivery. There has been a decline in the number of episodes of disrespect to health-care users, with over nine out of ten users feeling that the attitude of personnel had improved.

Improvements in service-provider accountability, responsiveness and effectiveness

This is achieved especially through the CSC process.

- In **Malawi**, a range of examples of corrupt practices was reportedly brought to light as part of the CSC process, including where a Primary Education Advisor had tried to extort funds from the parents of standard-8 class pupils. Through the Score Cards, the community exercised its ability to challenge and stop this practice.

- Also in **Malawi**, a school in Dowa, through the CSC process, identified significant gaps in terms of low levels of girls' enrolment. Further investigation highlighted a number of contributing factors, including poor facilities, but also an inactive and dysfunctional School Management Committee (SMC). As a result, the SMC was replaced and issues of girls' enrolment and participation were reported to have been given much closer attention.

- In **Tanzania**, at one local dispensary, an agreement was made between health-service workers and the leaders of its six surrounding villages to create an out-of-hours service. This would be free for pregnant women but all others attending outside normal hours would pay a fee. This *provided an incentive for health workers to attend during these hours and was cheaper for patients than the cost of transportation to other health facilities*.

- In **Ethiopia**, it was noted in interviews that prior to the CSC process, the Wereda (district) had only a few active WASHCOs (rural water and sanitation committees), with the rest largely inactive. The CSC process both clarified the duties of the WASHCO to the wider community and created an additional line of oversight through the CSC facilitators, which allowed closer monitoring from the government's Water Office. WASHCOs were given specific tasks to perform as a result of the interface meetings, which were then directly followed up. Brokering between different actors also seems to have played a role here, with both CARE and the Wereda administration providing additional training on management and maintenance duties. Interviews indicated that *WASHCOs had become significantly more active following the CSC process*.

Improvements in service availability

This is due to alterations in resource allocation in order to improve the availability of services.

- In **Rwanda**, three health centres within a hospital's catchment area were sharing one ambulance, creating access problems for the most distant centre located nearly 30km from the hospital. Following the CSC process, an *ambulance was relocated to this health centre, greatly reducing the waiting times for pregnant women in the area*.

- Also in **Rwanda**, a common theme which arose in the CSC process in Rusenge was the lack of experienced medical staff, particularly doctors and dentists, at the sector level. The community complained that nurses at the health centres were unable to provide the necessary medical treatment and that the long distance between the health centre and the hospital meant that they were unable to consult with a doctor. In addition, the lack of a dentist meant that the community members were forced to use the services of an unqualified village dentist. As this was not an issue which could be addressed locally, the health staff raised these issues at the monthly district health coordination meeting. As a result, the decision was made to send a doctor from the hospital to the health centre to undertake supervision visits twice a month. Although the decision took several months to implement, *doctors' supervision visits have now been sustained for two years*. Likewise, a dentist now also visits the health centre once a week.

- In **Tanzania**, the CSC process resulted in several recorded instances of *additional health workers being deployed to health centres in villages where this was prioritised in the CSC process*. In most cases, these were health workers who had been newly hired to the district, as opposed to being re-assigned from elsewhere in the district. For instance, an additional nurse was deployed to the Busisi dispensary; four additional staff were deployed to the Igogwe dispensary; and additional qualified staff were deployed to the Igala dispensary. This was coupled with various examples of district officials channelling additional resources to health centres and dispensaries to villages involved in the CSC process, such as additional beds provided to health facilities (Busisi, Igala) and additional birth kits disbursed.

- In **Peru**, monitors' efforts in participatory budgets improved maternal health services by successfully advocating for *the construction of birthing houses where women can stay before delivery*.

Improvements in service access

This can be achieved through new or renovated service infrastructure.

- In **Ethiopia**, the CSC process resulted in a brokered agreement among stakeholders to *build a new water point*, outside of the Annual Plan of the Water Office. The community contributed construction materials and part of the financing, the district water office contributed the remainder of funds needed and oversaw the construction, and CARE Ethiopia contributed industrial materials.

- In **Malawi**, the CSC process highlighted issues of gaps in accessibility to facilities and poor health awareness and engagement within communities. The subsequent action plan allowed for the community to mobilise and *build a new house for the health worker*, which will also include *a village clinic*.

- In **Tanzania**, the service infrastructure improved in a number of instances through the local community providing the bulk of the labour and the district administration providing the materials and contents. The results were the construction and renovation of *health centres*, the provision of *staff housing*, and the provision of user conveniences such as *toilets*.

