



Final Report

Mid Term Evaluation

Micro-Enterprise Development Programme (MEDEP) –PHASE IV

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DECC takes the responsibility of the information, analysis and data provided in this report except in the case of data from other sources (source indicated in such cases).

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Thank you,

Raghav Raj Regmi
Managing Director

Table of Contents

Acronyms.....	i
EXECUTIVE SUMMARY	iii
1. Introduction.....	1
1.1 Background and Context.....	1
1.2 Operating Environment of MEDEP-IV	1
1.3 Objective of the MTE	2
1.4 Organization of this Report.....	3
1.5 Methodology and Process	3
1.5.1 Approach to Data Analysis	4
1.5.2 Process Followed by the MTE team	5
1.6 Scope and Limitations of the MTE	7
1.6.1 Scope of the MTE	7
1.6.2 Limitations of the MTE.....	8
2. Description and relevance of the intervention, MEDEP	9
2.1 The problem MEDEP addresses	9
2.2 MEDEP.....	10
2.3 'Theory of Change' for MEDEP-IV	12
3. Major Findings and Analysis: Progress, effectiveness, and sustainability	15
3.1 Progress on implementing the components/interventions.....	16
3.1.1 Progress Analysis of Component 1	16
3.1.2 Progress Analysis of Component 2.....	24
3.1.3 Progress Analysis of Component 3.....	27
3.1.4 Progress Analysis of Component 4.....	30
3.1.5 Progress Analysis of Component 5.....	33
3.2 Progress on establishing a sustainable system for delivery of the MEDEP model–effectiveness and sustainability	36
3.3 Impact trend	44
3.3.1 ME creation, jobs generated, sustainability	44
3.3.2 Inclusiveness	45
3.3.3 Income.....	46
3.3.4 Social and other impact.....	47
3.4 An overview on GESI within the project.....	48
3.5 Project implementation set-up and management	51
4. Overall Conclusions.....	53
4.1 Major Success and Strengths of the Project.....	53
4.2 Areas of Improvements.....	55
5. Future directions – Recommendations.....	59
5.1 Strengthening Support on Institutionalization	59
5.1.1 MED Service Model Improvement.....	59
5.1.2 Shift focus from Delivery to Institutionalization	59
5.1.3 Review MEDPA Operational Guidelines	60
5.1.4 Work on Institutionalization of Capacity Development	61
5.1.5 Support MOI on new MED strategy and 14 th Periodic Plan of GoN.....	61
5.2 Strengthening Associations and MEDSPs for Sustainability.....	62
5.2.1 ME Associations at district level	62
5.2.2 Associations at national level.....	62
5.2.3 Strengthening MEDSPs	63

5.3	Clarity on MEDF issues	63
5.4	Improving Project Management.....	64
5.4.1	Review and Revise the Project Document	64
5.4.2	MIS	65
5.4.3	Project MRM and DCED standard	65
5.4.4	Find solution for MEDPA tendering and contract management issues:	65
5.4.5	Institutionalization Support Monitoring Plan.....	66
5.4.6	UNDP and DFAT Coordination and Communications	66
5.4.7	One Year Extension for MEDEP	66
6.	Beyond MEDEP.....	67
7.	Lessons learned.....	69
	Appendix- A: Data Tables	a
	Annex 1 – Evaluation TOR.....	I
	Annex 2 – MTE evaluation questions and framework.....	xiv
	Annex 3 – Documents reviewed	xxviii
	Annex 4 – People interviewed	xxxiii
	Annex 5 –The MEDEP/MEDPA service model and the delivery system	xlii

List of tables

Table 1 Progress against key output indicators Component 1	a
Table 2 Progress against key output indicators component 2	b
Table 3 Progress against key output indicators component 4	b
Table 4 Increasing Trend in the Number of MED SPs bidding	c
Table 5 Progress against key output indicators component 5	c
Table 6 Table Progress on main outcome indicators	d
Table 7 ME Survival over time	e
Table 8 Comparison of achievement of Gender & Social Inclusion Versus Target	e

Acronyms

APSO	Area Programme Support Offices
BMO	Business Membership Organisation
CBOs	Community Based Organizations
CCI	Chambers of Commerce and Industry
CSI	Cottage and Small industry
CSIDB	Cottage and Small Industries Development Board
CSIO	Cottage and Small Industries Office
CTA	Chief Technical Advisor
CTVET	Council for Technical Education and Vocational Training
DCED	Donor Committee for Enterprise Development
DCSI	Department of Cottage and Small Industry
DCSIO	District Cottage and Small industry Office
DDC	District Development Committee
DDF	District Development Fund
DEDC	District Enterprise Development Committee
DEDSP	District Enterprise Development Strategic Plan
DFAT	Department of Foreign Affairs and Trade
DFID	Department for International Development (UK Aid)
DMEGA	District Micro Entrepreneurs' Group Association
EDF	Enterprise Development Facilitator
EDU	Enterprise Development Unit
FGD	Focus Group Discussion
FNCCI	Federation of Nepalese Chamber of Commerce and Industry
FNCSI	Federation of Nepal Cottage and Small Industry
FY	Fiscal Year
GESI	Gender Equality and Social Inclusion
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoN	The Government of Nepal
GSS	Government Support Specialist
LDO	Local Development Officer
IEDI	Industrial Entrepreneurship Development Institute
MDS	Market Development Specialist
M&E	Monitoring and Evaluation
ME	Micro Enterprise
MErs	Micro Entrepreneurs
MED	Micro Enterprise Development
MEDSP	Micro Entrepreneurship Development Service Provider
MEDEP	Micro Enterprise Development Programme
MEDF	Micro Enterprise Development Fund
MEDPA	Micro Enterprise Development Programme for Poverty Alleviation
MEG	Micro Entrepreneurs Group
MEGA	Micro Entrepreneurs Group Association
MEU	Micro Enterprise Unit

MIS	Management Information System
MOAD	Ministry of Agriculture Development
MoFALD	Ministry of Federal Affairs and Local Development
MoFSC	Ministry of Forest and Soil Conservation
MoI	Ministry of Industry
NASC	National Administrative Staff College
MRM	Monitoring and Results Measurement
NEDC	National Entrepreneurship Development Centre
NGO	Non-Governmental Organisation
NMEFEN	National Micro Entrepreneurs Federation of Nepal
NPC	National Planning Commission
NPD	National Programme Director
NPM	National Programme Manager
NPSO	National Programme Support Office
NRs	(Nepalese) Rupees
UNDP	United Nations Development Programme
VDC	Village Development Committee
VEDC	Village Enterprise Development Committee
VEDP	Village Enterprise Development Plan

EXECUTIVE SUMMARY

I. Introduction

Document on hand is The Mid-term Evaluation (MTE) Report of Phase IV of the Micro Enterprise Development Programme (MEDEP) covering the period August 2013 to December 2015. It took place during 12 January 2016 to 25 April 2016. It was conducted by a team of international and national consultants, fielded by the Development Consultancy Centre (DECC). The overall purpose of the MTE was to:

- Assess progress at the mid-point of project implementation and pave the way for improved project delivery for the remaining project duration.

The primary objectives were:

- Project progress: To assess progress of MEDEP Phase IV compared to the project document, identify and assess the results and impacts as to their sustainability and on that basis to recommend whether the project is ready to hand over MEDEP to the Government to streamline with MEDPA.
- Future directions: To identify causes of possible underperformance or lack of sustainability, including in the context the project is operating in (such as the political economy), lessons learned and experiences gained, and on that basis make suggest changes (if any) in design, implementation arrangements, and/or institutional linkages in order to effectively and sustainably contribute to livelihood improvement in the target areas.

II. Project background

MEDEP is a poverty reduction programme largely funded by Department of Foreign Affairs and Trade - DFAT, implemented by the Ministry of Industry with support from UNDP, which also contributes funding. Its first three phases, which ran from 1998 to 2013, developed and delivered an integrated micro enterprise development programme, targeting women and the socially excluded. The programme gradually expanded coverage to 38 Districts by the end of Phase III. Given demonstrated impact on poverty, the Government decided to institutionalise the approach in the form of a Micro Enterprise Development for Poverty Alleviation Programme at the MoI, which is to cover all 75 districts by the end of 2018. The main intent of Phase IV of MEDEP is to support institutionalisation while gradually handing over its activities by its completion date (August 2018). The project is also to create 30,000 MEs.

III. MTE approach and Methodology

Taking the MTE's TOR as a starting point and on the basis of the Theory of Change (ToC) laid down in the project document and since refined by MEDEP, the MTE developed a simplified ToC, which it took as the basis for its evaluation matrix, development of research tools, and analysis. This ToC includes sustainable system for delivery of services for ME creation and resilience and growth as the expected change the project is to bring about (combining its two outputs). The five components the project is divided into¹, with their activities, are considered the interventions that are meant to achieve this.

¹The MTE has considered a 6th component, on a Management Information System and M&E as part of component 1 and project management respectively.

The key elements of the service delivery system are:

- Relevant GoN bodies under the MOI (Department of Cottage and Small Industries, DCSI, and Cottage and Small Industries Development Board, CSIDB) that manage and monitor MED, and in local Government (Village Development Committees (VDCs), municipalities and District Development Committees (DDCs), which include MED in their development plans; Micro Enterprise Development Funds (MEDFs) in which GoN, local bodies and donors (DFAT for the remainder of the project) pool their resources for implementation of MEDPA.
- The Micro-Enterprise Development Service Providers (MEDSPs), largely NGOs, who are contracted by the DCSI and CSIDB to provide MED services; and
- The groups and association made up of micro enterprises established under the programme, which provide support services and advocacy to their members: Micro-entrepreneurs Groups (MEGs) at the community level, Micro-entrepreneurs Groups Association (MEGAs) at Rural Market Centres (RMCs), District Micro Entrepreneurs Groups Associations (DMEGAs), and the National Micro Entrepreneurs Federation of Nepal (NMEFEN).

The MTE conducted interviews, consultative meetings and workshops in Kathmandu and five districts (Kalikot, Myagdi, Jhapa, Kailali and Sindhuli). All stakeholder groups and actors in the service delivery system were covered and consultations were held with the MEDEP team, UNDP and DFAT. A large number of documents were reviewed.

IV. Main findings and conclusion

a. Relevance of TOC and MED Service Model

The project follows the logics of the 'theory of change' that is provided by the project document for MEDPA. The basic philosophy that the TOC holds interms of empowerment of disadvantaged and poorest of the poor groups by providing them the opportunity to come out of poverty through MED services holds same level of validity as of its time of design. Reaching to the hard-core poor, poor and lower middle class people for their subsistence and income generation, and increasing their aspirations to achieve higher levels of economic benefit above the subsistence level remains as a challenge to the government service delivery agencies and developmental agencies. Nepal still having about 27% of its population, more in the rural areas, targeted interventions like MED for the disadvantaged, marginalized and vulnerable groups are still needed for quite a substantial period of time to make sure that needy people of such groups have access to such services.

b. Achievements on ME creation

ME creation and scale up targets by MEDEP directly and by MEDPA is largely on track. Considering the current achievement pace both MEDPA and MEDEP are expected have achieved the ME creation target of 32000 and 30000 respectively. Of the joint target of 73,000 (of which 11000 are to Local Bodies), 45 percent has been achieved. MEDEP itself has achieved nearly half of its target of 30,000.

The fund allocation for ME creation by MEDPA is in increasing trend so any budgetary limitation on this is not expected. The ME creation target of 11000 allocated for local bodies is lagging behind and it is less likely to be achieved to this extent by the end of the project period. The current target achievement progress under the local body's allocation is less than 10%. More VDCs now have VEDC and many of them are also developing VEDPs with some resource commitments and mobilization strategies, hence, in the next two years period they can be expected to achieve increased number of the targets, but likely to remain far behind the target of 11000.

c. Achievements on Access to Finance

In terms of providing sustainable access to credit, through Financial Service Providers and cooperatives, the system is functional at present and delivering important benefits to micro enterprises. The project has made considerable progress on the access to finance. The number of MEs accessing finance is at satisfactory level. The cooperative development target is significantly achieved; more FSPs are attracted and are put in contact with DEMEGAs and existing or newly created cooperatives through MEDEP support.

What will have been achieved by the end of the project is likely to remain in place, since the services are, or are likely to become, profitable. However, expansion is dependent on MEDEP and whether MEDPA will be able to continue this will require clear allocation of this function, capacity building and funds. These have so far not been provided. Having DMEGAs and Financial Service Providers sign MOUs, as has recently been started, is a positive step, but given the DMEGAs' questionable sustainability, it is likely to be insufficient. A system for managing and expanding access to credit beyond MEDEP's completion is therefore not yet in place. This is at least in part due to this having been insufficiently specified as an aim and in the Theory of Change in the project document, and MEDEP's strategy having further de-emphasized it.

Considering the high interest rates (14-22%) of most of the currently engaged FSPs, there is a need to expand the linkage with other FSPs and MFIs who have lower rate of interest (MFIs like RMDC, National Cooperative Banks are lending for local cooperatives and NGO MFIs at less than 12%). Capacity development of DEMEGAs in facilitating linkage between MEs cooperatives and interested FSPs remains a task to be continued to allow access to finance of more MEs with a focus to remote areas, where the MFIs still have limited reach.

d. Achievements in strengthening MED service delivery actors.

The actors involved in providing MED service to MEDPA and MEDEP such as MEDSPs, EDF training institutes are in-place and available in sufficient number to fulfil the given target.

Increased number of MEDSPs taking part in the bidding process has outstayed the concern of crowding in, rather different set of issues related to the question of professional survival of these NGO type of entities in the MED sector because of (small) scale of available business in post MEDEP period, and further growth of similar organizations in numbers have emerged to be faced by MEDEP and MEDPA. Delay in MEDSP selection, no provision for multiyear contracts for MEDSPs, delayed and complex process of final payment of withheld amount to MEDSPs are some areas required to be addressed.

There does not seem to be any issue about the availability of sufficient number of EDFs to serve for the scope (in one district a max of six working months involvement is available to one EDF) of the need for the delivery of MED services under MEDPA and MEDEP. At present their time is under used, but additional numbers are required mainly because of the stringent provision in the procurement rules for MEDSPs to have explicitly available team of EDF in each of the proposal. This is something like asking for a fleet of 18 persons to be available for a 50% job for 6 persons. The emerging EDF training capacity and business interest in it from the private sector is a very positive sign, given the need for more number of EDFs in the market the private sector holds that motivation and capacity to meet the increased demand.

An important achievement in relation to the MEDSPs but also to institutionalisation of MEDPA generally is the development of a training function for Enterprise Development Facilitators, with three levels of qualification and official certification through collaboration with GoN agencies like CTEVT and NSTB. As these training is now being delivered independently from MEDEP. This is the kind of result that represents true systemic change and should be a model for future interventions.

The potential importance of DEMEGA (district level associations of the MEs) in giving voice to the poor and excluded, and empowering them to take a role in micro enterprise development, is beyond doubt. However, their advocacy role has not been well-developed and their sustainability is questionable. So far DEMEGAs were also being engaged as service delivery agencies in the project (may be partly due to the provision in the project document). They are heavily depended on MEDEP funds and technical backstopping, run by hired team of EDFs and support staff. This has resulted into; i) dependency over MEDEP support, ii) drifting away from their formation mandate of 'advocacy, promotion, and protection for the member MEs' due to doing things that they should have not been doing, and, iii) not having any viable plan, for their sustainable operation without MEDEP support, that would not be either contradictory to their legal form of an association of private sector operators- the MEs.

A nation-wide, effective system for service delivery by DMEGAs cannot be expected by the end of the project. This is not due to an external risk to the Theory of Change but due to the project document's aim of "commercial" sustainability (of the Associations; mainly of DMEGAs) of services being unrealistic. The MTE team expects that, depending on various factors, including good business plans, development of the advocacy function, (limited) funding from the MEDFs or DDCs and entrepreneurial leadership, some will fail, some will be reduced to a bare minimum of services paid for from membership fees, and some will flourish by raising funds from different sources.

At the national level the apex bodies of DMEGA and MEDSPs like NMEFEN and NEDC are seem to be organizations with potential to support their network members in professional capacity and contribute in the sustainable MED services. However, engagement plans and strategy also needs to be inbuilt within the MEDPA delivery process so that the project benefits from these apex organizations and they serve as a link between the district level MEDPA delivery agencies and advocacy organizations.

e. Achievements on Institutionalization and System Building

One important success is that the regulatory and policy basis for MEDPA system are sound, in the form of the MEDPA Strategic Plan (FY 2070/71 - FY 2074/75), including a GoN allocation of NRS 1 billion, and the MEDPA Operational Guidelines (2014, since revised). These represent significant steps towards institutionalization.

The project has been delivering its targets on the institutionalisation aspect and planned activities are being delivered, the available financial resources are being utilized and some major achievements are also visible in the form of: increased level of commitment and ownership of MoI resulting into continued and increased level of funding for MEDPA year by year, adoption of the MEDSP outsourcing provision and making it a general practice of the project, revision of the MEDPA operational guidelines with more clarity and categorical provision on GESI targeting, out sourcing for scale up support as well, allocating dedicated team of high level staff at MoI and at the departments level, taking initiatives to start a process of creating additional MED professional staffs position at departmental and district levels. However, MTE feels that more efforts are needed in; developing long term capacity building strategy for MEDPA, institutionalizing through making it part of the regular planning and budgeting process, revising and elaborating the MEDPA operational guidelines on several unclear or less covered issues such as, GESI approach, role clarity among different actors at different level, recognizing the 'Advocacy' role of DEMEGAs and making them part of the local process, developing enabling procurement guidelines based on the experiences so far. Support to MoI is also needed for several other activities that are very critical for successful institutionalization, such as new MED strategy, facilitating to create 'capacity building' capacity of MoI and its agencies for MEDPA at ministry and departments level, developing a functional monitoring system, and create a sustainable and manageable MIS system, establish a support system for DEDCs, clarify and strengthen the MEDF function and many more. These hosts of activities would require extra efforts of facilitation and technical support from MEDEP side to MEDPA.

Different national level committees foreseen under the MEDPA Operational Guidelines have been set up. However, there are significant weaknesses that threaten sustainability and scale. Limited funding through the MEDFs and lack of capable or otherwise GoN staff are the most critical. The latter was identified as an influencing factor in the Theory of Change.

Given the limited funds in MEDFs and that MEDEP funding will come to an end, there is a risk to the longer term sustainability of the MEDSPs as organisations, and therefore service provision. The Theory of Change in the project document insufficiently foresaw this likely contraction of the market and that NGOs are not actually for-profit businesses. For-profit providers would have stronger incentives to look beyond MEDPA for additional clients.