- In **Rwanda**, there were numerous examples of where the CSC process was able to bring about improvements in infrastructure, with input from all levels (local, district and national) and across a variety of sectors (health, education, roads, water, etc). In one instance, following a request by the health centre whose catchment areas included 'administrative cells' which were two hours away by road, the district health authorities *approved the building of a new health post*, which was up and running about eight months afterwards. In several villages, the CSC process identified access to water as being particularly problematic for the local community. In one village, following the CSC process, the local sector leaders negotiated the *installation of a water pipeline* with technical assistance. The pipeline took a year to build with the community contributing to its construction through community works (known as *umuganda*). Finally, during an interface meeting, one village noted that the lack of nursery facilities was problematic because it was placing a burden on the older members of the community. In this case, an agreement was reached to use existing funds to support the *building of two new nurseries* which are now staffed by community members.

Improvements in service utilisation

Quality of services improves to such an extent that utilisation by the community grows.

- In **Peru**, greater confidence in the quality of care has translated into increased demand for services. CARE's quantitative assessment found *an increase in*: pre- and post-natal controls; women's access to laboratory exams; institutional birth delivery; and the proportion of women affiliated with SIS (health insurance scheme). Quantitative data also showed *increased access to the culturally-appropriate 'vertical birth delivery'* – from 194 in 2008 to 437 in 2009 in Azángaro Province.

- In **Rwanda**, the CSC process has *been beneficial to highly marginalised people by increasing their utilisation of facilities*. Beforehand they had been silent and didn't use the health centre facilities (for example to give birth). Since instituting the CSC process they now come in greater numbers: three gave birth in one centre only in November 2013 using their state health insurance cards. Others have started using family planning methods, and some have even submitted complaints. In one example of this, a community member came to the health centre's insurance office to pick up her health insurance card, paid for by the state. She didn't have a photo with her, however, so the health insurance officer refused to serve her. As the community member was sick, she went to the health centre director to complain, feeling that it discouraged people from attending the health centre. The director overruled her staff and insisted they give her the card. The health centre treated her first and then she returned with a photo afterwards.

Lessons from participatory monitoring in practice

CARE's experience with participatory monitoring and other forms of social accountability has yielded **a number of lessons highly relevant to the post-2015 consultation:**

PARTICIPATORY MONITORING IS DIVERSE AND ADAPTABLE TO CONTEXT

The concept of participatory monitoring is not monolithic. It covers a broad array of methodologies that, while sharing a common focus on the primacy of citizens and their voices, can adapt to the context in which monitoring is taking place and, more importantly, to the content being monitored.

COLLABORATION IS CRUCIAL

The CARE ethos places specific emphasis on participatory monitoring being collaborative processes. This means selecting partners and approaches that maximise cooperation and understanding through dialogue and joint action, and avoid confrontation between communities and service providers. Even in instances of corruption and service failure, it is important to recognise that these relationships must endure beyond the life of the CSC process and cannot function in an atmosphere of open hostility.

PARTICIPATORY MONITORING MUST BECOME MORE STRATEGIC

A recent analysis of social accountability has suggested that approaches that are tactically oriented (engaging only at one level on one issue) are less successful than those that are more strategic (working at multiple levels with many partners to achieve change) (Fox 2014). CARE's experience supports this contention; our CSC approach has evolved to become more strategic over its decade in use, based on our learning from previous projects.

LOCAL-LEVEL INFORMATION ADDS CRUCIAL TEXTURE TO GENERIC 'OUTCOME INDICATORS'

While indicators like those of the Millennium Development Goals (MDGs) and national development plans can capture significant quantities of data and explain significant data trends, they often miss the 'granularity' that local-level data can provide. Specifically, participatory monitoring delivers data on the **quality of services** over and above the quantity of services provided. This is a fundamental issue in explaining inconsistencies between seemingly complementary indicators. If primary school enrolments are up but literacy levels are stagnant, local level data answers the discrepancy in whatever form it takes. While this does little to help aggregate progress, it is essential for policy planning.

CONTEXTUAL ANALYSIS IS FUNDAMENTAL

To become strategic, it's crucial first to understand the context in which one is working in order effectively to tie programme interventions into existing accountability mechanisms, to respond to key interest groups, and to adapt the model for maximum effectiveness. This means spending the time in advance to analyse the political economy of the environment in which one will be working.