MEDEP has been engaging with academic institutions like Nepal Administrative Staff Collage, Local Development Training Academy, and Industrial Enterprise Development Institute develop collaboration with them for the capacity building of government officials. Progress on this would lead towards institutionalization of orientation and capacity building of GoN staff on MED services model and MEDPA at different levels through the training courses these institutions run regularly.

f. Achievements on GESI

The project has been successful in keeping its GESI target at the MED level. The ME creation and scale-up support data on GESI are in line with the expectations of the project, except the target of inclusion of 40% the Madhesi beneficiaries in the MED services is lagging behind. Empowerments effects at individual level and social economic impacts of increased level of income at household levels among the GESI group MEs interviewed by the MTE are clearly reflected. As a development sector agency having worked on MED in different remotest areas of the country, MEDEP holds a good understanding and commitment on 'GESI' not only as an cross cutting issue but also as priority agenda, this has been very clearly reflected by the MEDEP staffs interacted by MTE at different levels.

The MEDSPs and MEAs under the guidance of MEDEP also seem to have good understanding and commitment on GESI agenda. On the MEDPA side, theoretically GESI has been accepted, at the level of ME creation and scale up support level it is being practices as like in MEDEP and appears as commonly agreed priority agenda. The revised version of the operational guidelines includes the 'GESI' target norms, however incorporating the whole concept of 'GESI' at different critical aspects of MED service cycle and elaboration in the operational guidelines is needed to make sure that it does not gets fade away in the bureaucratic process of delivering government programs. At conceptual level most of the GoN staff is clear on GESI, the need is to provide them clear operational guidelines in the form of mandatory provisions, to be on safe side, this is how the system's work culture is-'go by book'.

The MEAs are sensitized on GESI, have inclusion provisions in their leadership roles and the minimum requirements are being fulfilled. Although some exceptional cases of MEs from underprivileged groups demonstrating 'exemplary leadership role' but the MTE felt that this is not a situation that can be generalized. In the MEAs MTE have noticed a 'higher level of institution lower the level of active and assertive participation of representatives of women and dalit groups', this may be because of the various 'social barriers' that these representatives are facing and breaking them may not be under the scope of projects like MEDEP or MEDPA, unless it is explicitly designed so.

At the 'resilience support' level because of the unavailability of GESI disaggregated data it was not possible for the MTE to assess how the 'GESI' targets were met by the project, however during the field observations and interactions with graduate MEs, indications of compliance of GESI considerations were noticed.

The CFC mechanism does contribute to 'GESI' aspect of the project in particular to women and dalits. Further elaboration of the purpose and intension of 'CFC' provision in general and more specifically from GESI point of view is needed in the operational guidelines. The design and physical facilities at majority of the CFCs visited by the MTE are not up to the set standards in terms of enough places for work and storage, good drinking water, hygiene and sanitation and child care facilities etc.

g. Achievements on MIS and Data Management

As the MIS of the project is in a process of transition from the existing system to a new improved system, this is an area where the project is in a hazy situation. The existing data base is almost dysfunctional and the data import to the new system is not complete, data reporting in MEDEP is not in order. There is very little evidence of the MIS data contributing in the planning and decision making process. The MEDPA database needs extra efforts to make it up to date and functional so that real time data can be reported. The data at district level are scattered in DMEGA, and MEDSP level to be reported to APSO MEDEP, and MoI district implementing offices to come to the two central departmental offices of MoI (CSIDB and DCSI) for MEDPA. Within MoI district and departmental level agencies responsible for the management of MIS and database there are 'IT and MIS' expertise and resources issues also. MTE felt that there is need for developing a simplified MIS data base system that is within the competence level of local stakeholders responsible for data collection and reporting, address the 'capacity issues' in a sustainable manner at MEDSPs level, district level agencies and central level agencies. MoI would need a consolidate real time data reporting for effective and regular monitoring, evaluation, and planning and budgeting purpose through a manageable functional MIS system.

h. Impacts and Sustainability

i) At ME level

Increased level of self-esteem and confidence, good exposure to various public institutions, feeling of empowered and respected at home and community are some of the common impacts that most of the MEs interviewed by the MTE would like to value as the contribution of the project. Increased level of cash income, although mostly at subsistence level, do show clear improvements in the life quality of the families of the MEs include improved nutrition, health and sanitation and education status. Over the period of time MEs among from poorest of poor and marginalized groups may not stick to the same type of enterprise that they have started through the support of MEDPA and MEDEP, however they seem to fully convinced that the impact on their awareness, confidence, and life quality are going to remain with them as a new lifestyle, which is a quite achievement for them.

A smaller percentage of the MEs have been also able to take the project benefit to the extent of functional ME activities with a higher level of transaction, more income, more investment, and creating jobs for few others as well. Such success cases are going to be sustainable in terms of their existence and potential as well.

Impact on jobs and incomes can be expected to be good, based on studies done before and during this phase. An average of a 56 percent increase in income can be attributed to MEDEP². Further impact on social and quality of life indicators has been demonstrated. ME survival rates are high, at around 50 percent after a period of 10 years. These are important achievements that validate the MED services model the project has developed.

²(No author), "Impact study on Empowerment of Women, Dalits, Indigenous Nationalities and other hardcore poor through MEDEP", December 2015; this study compared with a control group.

ii) At system level

The growing adoption of MEDPA by the MoI and its agencies can be expected gradually influencing the 'output' oriented short term skill training delivered through MoI's agencies by the concept of 'full spectrum result oriented MED approach', as such possibility has been indicated by the MoI officials during the interviews with MTE team. This is a very positive indication of emerging change in the mind sets of impact on jobs and incomes can be expected to be good, based on studies done before and during this phase. An average of a 56 percent increase in income can be attributed to MEDEP³. Further impact on social and quality of life indicators has been demonstrated. ME survival rates are high, at around 50 percent after a period of 10 years. These are important achievements that validate the MED services model the project has developed.

V. Project Management:

Overall the structure of the project management is appropriate and common management systems and practices are in place.

While the project document foresaw a transition from an implementation to a facilitation role this has not been adequately realised. In practice District level staff focuses on achieving the target for ME creation, and their institutionalisation function is not well fulfilled. This is in part due to the target being high, but also to ME creation being staff's "comfort zone", and the institutionalisation task being a complex and overwhelming one for which the project (also at national level) is not fully prepared.

The overall quality of projects progress reports and financial reports could be further improved for its comprehensiveness, synergy with the project document and annual work plans, presentation of achievement data in comparable and cumulative manner, and including self criticism of what it could not deliver and why. This will add further credibility to the project.

The project communication between UNDP, MoI and DFAT could be further improved as there seem to have some communication gaps and role un-clarity that has been creating ups and downs in the management of the project.

VI. Some other conclusions, Issue and Observations of MTE

- Implementation progress has been good overall, in spite of difficult circumstances, including insecurity and the 2015 earthquake. In addition staffing was completed 9 months after project start only and a Senior Institutionalisation Specialist was never assigned. The MTE did not find, however, that good implementation progress has resulted in a level of institutionalisation that could be expected mid-way the project, though there too some good achievements were realised.
- Evidence-based policy making is unlikely to be in place by the end of the project. It is doubtful that research for ME policy making and advocacy would survive beyond the project unless donor funds can be accessed for this purpose. The project document's Theory of Change assumed a market for research and evidence based policy making. Advocacy for MEs by NMEFEN, however, may continue if MEDEP takes a purely facilitative and capacity building role.
- Facilitation and implementation combined in one project is also generally unworkable. UNDP's and DFAT's "vision" for the project and its strategy for achieving do not appear to coincide, and

³(No author), "Impact study on Empowerment of Women, Dalits, Indigenous Nationalities and other hardcore poor through MEDEP", December 2015; this study compared with a control group.

competing demands have left the project with one safe haven, the project document and its targets for both ME creation and institutionalization, focusing on delivery rather than on consideration of whether activities are likely to result in a sustainable MED service delivery system. This is not to diminish MEDEP's important achievements in both areas, but to indicate the need for change to enhance the project's effectiveness especially in terms of facilitating the institutionalization of MEDPA.

- While, MEDEP achievements have been positive in many areas, there are major concerns with regard to the final result that can be expected. This is in part due to an over-ambitious project design, logical assumptions in the Theory of Change that did not hold true and high levels of risk that did not sufficiently inform design. In the MTE's view the inclusion of creation of a large number of MEs by MEDEP itself was a design error that has severely affected MEDEP's ability to facilitate the establishment of a sustainable MED system at scale.

VII. Main Recommendations of the MTE

The full report includes detailed recommendations in the hope these will contribute to greater progress on institutionalization of MEDPA. A summary of the key recommendations are presented in this summary.