PROCESS MATTERS WHEN IT COMES TO DATA COLLECTION AND SERVICE-DELIVERY

Data is clearly crucial in the world's fight to eradicate poverty and deliver basic services to all. In ensuring that data is collected and services delivered, however, it is important to take into consideration the process by which it is accomplished as well as the success of the final outcome. The chronic issues that afflict many developing countries must be addressed, but it should not be 'by any means necessary'. CARE's experience with participatory monitoring suggests that the process can have a tangible impact on the ultimate outcome of a project or policy. Involving communities not only empowers them, it also gives all participating an incentive in seeing the process achieve results. Future development goals cannot be isolated indicators viewed as the sole preserve of the international community and national statistics offices; they are too important for that and require a process that reflects all those who have a stake in their achievement.

PARTICIPATORY MONITORING SHOULD COMPLEMENT AND INFORM EXISTING ACCOUNTABILITY MECHANISMS

The gains observed thus far have been largely at the local level, with a few notable exceptions like Rwanda and Peru. For participatory monitoring to be scaled up effectively and make substantial impact at national level ('vertical integration'), social accountability mechanisms should tap into indigenous accountability systems and feed the collected data into government performance-assessment mechanisms. It is not sufficient to generate information only; service providers and public authorities must be able and willing to use and act upon that information. In other words, top-down accountability mechanisms need to be accompanied by bottom-up mechanisms to generate transformative processes.

Post-2015 implications:
A new approach to the data revolution

The new framework for sustainable development will be adopted in September 2015, to continue, and hopefully accelerate, the process begun with the Millennium Development Goals, which expire at the end of that year. There has been widespread determination that the new SDG framework must eliminate the gaps in measuring the MDGs. This means that a robust monitoring system must be put in place to track progress in a consistent and rigorous manner, before governments around the world begin to implement the new SDG framework on 1 January 2016.

Towards a data revolution

Experience from monitoring the MDGs revealed that official statistics in many developing countries are woefully inadequate and unreliable. In response to this failure, the UN High Level Panel on post-2015 development goals has called for a 'data revolution' to improve tracking of economic and social indicators in Africa and the rest of the developing world (United Nations 2013). The agenda emerging from discussions about the data revolution has tended be based on the assumption that additional funding and improved technology will solve the problem. This has led to a focus on expansion of survey data-collection efforts, and greater transparency of data from national governments.

Indeed, since the adoption of the MDGs in 2000, it is argued that the developing world has made some headway in improving its data collection and reporting systems. These systems nevertheless remain characterised by under-funding, reliance on donor support, particularly for household surveys, and very weak administrative data systems. In some countries, the basic demographic information needed to underpin key indicators remains out of date, and funding for major activities, such as population censuses, continues to be difficult to obtain. Data from national statistical systems and household surveys are often incomplete and of poor quality. Because the data often come with too great a time delay, the MDG indicators have neither been useful for planning nor for measurement and accountability purposes.

A recent report from the Centre for Global Development (CGD) finds that the problems are more deeply rooted. Surveying datasets from several African countries, the authors found "there are significant inaccuracies in the data being published by national and international agencies. These inaccuracies appear to be due in part to perverse incentives created by connecting data to financial incentives without checks and balances, and to competing priorities and differential funding associated with donor support." (Sandefur and Glassman 2014)

There is certainly a strong argument that a **much greater investment in building national statistical capacities and strengthening quality and standards** will be required for the SDG indicators to fulfil their potential. The CGD report notably asserts that "statistical agencies in the region, particularly those in Anglophone Africa, lack functional independence, fail to attract and retain high-quality staff, depend on external funders for the majority of their spending and experience significant volatility and unpredictability in their year-to-year budgets. Plans are often divorced from budget realities, thus forcing NSOs [National Statistics Offices] to prioritise 'paying customers' rather than national priorities and core statistical activities as articulated in country development plans." (*ibid*)

CARE believes that a data revolution requires more than just better technology, more government surveys and more government transparency in publishing data. This is only one side of the equation. We would argue that **a real data revolution that will contribute to the achievement of the SDGs and to tracking service-delivery outcomes requires three elements: 1) a change in levels; 2) a change in actors (citizen-generated information); 3) a change in the type of information collected**.