The MTE felt that the progress on 'Institutionalization' still requires highly concentrated efforts. Therefore, MTE's recommendations on these aspects are as follows:

i) Add in Value Chain Development in the Model: Include value chain development concept in the MED model, with proper reflection in the capacity building plans that are targeted for different stakeholder involved in the delivery of the model.

ii) Shift focus from Delivery to Institutionalization: Stop direct ME creation by MEDEP from 2017 onward to give more focus on 'Institutionalization' output of the project. Transfer MEDEP to a complete facilitation role.

iii) Support MoI to Review MEDPA Operational Guidelines

Support MoI for a next round of revision of the Operational Guidelines through a consultative review process run by external consultants with relevant experiences.

iv) Develop Comprehensive CB plan: Provide TA to MoI to develop a comprehensive Capacity Building Strategy for MEDPA, and prepare a MEDEP plan to support MoI in the Institutionalization of the Capacity Development Plan and work through it.

v) Support MoI on formation of new MED strategy: Provide MOI with technical assistance for revision and updating of the MEDPA Strategy for the next five years, and preparing MED input for the Three Year Plan preparation process of NPC.

vi) Strengthening ME Associations at district level

Review the context of DMEGA, to reorient them on the 'Advocacy' track, prepare and support a plan to help them for their capacity building, and developing sustainability plans from a new perspective as suggested by MTE.

vii) Clarity and shared vision on MEDF

Create clarity on MEDF issues by undertaking joint reviews, so that all three key partners will have a shared vision and common position on it. Revisit the district graduation process to have a clear purpose of the graduation and consider using a more simplified assessment process.

viii) Review and Revise the Project Document

The MTE recommendations lead towards several structural changes in the project document on top of the provisions those already needed to be revised. Undertake a joint process (of UNDP, DFAT and MoI) to revise the project document to make changes that have been already realised needed, and those emerged from the recommendations (when accepted) of the MTE.

ix) Advocacy and dialogue as a separate component: Integrate work on MOI policy making and leadership in initiating dialogue into Component 1, and work on advocacy with NMEFEN and DMEGAs into Component 3.

x) Improve MIS and finalize the Database

A MEDPA based MIS and database needs to be made sustainably functional with required capacity within the MOI system. Simplify data collection and verification procedures, and reduce the frequency of data collection (e.g. on a six-monthly basis), but introduce spot checks to check quality.

xi) Review MEDSP Procurement process

Find solution for MEDPA tendering and contract management issues such as multiyear contracting, non exclusivity of the EDFs in one contract, and third party monitoring of MEDSPs task for milestone payment.

xii) Prepare and follow Institutionalization Support Monitoring Plan

Going through a tripartite effort develop a 'institutionalization support monitoring plan' with key milestones and activities intended for supporting institutionalize and use it as an achievement monitoring and staff performance tool for the remaining period of the project, this should be complimentary to the AWP that the project would have.

xiii) Improve UNDP and DFAT Coordination and Communications

Create common vision and understanding on the different issues between the both parties, specially a role clarity in the day to day management of the project, and putting planned demands and expectations from each other over the table through a transparent process may help resolve any communication gaps (if any) between the both partners.

xiv) One Year Extension for MEDEP

MTE recommends for an extension of one year for MEDEP continuing under the UNDP management to allow focused and intensive technical support and facilitation to make institutionalization process more effective and sustainable within MoI system.

VIII. Implementability assessment of the major recommendations

Implementability Assessment of Recommendations of MTE

SN	Key Recommendations	Urgency	by when	Implementability	Relevance
1	MED Service Model Improvement	Immediate	before the next years ME creation cycle begins	Commissioning (ideally by MoI, through MEDEP support) a consultancy support through a well designed ToR is needed, which is quite manageable by MEDEP; however the TOR should be developed engaging all national level partners.	Very high as the model needs to be improved to link the MEs with value chain system through the model for better economic benefits.
2	Shift focus from Delivery to Institutionalization	short term	by 2016	Needs a management decision and common agreement between DFAT-UNDP, and DFAT-UNDP-MoI. Alternative measures need to take for intensive work on 'Institutionalization' with improve quality of support, if this decision is not taken up. May need some structural changes within the project management; a detail assessment of such will be required as soon as possible.	Very high as MEDEP needs to focus on 'Institutionalization' to create significant impact within MEDPA implementation process and the MEDEP management is more comfortable in direct service delivery, and lack appropriate skill mix required for a higher level input on 'Institutionalization' facilitation role. Implementation and facilitation roles cannot go together effectively.
3	Work on Institutionalization of Capacity Development Plan	short term	by 2016	Manageable with external consultancy and facilitation support. Design the TOR and hire a consultancy firm with high level of expertise.	Very high as the 'institutionalization' of Capacity Development approach within MEDPA is one area that needs significant improvement in culture where MEDPA custodians feel that Capacity Building is 'MEDEPs' role.
4	Support MOI on new MED strategy and 14 th Periodic Plan of GoN	Urgent	ASAP	It is manageable through the CTA team which is now already at MoI.	Very high for the sustainability and renewed GoN commitment of MEDPA at policy and planning level. This will allow MoI in a more systematic and comfortable position in taking MEDEP in an up-scaled manner from next FY onward.

SN	Key Recommendations	Urgency	by when	Implementability	Relevance
5	Strengthening Associations and MEDSPs for Sustainability	Medium	by early 2017	<p>A key to this is to create a common vision of the need and agree on reform activities by MEDEP and MoI.</p> <p>The most critical is reviewing DEMEGAs position and reorienting them on the 'Advocacy Line'. Need external consultants with proven expertise on association and network strengthening to build upon the existing quality studies. MoI needs to be taken onboard into this process.</p>	<p>This is highly relevant for making DMEGAs effective, relevant and sustainable.</p> <p>Positing and strengthening the apex bodies of MEDSPs and MEAs at national level within MEDPA will assure the effective delivery of the project in sustainable manner by creating complementarity.</p>
6	Clarity on MEDF issues	Medium	By mid 2017	<p>A review and operational design needs to be undertaken including the graduation assessment process.</p> <p>This</p>	Moderate to high, in the long run MEDPA need to make it functional for allowing DEDC to be active and sustainable.
7	Improve MIS	Medium to long	by 2017	<p>Close and high level of professional support is needed for this to do a status and issue assessment of MIS and its future institutionalization within MEDPA domain. This is doable with a clear TOR and support from high quality consultant.</p>	Highly relevant as the consolidated, simple and manageable MIS system needs to be developed and institutionalized within MoI.
8	Find solution for MEDPA tendering and contract management issues:	Medium	Before next procurement cycle	<p>A quick review is needed to establish the extent of the issues and need; MoI needs to be onboard as it may require interventions at the level of Public Procurement Act and Regulations as well. If suggested and agreed for a third party monitoring system, this may also need to be owned by MoI and included in the Operational Guidelines.</p>	Highly relevant to assure a quality service and commitment from the MED SPs.

SN	Recommendations	Urgency	by when	Implementability	Relevance
9	Institutionalization Support Monitoring Plan for MEDEP	short term to Medium	by 2016	This is manageable after the finalization of the refocused work plan (of MoI) on 'Institutionalization', MEDEP needs to set its own approach and milestones for measuring its achievements as a facilitator and TA to this institutionalization plan of MoI.	Very relevant as it will serve as a mile stone checker for MEDEP.
10	UNDP and DFAT Coordination and Communications	short term	ASAP	Depends upon the interest of both parties, but not a complex process to take-up, it is just opening up more with issues and expectations for both side.	Highly relevant as this affects the project implementation at large.
11	One Year Extension for MEDEP	short term	by 2016	Depends on the negotiations between DFAT and UNDP.	
12	Review and Revise the Project Document	short term	by the end of 2016	This is manageable through a facilitation and input of a consultant working closely with MEDEP, UNDP, MoI and DFAT for next two to three months.	Very relevant, as various revisions in the project document is needed to clarify the focus, understanding and also adjust project interventions to the new line of 'explicit facilitation role' for MEDEP.

IX. Key Lessons from MEDEP

In the MTE's view the main lesson learned from the experience of MEDEP IV is:

- That combining facilitation and direct implementation roles in a project is not workable. The two roles are contradictory and should not be combined. This is more pertinent in the case of the later have become a regular phenomenon.
- That certain minimal conditions need to be in place for successful institutionalisation, most importantly, people to institutionalise *with* or *in*. Without such conditions being in place, sustainable results will not be achieved.
- That a focused and clear targeting guidelines at all input levels of a project can be useful approach for mainstreaming GESI target. GoN agencies do take care of GESI targeting through such clear provisions in project implementation guidelines and policies.
- That clear opportunities with proper guidance can bring remarkable good practice in bringing about systemic change by institutionalising the training of Enterprise Development Facilitators, largely through private training providers. This is a good example of a project function being taken up by independent market players, which demonstrates the kind of thinking that the remainder of the project should be based on.

X. Thinking Beyond MEDEP

The MTE team has noted many different suggestions for a follow-on project to MEDEP. It has no definite views on these or alternative development options in the sector beyond MEDEP IV. These should be assessed by a separate identification mission once GoN's 14th Plan is available. In the interest of scale of impact and sustainability, this mission should consider approaches to poverty reduction through private sector development that are not based on direct support to enterprises, and not limited to MEDEP or MEDPA created enterprises. This should include consideration of approaches to market systems and value chain development. Another emerging opportunity is working for the development of a national system of 'Small and Medium Enterprise Development' type of interventions that would require to work at higher levels including banking and private sector of the country but at the same time keeping link with what MEDEP has achieved at large. This would be also in line with the context of 'SDG' and Nepal's vision to graduate the country to a level of 'developing country' from its current level of 'least developed country', it also to be noted that the next UNDAF for the country is expected to support GoN in achieving this goal.