A data revolution requires a change of levels

The Sustainable Development Solutions Network (SDSN) asserts in its recent report that "in addition to national-level reporting of SDG indicators, data should also be collected and reported sub-nationally (eg for cities and states/provinces). Ideally, the schedule for sub-national reporting would track the international schedule for harmonised country reporting." (SDSN 2014)

In all countries, there is a frequent disconnection between international, national, and local priorities. Effective service delivery is the result of **effective governance at all these different levels**, so it is crucial to ensure that they are interlinked – alignment from the top down and from the bottom up will help close the 'implementation gap' between what is proposed globally and what is achieved locally. **Without vertical integration, there will be a disconnection between what we claim we want to achieve at both global and country levels and what is actually implemented, ultimately undermining the effectiveness of the post-2015 framework. CARE believes that** *participatory monitoring from the local level is the current missing piece* **in the existing proposals for tracking progress against the post-2015 SDGs**.

This requires a major, concerted push to ensure that the local level is effectively included in the design, implementation and particularly the monitoring of the post-2015 framework. **Local governance is the first point of contact between citizens and the state. Institutional performance at the local level will determine both** *if and how* **the SDGs are achieved.** Indeed, it is at the local level where we can engage with the *process* of service delivery, going beyond simply measuring an outcome, to understanding *why and how* that outcome came about. If the incentives of local and national governments are to be shifted away from donor priorities to locally-relevant reform, it will have to occur at process-level, learning what works and what doesn't, and making corrective adjustments along the way.

Building participatory monitoring into the SDG process can provide the *link to local processes that was lacking in the MDG system*, **giving an internationally-led mechanism local relevance and ownership.**

A data revolution requires a change in actors collecting the data

The same SDSN report argues that "the revolution in information and communication technologies and the growing role of civil society organisations and businesses offer unprecedented opportunities for complementing metrics and data." (*ibid*)

First and foremost, the **SDGs should include** *citizens*' **(service users') perspectives on public services. So, we need to produce citizen-generated data to complement official data**.

Secondly, the aforementioned inaccuracies discovered in official statistics also point to a need for **greater citizen scrutiny and government accountability for this data**. Citizens and civil society organisations (CSOs), existing and new, should thus be supported to generate data to verify or challenge the findings presented by state authorities.

Building participatory monitoring into the post-2015 SDG implementation process can mobilise new actors to voice their views on the quality of service provision and corroborate or contest data from official statistics.

A data revolution requires a change in the type of information collected

For the data revolution to work, we not only need to put emphasis on new levels and new actors, we also need to generate new information. Official data can only tell half the story. We must also check whether that data is credible, whether it is the right data, and indeed whether it is all the data you need. **Citizen-generated data through social monitoring can help to tell the whole story.**

CARE proposes that official statistics derived from surveys should be **complemented by a citizen-generated 'shadow reporting' system**. Training citizens and CSOs to carry out shadow reports is a highly effective way to determine the credibility of national-level official data being reported by service providers and line ministries, and whether or not it actually reflects the reality at the local level. **Community Score Cards and citizen oversight mechanisms such as that employed in Peru would allow the post-2015 accountability system to confirm the accuracy of certain statistics against local data trends.**

Secondly, a social monitoring approach and methodology allows **citizens to produce locally validated information and feedback on the actual quality of services**. This would help to realign incentives around the quality of services as much as the basic outcome those services provide. Governments would be required to report accurate 'headline' human development indicators if the underlying service-provision data were both available and contradictory to official statistics. If the adage 'what gets measured, gets done' holds, then the incorporation of participatory monitoring into the post-2015 SDG implementation is essential to ensure that the national governments and the international community start getting the quality of services right.

CARE views the post-2015 process as an opportunity to improve not just the quality of data but also the kind of data collected and the process by which it is gathered. By adopting a more participatory and inclusive approach to the data revolution, the SDGs can contribute to citizen empowerment. Fortunately, the post-2015 agenda already identifies the need to encourage "meaningful civil society participation via a rights-driven framework". Participatory monitoring can facilitate this by fostering active participation from the ground up.

By providing a mechanism for direct dialogue between service providers and the community, participatory monitoring also creates opportunities to reduce inequality and social exclusion, empowering the public to voice their opinion and demand improved service-delivery. Participatory monitoring also creates incentives for **participants on both sides** to drive the accountability and transparency agenda forward, building from local origins to catalyse broader transformative change.