Mid Term Evaluation Report of

Micro-Enterprise Development Programme (MEDEP)–PHASE IV/UNDP

1. Introduction

1.1 Background and Context

The Micro Enterprise Development Programme (MEDEP) Phase IV (Aug 2013-Jul 2018) is funded by Department of Foreign Affairs and Trade (DFAT) and implemented by the Ministry of Industry (MoI) under the UNDP National Execution modality. UNDP Nepal provides technical assistance (assurance) as well as additional funding. The project is run by a MEDEP team based at a National Programme Support Office (NPSO) in Kathmandu, Area Programme Support Offices in 8 regional locations, and District Focal Points in the districts.

MEDEP IV was preceded by Phase I (1998-2003), Phase II (2003-2008) and Phase III (2008-2013) in which the project delivered its own Micro Enterprise Development (MED) approach to support women, *Dalits*, Indigenous Nationalities, *Madheshis*, Muslims and Youth to come out of poverty. The project also started building capacities to deliver its approach among GoN and other organisations involved. The main focus of MEDEP IV is on institutionalisation of the Micro Enterprise Development for Poverty Alleviation (MEDPA) programme, which is designed along the MEDEP model. It is being implemented by the GoN (Ministry of Industry and its Department of Cottage and Small Industries and Cottage and Small Industries Development Board and their district offices) in 64 districts in 2015 with a plan to cover all 75 districts by 2018. MEDEP is strengthening the capacity of GoN actors, largely NGO MED Service Providers, and ME Associations as advocates for the rights of MEs, ME-friendly policies and service provision. At the same time MEDEP is expected to create 30,000 MEs.

As per the project document, UNDP required to conduct a midterm evaluation of the project. UNDP have selected Development Consultancy Centre (DECC); a Nepali consulting firm that provides consultancy services and process facilitation in the development sector; to undertake this MTE through a competitive international bidding process.

1.2 Operating Environment of MEDEP-IV

The journey towards institutionalization of democracy in Nepal for last 20 years has not been very smooth. It has experienced several political stumbling blocks and the devastating 'conflict' that took the life of about 18000 people and development of the country has been severely pushed back. After the signing of Comprehensive Peace Accord in Nov 2006, the country took a long way to make progress on the peace process. The failure of the first Constitutional Assembly (CA) in drafting a new constitution for the country led to severe political instability, armed and peaceful agitations in Madhesh and other parts of the country in relation to the 'federal structure' and other major provisions related to governance modality of the country.

At the time of MEDEP phase IV being negotiated the country had an interim ministry to undertake a general election for the 2nd CA, was held during Nov 2013. This has provided some hope to bring political stability and give a new drive to the development efforts in the country, however the political instability

continued because of dispute among the political parties on various issues in the draft of the constitution, and also because of the struggle in forming the government as no political party received majority to form the government. MTE team have noted that the start-up phase of MEDEP IV did not enjoy a very enabling political environment. The political predictions and assumptions were not coming in a very positive manner which obviously had influenced the working efficiency of GoN ministries in many ways.

In April 2015, Nepal experienced a devastating earthquake causing death of almost 9,000 people and massive loss of private and public houses affecting the basic service deliveries like education, water, health, transportation etc. For almost next four months the total GoN machinery, UN agencies, NGO/INGOs, Donor agencies, Private Sectors, and International Communities were fully involved in the rescue, relief and recovery activities.

Immediately after the earthquake Nepal was able to finalize the draft of the constitution, which was passed by the CA and proclaimed on Sept 22, 2015. Immediately a new hope for political stability and development was raised among the people, however it did not last for 24 hrs, as from Sept 23rd Madhesi parties started agitation against the constitution and blocked the boarder between India and Nepal restricting the flow of goods including medicines and petroleum products. This continued for more than four months. The fuel crisis and blockade of roads created severe constraints in the movement of people and goods in the country. The development interventions from the government, NGOs, INGOs and also from development partners and international agencies experienced a standstill situation during this period.

By the time MEDEP-IV reached to its midterm, it has come through all of the above explained political and natural disturbances. It is difficult to assess the nature and degree of impact of these events on MEDEP's pace and process of implementation, however this time period cannot be imagined as a period of 'normal business period' for the project.

After the earthquake, DFAT gave UNDP the responsibility of delivering a Rapid Enterprise and Livelihoods Recovery Project (RELRP) in the earthquake affected areas for the revival of 12,059 affected MEDEP/ MEDPA Micro Entrepreneurs, at least 1,500 new micro entrepreneurs created, 71 Community Facility Centres repaired, 52 rebuilt and 22 new built, at least 16,000 new jobs created/ recovered, which will benefit 80,000 family members. MEDEP management mechanism was also used to deliver this project which has a funding of US \$ 6.1 Million. This was an additional responsibility for MEDEP but at the same time it was a good opportunity to support the affected MEs for their recovery. A separate staffing and delivery mode was used by UNDP through MEDEP for the implementation of this project; therefore adverse workload situation within MEDEP due to this project has not been the case.

1.3 Objective of the MTE

A Mid-Term Evaluation (MTE) was conducted between 12 January and 25 April 2016. It provides an assessment of progress at the mid-point of the MEDEP Phase IV, from August 2013 to December 2015. It covers all components and the indicators included in the logical framework (or Result Framework) of MEDEP Phase IV. Progress so far is assessed by component and with regard to the outcomes and impact, at the national and the District level. Its objective was to assess progress at the mid-point of project implementation and pave the way for improved project delivery for the remaining project duration. More specifically the MTE has aimed to:

- Assess progress of MEDEP Phase IV compared to the project document and MEDEP's strategies and plans, identify and assess the results and impacts as to their sustainability.

- Identify causes of possible (over/under)performance or lack of sustainability, including in the context the project is operating in (such as the political economy), lessons learned and experiences gained. .

In accordance with the TOR, the overall purpose of MTE is to:

- Assess progress at the mid-point of project implementation and pave the way for improved project delivery for the remaining project duration.

The primary objectives are:

- Project progress: To assess progress of MEDEP Phase IV compared to the project document, identify and assess the results and impacts as to their sustainability and on that basis to recommend whether the project is ready to hand over MEDEP to the Government to streamline with MEDPA.
- Future directions: To identify causes of possible underperformance or lack of sustainability, including in the context the project is operating in (such as the political economy), lessons learned and experiences gained, and on that basis make suggest changes (if any) in design, implementation arrangements, and/or institutional linkages in order to effectively and sustainably contribute to livelihood improvement in the target areas.

The MTE has considered the project's entire geographical coverage (38 Districts) and all target groups. The detail TOR of the MTE is provided in Annex-1 of this report.

1.4 Organization of this Report

In writing the report the MTE has attempted to follow the UNDP Outcome Evaluation guidelines. At the same time, the DECC's proposal specified that the MTE would follow the structure MEDEP's Theory of Change (TOC), which was clarified with the MEDEP team. Chapter 1 presents the Introductory part of the report and elaborates the process and methodology used by the MTE, Chapter 2 therefore covers a description of MEDEP's design based on its TOC, Chapter 3 is the main body of the report, deals with the findings and analysis of component wise achievements of the project, Chapter 4 presents overall conclusion drawn by the MTE on the major success, strengths, areas for improvement and other issues. Chapter 5 discusses the future directions and recommendations of MTE, in chapter six MTE presents emerging niche area for UNDP to take the achievements and learning's of MEDEP to a next level of economic intervention, and finally chapter 7 presents some lessons that the MTE has drawn.

1.5 Methodology and Process

The MTE took place from 12 Jan 2016 to 25 April 2016, including consultative meetings and fieldwork in Kathmandu and 5 districts conducted between 02 Feb 2016 and 07 Feb 2016 (Kalikot, Myagdi and Jhapa), 10 Feb 2016 to 13 Feb 2016 (Kailali) and 19 Feb 2016 to 21 Feb 2016 (Sindhuli). It was conducted by a team of international and national consultants, fielded by the Development Consultancy Centre (DECC). A detail evaluation matrix developed and followed by the MTE is provided in Annex 2 of this report.

The key methodologies used by the MTE Team were:

- Desk Review of relevant documents of the project: Comprehensive range of project related documents (project documents, progress reports, studies and research papers, manuals, policy documents, and guidelines etc..) were reviewed by the MTE Team. A list of documents reviewed and consulted by the team is provided in Annex 3 of this report.
- Consultation Meetings: Consultation meeting were held with different stakeholder of the project at central as well as district level. This included the GoN stakeholders, donors, DFAT, UNDP, MEDEP, Service Providers Associations, and ME Associations.
- Unstructured/Semi Structured Key Informants Interviews: Unstructured and semi structured interviews with different key stakeholders at central and district level were conducted. Predesigned checklists of guide questions were mainly used.
- Workshops: Discussion workshops were held; i) with MEDEP staff to discuss and review the TOC of the project, ii) with MoI, DCSI, CSIDB, UNDP, MEDEP staff to discuss on the institutionalization issues of the project.
- FGDs: Focus group discussions were also conducted at CFC level with the project beneficiaries and graduated MEs.

DECC fielded a team of four consultants. The team comprised of an international expert as a team leader and three national experts.

Team Leader	Roel Hakemulder	Consultant in inclusive private sector development, market systems development
Deputy Team Leader	Tej Raj Dahal	Institutional development specialist
Social Development Expert	Sumedha Gautam Mainali	GESI and poverty alleviation
Data Analyst	Harihar Nath Regmi	MIS
Peer Reviewer/Project Director	Raghav Raj Regmi	DECC Executive Director, Project Evaluation , and social and economic development specialist

During part of the assignment the team worked with Dr Linda Kelly, an international development specialist assigned by DFAT, who has also assisted by reviewing a draft of this report.