What is required is a model for incorporating participatory monitoring into existing proposed systems for measuring, monitoring and tracking the effectiveness of the delivery of SDGs. Based on our experiences in social accountability, we have developed an indicative model. This is presented in the following section.

Towards a model for participatory monitoring of the SDGs

The starting point for our model is that the **Sustainable Development Goals agreed in the post-2015 framework must be measured and monitored at all levels** from the start with a standard methodology. Likewise, **accountability mechanisms to measure the performance of governments need to start at the sub-national level**. This means going beyond discussions about how to strengthen national statistics offices and the quality of quantitative data at national level. While vital, focusing only on this level of the process ignores the **critical importance of data on service-delivery quality and performance at the local level**. This is where the impact of service-delivery outcomes is felt and where information is currently least available. **Community Score Cards and similar approaches generate easily comparable data that can be assessed against agreed standards** *across levels and countries*.

CARE proposes a **two-tiered approach for participatory monitoring** (see diagram on next page) in which processes like Community Score Cards and citizen oversight mechanisms provide necessary **accountability over outcome level indicators in the form of shadow reporting** while also providing **new data on the quality of service-delivery inputs at the local level**, feeding into **national level policy-making and international mechanisms for learning and analysis**.

Our two-tiered approach builds on the proposal of the SDSN to create two sets of indicators for the post-2015 SDGs. Its report proposes that "the first set consists of Core Indicators that would be applicable to every country and would track the most essential dimensions of the targets. The second set consists of 'Tier 2' indicators that would track issues that may be applicable to some countries only or that may give countries greater scope in applying complex concepts to their specific needs." (SDSN 2014) We consider this a novel and pertinent approach but one that requires further development.

In the SDSN model, the Tier 1 indicators most closely match the existing MDG indicators. They are designed to capture human development outcomes; are nationally focused; and rely upon statistics and data from national statistics offices and other official sources. As addressed above, there are several persistent challenges to monitoring these indicators effectively. However, **existing participatory monitoring approaches are not best placed to capture this level of data**. Rather, we envision a role for these community-driven processes in providing context to these rather 'abstract' statistics and in **reinforcing a nationally-focused accountability mechanism** to offset the dominance of the international system.

While data gathered from participatory monitoring *would not feed directly into the SDGs*, **the evidence could be anchored to the Tier 1 indicators**. For example, high level indicators such as access to health-care or health expenditures can be linked with indicators on the quality of care such as the following: the availability of accessible information on maternal and child health (ie published in local languages); the reception of health-care users at the facility (respect for users' cultural customs/use of language); reports of under-the-table payments for drugs that should be free.

LINKING TIER 1 INDICATORS WITH PARTICIPATORY MONITORING

Proposed Tier 1 indicator: *Neonatal, infant, and under-five mortality rates*

Underlying data available for participatory monitoring:

- Whether health centres are fully and consistently equipped and supplied to provide a basic package of services
- Whether the staffing of health professionals in the area is proportionate to the population
- Whether children and their parents have access to affordable essential drugs and commodities on a sustainable basis

Source: SDSN 2014

Tier 1 Indicators

Source: international community, delivered top-down

Information collected: outcome level data on service delivery, capturing the impact on people's lives

Tier 2 Indicators

Source: mixed, from consultation between communities and district and national government, aligned at national level to aid comparison

Information collected: input level data on service delivery, capturing people's experience with service delivery to contextualise Tier 1 data

Responsibility for Data Collection

For Tier 1 indicators, national statistics offices and the international community lead a principally top-down process of gathering information through improved household surveys and other statistical tools

Participatory monitoring provides little direct input but 'shadows' official data as a form of accountability mechanism
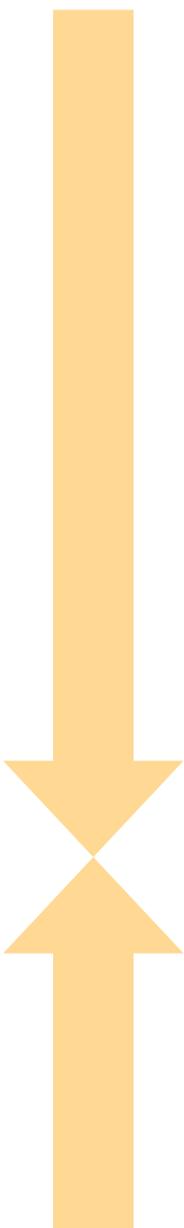
Responsibility for Data Collection

For Tier 2 indicators, national level actors function as aggregators and audience for information data

Participatory monitoring takes the lead on collecting data at this tier, mobilising along civil society platforms on a sectoral or geographic basis. Data on service delivery will be fed into the official system at district level followed up the chain to ensure strong linkages and to facilitate policy responsiveness

The Tier 2 indicators as proposed by the SDSN remain somewhat less well-defined. Designed to be national in scope but addressing issues that may be specific to individual countries, they have **good potential, if developed, to be more ambitious in their coverage**. First, the process by which they are developed should be expanded. While a certain number of indicators may need to be directed from the top down, CARE believes that the majority of them should be formulated through open consultation between communities, district offices and national ministries. This is necessary to ensure they reflect the specific needs of the country and, importantly, they provide the data necessary for policy changes to be effected where necessary. **Locally-identified indicators would then need to be adapted at the national level to allow for comparisons and aggregation across different areas and to enable more strategic interventions across districts**. This is an important issue for discussion and collaboration, one that could be initiated through an approach like the CSC process.

EXAMPLES OF TIER 2 INDICATORS WITH POTENTIAL FOR PARTICIPATORY MONITORING

Water and Sanitation:

- The level of integrated water management in a community
- Sanitation and hygiene levels within public facilities

Education:

- Quality and availability of teaching and management
- Quality and reliability of the school infrastructure and services

Source: SDSN 2014

Second, the **kind of information these Tier 2 indicators aim to measure should be broadened to include data on the quality of service delivery at the 'input' level rather than remaining at the 'outcome' level**. At the local and community level, the Community Score Card and social monitoring approaches offer unequalled access to service-delivery data that can inform policy-making and contribute to the SDG indicators. The data gathered would speak to the **quality of services delivered and enable officials to enforce existing standards across governance processes**. The information collected would be **distributed to district authorities and sectoral working groups at district level** tasked with improving service performance, **before being aggregated up to the national level to 'shadow' official statistics**.

Under CARE's model, a community process managed through local and national CSOs could provide regular and consistent feedback on the performance of available services and raise quality issues that should be addressed either at district level or passed up the chain to national decision-makers. Issues that are fundamental to the post-2015 SDG framework include: access to services in terms of quality and reach; the use of services in terms of availability and continuity of service; relations between service users and providers in terms of responsiveness to citizen needs and concerns; and the effectiveness of facilities and staffing. The processes would be repeated on a quarterly or semi-annual basis.

Six-step model for participatory monitoring of the SDGs

CARE envisions a six-step model for participatory monitoring in conjunction with the SDGs. Drawing upon the success of the CSC and social monitoring processes, the six steps are presented below.

STEP 1: PREPARATION AND TRAINING OF LOCAL FACILITATORS AND COMMUNITY AGENTS
The first common step in our social monitoring model should be to select community members and civil society organisation representatives. These actors will be trained in social monitoring methodologies to become local **facilitators** for the community scoring process. These same actors (or other local representatives) will also be trained as **community agents** to visit government facilities or projects and to interview local service users regarding the quality of public services.

STEP 2: COMMUNITY VALIDATION OF INDICATORS AND SCORING
Using Tier 1 indicators as an anchor, community members will be facilitated (by community facilitators) to identify which Tier 2 indicators are most important for their communities and on which they want to track changes. In a focus group, these indicators are then refined and community members are asked to score the performance in the delivery of the targeted public service linked to the SDG.

STEP 3: SERVICE PROVIDERS SCORE ON THESE INDICATORS
Service providers are supported by community facilitators to score on their own performance against these Tier 2 indicators and certain relevant quantitative Tier 1 indicators.

STEP 4: DATA GATHERING ON SERVICE-DELIVERY OUTCOMES BY THE COMMUNITY
Community agents visit government facilities or projects to assess the quality of service delivery, interviewing service users and/or using ICT (information and communication technologies) to monitor implementation against agreed indicators. They then compile reports which are shared with service providers.

STEP 5: INTERFACE MEETINGS BETWEEN SERVICE PROVIDERS, SERVICE USERS AND PUBLIC AUTHORITIES
Community facilitators convene a meeting between service providers, service users and public authorities. Here each stakeholder group is invited to present their findings, detailing positive and negative outcomes. Service providers will share findings against both Tier 1 and Tier 2 indicators. Sharing regular updates on local progress against outcomes (Tier 1 indicators) will further promote a culture of accountability and introduce an element of public hearing into the model. These actors then **jointly agree commitments** to improve service-delivery outcomes against the identified indicators and **generate an action plan with clear responsibilities assigned to appropriate actors**.