1.5.1 Approach to Data Analysis

The MTE has used the method of comparative analysis (especially target versus achievements) where quantitative data/information was available. References to the project document and official documents (including assessment and study reports) were made to substantiate such comparisons and drawing inferences from analysis. Considering the complexity of the programme in terms of variation of the interventions within the MEDEP/MEDPA project framework, the MTE deliberately did not opt for using any scale or rating to evaluate the performance against each and every indicators; however the official outputs and indicators from the log frame are assessed using the data from annual progress reports of MEDEP as well as additional detailed data MEDEP had already prepared and also provided on request.

The MTE followed an evidence based approach where observations and conclusions are substantiated with verifiable information, data and facts/figures collected and documented from primary and secondary

sources as appropriate. MEDEP MIS data and a wide range of documents were considered while validating observations and assessments in order to come to conclusions.

Data and information generated from literature reviews are used with appropriate referencing and citation for ensuring authenticity and relevance of the findings. Data/information from MEDEP/MEDPA and MIS are used as basis for analysing achievements versus targets under various programme components. Observations and qualitative information was validated by triangulation, including with MEDEP component managers. Institutional and other key issues that emerged from the consultations at national as well as local level were shared, discussed and validated with project stakeholders (officials of GoN, UNDP and MEDEP) in two separate workshops in Kathmandu.

The MTE made use of pre-developed checklists and guide questions for semi-structured interviews and Focus Group Discussions. These checklists and guide questions were discussed and agreed with UNDP before the field visits and interviews. Relevant MEDEP and other stakeholder documents have been reviewed, and analysed against the MTE's evaluation matrix.

1.5.2 Process Followed by the MTE team

i) Preparatory Activities

At this stage the MTE team have undertaken the following activities:

- Initial briefing and consultation with MEDEP, DFAT and UNDP
- Review of documents, and data sources
- Collection of quantitative data from MEDEP
- Development of guide question check lists
- Preparation of inception report and finalization of methodology and work plan.

ii) District Visits

Five Districts (One mountain, 2 hills and 2 Tarai districts) were visited, as indicated by the TOR. These were: Jhapa, a Tarai district located in the Eastern Development Region; Sindhuli, a Hill district, in the Central Development Region; Myagdi also a Hill district but located in the Mid-west Development Region; Kalikot, a Mountain district, in the Mid-west development region and Kailali also a Tarai district, in the far west development region.

These districts were selected to:

- Include diverse segments of the population targeted by MEDEP: Indigenous and ethnic populations, mixed community, Dalit, hill community, Tharu majority.
- Include both graduated and non-graduated Districts (in the former MEDEP is meant to gradually phase out its implementation role in ME creation).

iii) Stakeholders Consultations

Consultative meetings with MEDEP stakeholders and fieldwork were carried out in Kathmandu, Kalikot, Myagdi, Kailali, Jhapa and Sindhuli, which comprised. These consultations were among the main sources of information on MEDEP's role, the institutionalization process, financing mechanism and other implementation arrangements, including challenges, through consultative meetings and semi structured

interviews. Preparatory work devising strategies and strategic frameworks/documents for taking over MEDEP by MEDPA in future was also discussed.

Building further on the suggestions by the ToR for inclusion of representative groups of project stakeholders, MTE consciously made efforts to engage stakeholders from national to local level. With support of MEDEP prior appointments were made with key informants to ensure usefulness of bilateral and group meetings with people who could provide relevant inputs to the MTE. At all levels, the stakeholder engagement was commendable and consultative meetings were conducted mostly at respective stakeholder's office or place. The MTE team explained on all occasions the objectives of MTE to the respondent/s to set the context right for focused discussions and deliberations, and assured confidentiality. In compliance with the ethical considerations for protecting the rights and confidentiality of the informants, the MTE consciously has not used direct quoting and/or reference to bilateral consultations and particular inputs from the organisations and individuals consulted as part of the MTE.

- **Consultation with target beneficiaries:** Micro Entrepreneurs considering women, youths, dalit, janajatis, madhesi as defined in the Project Document were consulted through Focus Group Discussion (FGD) in Common Facility Centre (CFC) built with the support of MEDEP or MEDPA with an objective to assess effectiveness and efficiency of MEDEP, MEDPA support to Micro Entrepreneurs, capacity development activities, programme achievements, lessons learnt and feedback. Altogether 10 FGD discussions were conducted with MEs at CFC level; however some graduated MEs were also included in the participants of the FGDs. Almost 100 MEs have taken part in the FGDs out of which about 80% were from women, dalit and Janajatis groups.
- **Consultation with District level partners:** Local Government Agencies VDCs, DDC, Municipality, Cottage and Small Scale Industries Office (CSIO), Cottage and Small Scale Development Board District offices (CSIDB), District Chamber of Commerce and Industry, District Enterprise Development Committees were visited for the consultation to assess support provided by MEDEP and the relevance, effectiveness, and efficiency of the MEDEP/ MEDPA implementation modalities and the roles of the stakeholders. At the same time, institutional sustainability of the MEDEP/MEDPA delivery system, process and results at district level were considered by investigating capacities and institutional arrangements for continuation of the programme in the remaining programme period and beyond.
- **Consultation with MEDEP Area Programme Support Offices:** MEDEP staffs were interviewed to assess their role, progress, challenges, and obtain views on likely sustainability. The MTE visited four APSOs (Dhangadhi, Surkhet, Pokhara, Biratnagar, and Kathmandu) and held discussion meetings with the APSO staffs. A preliminary meeting with all professional staff of MEDEP was also held during the inception period of the MTE at Kathmandu during Annual Planning Meeting of MEDEP. The staffs from APSO Hetaunda were consulted at Sindhuli during the field visit of the district.
- **Consultation with Associations** (NMEFEN, NEDC, DMEGAs): Discussion meetings with office bearers and staff of DMEGA in all five districts and with NMEFEN office bearers and staff at Kathmandu were also held. Meetings with apex body of the MED-Service Providers (National Entrepreneurship Development Centre). Interviews and discussions with Boards, executives and staff captured the capacity strengthening support provided by MEDEP, the roles of the associations, plans and their sustainability.

- **Consultation with Training Institutes and Academic Institutions:** Consultative meetings with academic and training institutes (Industrial Enterprise Development Institute and Council for Technical Education and Vocational Training) were also conducted by the MTE Team to discuss the issue of sustainable EDF training and other capacity building issues.
- **Consultation with Service Providers** (MEDSPs, Financial Service Providers and cooperatives providing savings and credit): Individual meetings were held with MEDSPs, FSPs and cooperatives in the visited districts. MEDEP support, current status and capacities to handle effective implementation of the programme activities, sustainability and future plans have been assessed through semi structured interviews and consultative meetings, as well as a Focus Group Discussion with FSPs.
- **Consultation with National level GoN stakeholders:** Several consultations with National Level Government officials were held in groups as well as individual meetings, these included; i) the MEDEP, and MEDPA team including the NPD at MoI, ii) Project Steering Committee members from MoFALD, MoE, MoAD, MoF, iii) DG and related senior staff from DCSI and CSIDB, iv) Member and senior officials responsible for MEDPA and MEDEP at NPC, v) MoF officers from Foreign Aid Coordination division.
- **Consultation with Other donor projects and development agencies:** DFID (Samarth programme), GIZ (Include), ILO and World Bank (EVENT) were also consulted to seek their views on MEDEP and MEDPA and its institutionalization process, solicit opinions and possible interest in for future support to MEDPA and gain an understanding of the approaches they apply and for what reasons.

A list of main contacts is attached in Annex 4.

1.6 Scope and Limitations of the MTE

1.6.1 Scope of the MTE

The MTE provides:

- An assessment of the scope, quality, significance and relevance of the outputs, outcomes and impact of MEDEP Phase IV produced to date in relation to expected results.
- An assessment of the functionality and sustainability of the institutional structure that is being established, including the Management Information System, and the extent to which it has reached scale. Achievements that are sustainable and have reached scale constitute systemic change.
- An assessment of the likelihood that the overall objectives and expected outcomes will be realised (including sustainability and scale) by the end of the project.
- Analysis of the causes of underperformance, to the extent this is the case.
- An assessment of the effectiveness and efficiency of the project set-up and monitoring mechanisms currently employed by the MEDEP in monitoring on a day to day basis.
- An assessment of the extent to which MEDEP has been successful at shifting from a direct implementation to a facilitation role, while handing over implementation to MEDPA.
- Recommendations relevant to the above.
- Lessons learned.

These consider cross-cutting themes (gender equality and social inclusion, human rights based, good governance, environmental safeguards, conflict sensitivity) where relevant and possible. The focus is on gender equality and social inclusivity, as this is central to MEDEP's intended outcome.

While the MTE has considered all levels in the project's Theory of Change, the main focus has been, as stated in the Inception Report, the extent to which the institutionalisation of the MEDEP approach has progressed, and is likely to be successful, as a result of the MEDEP's interventions. This is in agreement with the project design. The original evaluation questions in TOR and the full set of questions developed by the MTE (the evaluation matrix included in the Inception report) are provided in Annex 1 and 2 respectively.