STEP 6: COMMUNITY AGENTS CORROBORATE FINDINGS AND FOLLOW UP ON THE ACTION PLAN
Community agents visit facilities or projects to check whether commitments made are being delivered by service providers, local authorities and citizens.

Process starts again.

Advantages of the six-step model

This model's consultative focus and its inherent reliance on community involvement ideally suits the proposed Tier 2 indicators and, if institutionalised within existing reporting structures, could produce a significant shift toward evidence-based policy, decision-making and planning, even at local and district levels. **The lack of reliable information at this level has severely impeded progress on improving service provision, particularly in rural areas. Well-managed and well-coordinated CSCs could provide a compelling option to quickly expand the base for data collection in these marginalised areas while having the positive side-effect of engendering greater cooperation and trust among community members, service providers, and local government officials.**

Taken as a whole, CARE's model presents a robust and varied set of options for monitoring the SDGs at both the national and sub-national level. Each element contributes significant information to government data collection, be it at district level or through national ministries. **Participatory monitoring adds value to the successful implementation of the post-2015 framework in three distinct ways.**

One, it develops an **indigenous accountability mechanism in the form of 'shadow reporting'** to provide oversight of the data passing through the official system.

Two, it introduces new, **critically important contextual information on the quality of service-delivery inputs that has been lacking in previous monitoring systems**. Responding only to outcomes leaves governments constantly 'behind the curve'. Understanding and making the link between inputs and outcomes gives both national and international communities more robust options for improving service-delivery in a timely fashion.

Three, **it links local communities with an activity that has largely been the remit of the international community, delivering a greater sense of ownership and potentially shifting incentives in a positive direction**. If developed further and ultimately implemented, we believe it will provide a necessary complement to whatever official UN/World Bank monitoring system will be established for January 2016.

Indeed, it is important to reiterate that CARE International does not see this model for participatory monitoring as superseding any such official monitoring system. We welcome efforts to improve national statistics offices and to increase the quality and frequency of household surveys and censuses that provide the foundations of a country's demographic database. Rather **this model for participatory monitoring** is designed to complement official government-led monitoring, contributing where appropriate **to supplement missing data or to 'triangulate' (cross-confirm) unverified information**.

The ultimate aim of the SDGs is that they deliver better livelihoods for people living in the developing world. CARE believes that those people should have a significant role in determining how the success or failure of these goals is measured and assessed.

Conclusions

CARE International's experience of over 10 years of implementing participatory monitoring approaches such as Community Score Cards and social monitoring has convinced us of their capacity to capture robust and relevant information. While participatory monitoring cannot alone substitute for rigorous statistical surveys and analysis, it is a necessary complement to an effective monitoring system. Indeed, we would argue that without citizen-generated monitoring data, any system established to monitor post-2015 sustainable development outcomes would be incomplete.

The MDG experience has demonstrated the pitfalls of creating a system with insufficient accountability and local ownership. Faced with purely external incentives, the MDG outcomes have become more an exercise for governments to tick off indicators than to achieve substantive, sustained change. In this sense, participatory monitoring should be positioned not as a means of collecting Tier 1 SDG outcome data but rather as a means of measuring the real experience of service-delivery among local populations.

In addition, social, economic, political and environmental contexts are crucial to measuring development outcomes, but international systems predicated on cross-national comparability tend to dilute complexity in favour of consistency and replicability. Participatory monitoring puts local, specific texture into the post-2015 SDGs. Through strategic interactions across multiple levels of governance, it can validate, refute, or contextualise official data, enriching the content of the SDGs and ultimately providing local, national, and international officials with more reliable and more actionable information on service-delivery standards in all countries.

Through our two-tiered model, there is an opportunity to create a measurement and monitoring system for the post-2015 SDG framework that both delivers the data required for the international community and changes the incentives of national governments to respond to domestic as well as international priorities when setting development agendas. Progress on these complementary objectives will culminate in potentially a stronger monitoring system and better sustainable development outcomes for the world's population.

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Cover photo: a Community Score Card focus group discussion in Ntcheu District, Malawi.
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