The MTE applied the usual DAC evaluation criteria, also used in the TOR: relevance, efficiency, effectiveness, sustainability, and impact. These are all pertinent to the MTE's purpose and objectives. In agreement with the emphasis on institutionalisation, sustainability, and scale of impact, has been the main focus.

1.6.2 Limitations of the MTE

As determined by its scope, the MTE does not cover everything the project has done or achieved in detail. These are well reflected in the MEDEP's progress reports and Annual Work Plans. Additionally, MTE chose to present the indicators from the overall project log-frame or results measurement framework as reference for analyzing achievements rather than presenting all the indicators used for the components. These have, however, been used for assessing progress at all levels.

The MTE has made its best efforts to interpret and refer to the available data/information from MEDEP, MEDPA sources and relevant assessments and studies undertaken by the project and/or by independent third parties (consultants, missions, etc.). The MTE team accepts responsibility for interpretation and presentation of particular references and data/information from those sources in this report as ours.

Limited functionality of the existing MIS has had considerable influence on data compilation. The MTE had to dig into annual reports and other documents to compile and verify accuracy of data, which has been a time consuming back and forth process. MEDEP staff cooperated fully but were also clearly handicapped by the difficulties in retrieving data from the MIS.

The field visits were limited to five districts only as per the requirement of the TOR and due to limited time frame of the assessment. Considering the wide spread of the MEDEP interventions in 38 MEDEP districts and also in other MEDPA districts (all together 64 districts) the number of district visited were not enough, DECC has indicated this in the proposal and suggested to increase the number of district to seven, which has not been possible on various grounds. MTE would have benefited more in understanding the status of the project in different socio-economic and physical conditions of the project area through additional district visits.

The MTE was not designed to have any kind of hh survey for quantitative or qualitative information at household level; rather it was designed as a qualitative assessment of the beneficiaries' perceptions and impressions of the project, which has been done through FGDs.

2. Description and relevance of the intervention, MEDEP

2.1 The problem MEDEP addresses

GoN reports that absolute poverty in Nepal has been reduced substantially over the past 20 years, from 42 percent in 1995 to 23.8 percent in 2015⁴. The World Bank, using the \$1.25 a day poverty line, reports that the percentage of people living on less than this has been halved in seven years, from 53 percent in 2003-04 to 25 percent in 2010-11⁵. The country has also progressed steadily on the Human Development Index value, though its ranking is still in the lower category, at 145 out of 188⁶. Progress towards the Millennium Development Goals has been good, with some goals having been reached (e.g. halving absolute poverty, reducing infant mortality, and increased access to safe water) and progress on others reported to be “on track”.

These achievements have been realised in spite of the armed conflict between 1996 and 2006 and a fragile political, economic and social post-conflict situation. A new constitution was promulgated in 2015, establishing Nepal as a secular, federal republic. The transition period is likely to lead to further insecurity as indicated by unrest and border closures the end of last and the beginning of this year. Other constraints include “...deeply entrenched forms of social exclusion, and weak governance structures in all spheres of the state” (page 1), poor infrastructure and an inhibiting regulatory environment for private sector development⁷. Economic growth has continued to be slow, at an average 4 percent since 2005. The 2015 earthquake has been a significant setback, with an estimated 700,000 people having been pushed below the poverty line⁸. The blockade of the border with India is said to cause more economic damage than the earthquake, with the Government reducing its growth forecast for 2016 from 6 to 2 percent.

The overall gains in poverty reduction mask significant inequalities. Poverty incidence is 27% in rural Nepal, home to some 80% of the population, compared with 15% in urban areas. In the far and mid-western regions and mountain districts poverty rates are above 40%. They are higher for socially disadvantaged groups with e.g. in 2014 some 10 percent of Hill Brahmins (the upper caste) living below the poverty line, compared with 44 percent of Hill Dalits (lower caste) ⁹(page 60). Gender equality in general is still low, with Nepal ranking 108 on the gender inequality index¹⁰.

The income earning opportunities for the poor and socially excluded are limited in an economy where most are engaged in subsistence agriculture and some 1.3 million households are landless or land-poor.¹¹ Migration is therefore the preferred option for many, with the “absent population” increasing from 3.2 percent in 2001 to 7.3 percent in 2011¹². Remittances contribute to GDP (nearly 30 percent) and to development of the families and communities left behind. The GoN estimates that poverty rates would be

⁴ Government of Nepal National Planning Commission, “Sustainable Development Goals; 2016-2030 National (Preliminary) Report”, 2015. This uses the national poverty definition.

⁵<http://www.worldbank.org/en/country/nepal/overview>

⁶<http://www.adb.org/countries/nepal/poverty>

⁷<http://www.worldbank.org/en/country/nepal/overview>

⁸ Government of Nepal National Planning Commission, “Post Disaster Needs Assessment Report”, 2015

⁹ Human Development Report, page 60

¹⁰ Human Development Report, page 226

¹¹<http://www.worldbank.org/en/country/nepal/overview>, <http://un.org.np/oneun/undaf/landless>

¹²Government of Nepal, Ministry of Labour and **Employment** "Labour Migration for Employment, A Status Report for Nepal: 2013/2014", 2014, page 7

back to around 35 percent without them. However, the social costs of migration, in terms of family breakdown and lack of parenting for children are said to be serious¹³.

The GoN therefore considers creating more income earning opportunities for the poor and vulnerable through, amongst others, micro enterprise development a priority. This is for instance, indicated by the Micro-enterprise Development Policy 2008; the Industrial Policy 2010, implementation of MEDEP for the past 17 years, and the decision to institutionalise this programme.

2.2 MEDEP

MEDEP is a donor funded poverty reduction programme implemented by Ministry of Industry, Commerce and Supplies (now Ministry of Industry) with support from UNDP since 1998. Its first three phases, which ran up to 2013, developed and delivered an integrated micro enterprise development programme including entrepreneurship development and technical skills training, access to finance (including grants), technology transfer, business counselling and market linkages. The programme gradually expanded coverage to 38 Districts by the end of Phase III, creating a reported 75,000 micro enterprises and 79,000 jobs¹⁴. It targeted the poor, women and socially excluded, whose per capita income increased significantly more than non-participants (by 512 compared to 192 percent)¹⁵. MEDEP also contributed to the Micro-enterprise Development 2006 and Microfinance Policies 2008 and the Industrial Policy 2010 and so contributed to an enabling environment for MED. Since 2006 is became engaged in developing the MED capacity of GoN and other partners, though not in any systematic manner.

In part as a result of MEDEP advocacy, GoN incorporated micro-enterprise development for poverty reduction into its *Three Year Plan Approach Paper* (2013/2014 – 2015/16) targeting people leaving below the poverty line. Establishment of the Micro Enterprise Development for Poverty Alleviation (MEDPA) programme under the Ministry of Industry was included in this strategy. The project supported development of the MEDPA programme document and operational guidelines. MEDPA is to take over MED from MEDEP, institutionalising MEDEP's approach, and expand it to all 75 Districts of the country. The key aim of MEDEP's Phase IV, which runs from August 2013 to July 2018, is to support this process. This includes the strengthening of the three key institutional components of the service delivery model (more detail on the roles of the partners and the MEDEP service model is provided in Annex 5):

- Relevant GoN bodies under the MOI (Department of Cottage and Small Industries, DCSI, and Cottage and Small Scale Industries Development Board, CSIDB) that manage and monitor MED, and in local Government (Village Development Committees (VDCs), municipalities and District Development Committees (DDCs), which include MED in their development plans;
- The largely NGO Micro-Enterprise Development Service Providers (MEDSPs) who are contracted by the DCSI and CSIDB to provide MED services; and
- The groups and association made up of micro enterprises established under the programme, which provide support services and advocacy to their members: Micro-entrepreneurs Groups (MEGs) at the community level, Micro-entrepreneurs Groups Association (MEGAs) at rural Market Centres (RMCs), District Micro-entrepreneurs Groups Associations (DMEGAs), and the National Micro-entrepreneurs Federation of Nepal¹⁶ (NMEFEN).

¹³ Ibid, page 9, 36, 42

¹⁴ MEDEP MIS

¹⁵ NARMA Consultancy, "Impact Assessment of Micro-Enterprise Development Programme, November 2010

¹⁶ A federated body of District Micro-entrepreneur Group Associations (DMEGAs)

The three **objectives** the project document includes refer to this:

1. To support Government of Nepal to take over the delivery of Micro Enterprise Development activities through MEDPA programme.
2. To build the capacity of GoN and the private sector MED service providers to sustainably deliver MED.
3. To strengthen the capacity of micro entrepreneurs associations to sustainably provide members with a number of business development services such as access to markets, access to finance, improved technologies and advocacy¹⁷

The expected outputs are:

Output 1: A sustainable delivery system for Micro-Entrepreneurship Development in Nepal.

Output 2: Micro Entrepreneurs have sustainable access to a number of business development services such as social mobilization for enterprise development, access to technical skills, access to markets, access to finance, improved technologies and advocacy mobilizing micro entrepreneurs associations and MED service providers on a cost recovery basis.

This should contribute to the following outcome:

Outcome: At least 73,000 new micro entrepreneurs will be created during 2013-2018, of which 60,000 will be resilient within a given timeframe¹⁸. Out of the 60,000 total, 70 percent will be women, 30 percent men. Considering the 60,000 as a total, 30 percent will be Dalits, 40 percent Indigenous Nationalities categorized within group 1-4 by NEFDIN (National Foundation for the Development of Indigenous Nationalities – Government of Nepal); other caste – 30 percent, unemployed youths as per government policy of age group between 16-40 years 60 percent, unemployed youths in this age group migrate for job abroad age group 40 percent; Madheshi 40 percent includes Madheshi origin Dalits, INs, women, men, youths, and other castes.

The focus is to be on the “hard-core poor”, with an income of less than 60% of the national poverty line. Of the 73,000 new MEs, 30,000 are expected to be created by MEDEP through direct implementation, the remainder by MEDPA.

The project document and logical framework also states that the project contributes to the following outcome in the UN Development Assistance Framework (UNDAF), i.e.:

Outcome: Vulnerable groups have improved access to economic opportunities and adequate social protection.

The following goal is included in the text but not in the logical framework:

The primary goal will be to contribute to poverty reduction and employment generation in Nepal.

¹⁷ MEDPA Phase IV project document pg. 19

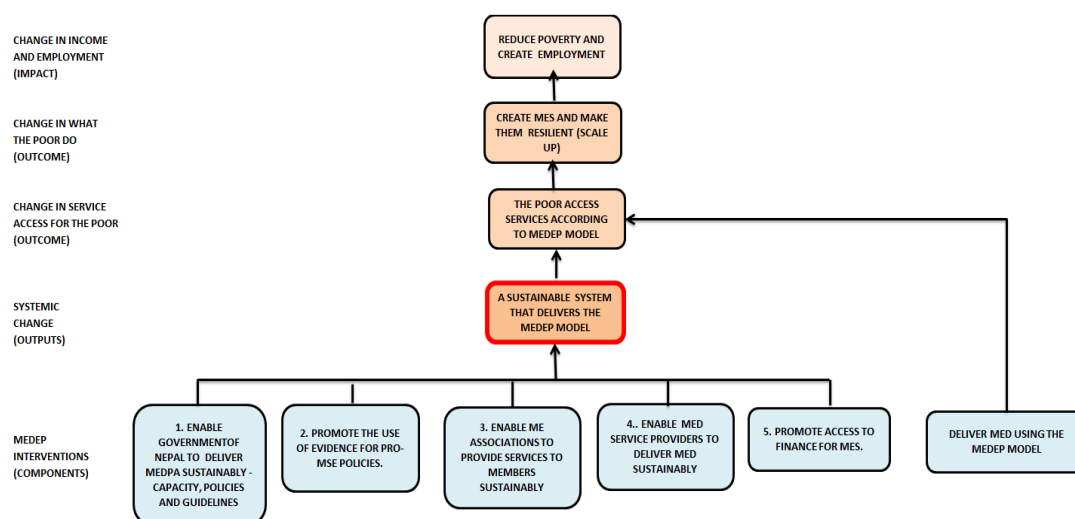
¹⁸ The MTE assumes this must be a mistake in the project document as, given the time required to make MEs resilient, this is not possible. The project is expected to propose that the target be reduced to 20,000.

2.3 'Theory of Change' for MEDEP-IV

The logical connections between the different elements are laid down in the project document through a Theory of Change (ToC) described by an impact logic for the project and detailed impact chains for its five components with accompanying narratives¹⁹. This does not include the creation of MEs and the project impact logic does not clearly reflect the project's 5-component structure. The MTE team has, for the purpose of the evaluation, simplified the ToC, including through a workshop with the MEDEP team. This makes use of the usual impact logic for market systems development programmes, an approach the project document subscribes to. It uses the distinctions between “interventions” (what the project does, the activities under its five components), the systemic change this should result in (which in the project document are called outputs), the change in access expected from this (outcome), the change in behaviour this contributes to (ME creation; outcome) and finally the change in income and employment (impact). This is reflected in the diagram below, with the box outlined in red being the key systemic change MEDEP aims at: a sustainable system that delivers the MEDEP model. This has two elements:

- Sustainable delivery of MED services for start-ups, basically through the MOI, DCSI/CSIDB, other Government institutions, and private sector MEDSPs (covered by Output 1).
- Sustainable delivery of services for MEs that have graduated (usually two years from start-up), through the associations of MEs that were started as a result of the MED services, including access to finance (covered by Output 2).

Diagram 1: MEDEP's simplified Theory of Change



¹⁹The component logics have since been revised and expanded with the assistance of the Methods Lab project. Methods Lab is an action-learning collaboration between the Overseas Development Institute (ODI), Australian Government Department of Foreign Affairs and Trade (DFAT) and Better Evaluation. Ref Microenterprise Development Programme in Nepal: Designing an impact-oriented monitoring and evaluation system, including impact evaluation options July 2014 Finalised September 2014

This theory of change can be described as follows:

Poverty can be reduced and employment created by women and men starting and developing micro enterprises.

This can be contributed to by:

Women and men accessing financial and non-financial micro enterprise development (MED) services, including for market access, and MED advocacy for a better business environment for MEs.

This can be contributed to by:

A system for delivery of MED services that is led, managed and partly funded by the public sector, comprising public sector players at the national and district level, drawing on a variety of service providers, including NGOs, the public sector, micro enterprise associations, microfinance institutions, cooperatives, and ME associations, who provide (or provide access to) services and contribute to public-private dialogue with a focus on women, marginalized groups, dalits, and poorest of the poor. This is what the project document and stakeholders refer to as the institutionalisation of the MEDEP approach in MEDPA, the GoN's Micro Enterprise Development for Poverty Alleviation programme which will take over MEDEP's functions over the project period.

This can be contributed to by:

MEDEP developing and implementing interventions and activities that facilitate the development of this system, in partnership with the market players concerned. Intervention areas fall under five main headings or components²⁰, which together make up the project's **strategy**:

1. Aims to enable GoN at central and local level to plan, coordinate, procure and monitor the sustainable delivery of MED services through MEDPA. This requires putting systems and policies in place, including for the pooling of financial resources, as well as developing capacity.
2. Aims to increase evidence-based, pro-micro-entrepreneurship policy making by GoN. This requires capacity building in GoN, supporting research institutions to profitably undertake relevant research and fostering active mechanisms for dialogue. On dialogue this component is closely related to the next.
3. Aims to enable microenterprise group associations (MEGAs) to deliver (access to) microenterprise services to MEs started under MEDEP and MEDPA, monitor implementation of the programme (including for improving it) and participate in advocacy for a better business environment, in a sustainable way. This requires capacity building and planning for sustainability.
4. Aims to develop private sector (including NGO) microenterprise development service providers so that MED services can be delivered effectively and sustainably in response to GoN tenders and using funds from other sources. This requires capacity building including institutionalisation of training of Enterprise development Facilitators (EDFs).

²⁰ The MTE has considered a 6th component, on the Management Information System and M&E under component 1 and project management respectively, the MIS serving all players in the system but being in the first place a GoN responsibility and supporting its planning and coordination function; and M&E being a project function.

5. Aims to improve access of microenterprises to financial services from formal financial services providers (FSPs) and cooperatives. This requires partnerships with FSPs to develop appropriate products and expand their coverage and development or strengthening of cooperatives.

While engaging in this institutionalisation process MEDEP is also expected to provide MED services directly and so contribute to the development of 30,000 MEs for the project period.

As also stated in the project document, the institutionalisation of the MEDEP approach in MEDPA entails MEDEP changing from the role of manager of MED service delivery to one of facilitator of development of a sustainable system that provides MED services at scale. MEDEP is expected to have an advisory and technical backstopping function. In line with this shift, MEDEP is expected to gradually “hand over” operations in the 38 Districts of its operations to MEDPA, while MEDPA in addition expands gradually across the country. MEDPA is expected to create 32,000 MEs over the project period.

The basic **logical assumptions** underlying the logic from outcomes to impact are plausible. That the poor accessing services according to the MEDEP model contribute to their starting MEs and that this contributes to poverty reduction and employment has been established through impact studies²¹. That the delivery system MEDEP uses provides greater access to these services has also been established. That MED services more generally contribute to poverty reduction has also been demonstrated globally²².

That the delivery system can be sustainable, i.e. function with the current partners but without MEDEP, is untested. That this can be achieved through the six components (including the MIS and M&E to be institutionalized), which basically rely on building capacity, and putting systems and a regulatory/policy framework in place, seems plausible but is also untested. Moreover, this does not depend on MEDEP alone, as factors such as availability of human and financial resources are beyond its direct control. It is these two logical assumptions which are the main focus of this evaluation.

Factors that can influence this impact logic are specified in the project document as “risks”:

- Absence of elected local bodies – currently local bodies are not elected which can affect oversight and accountability
- Prolonged Transition and political instability – political issues could take precedence over regular functions
- District Development Committee offices exposed to volatile security situation, frequent protests, individual threats and political pressure, and office shut down – this could affect the programme’s operations.
- Frequent transfer of the Government officials – this could affect the results of capacity building and awareness creation
- Human Resources for MEDPA as provisioned by the MEDPA Five Years Strategic Plan not appointed – this could affect the effectiveness of MEDEP’s capacity building, effectiveness of MEDPA, the likelihood of establishing a sustainable MED delivery system.

The workshop with MEDEP staff confirmed these, and added that:

- Introduction of the federal system will mean adaptation in the delivery system.

²¹ UNDP, “Human Development Report 2015 Work for Human Development”, 2015

²² See for instance Yoonyoung Cho and Maddalena Honorati, “Entrepreneurship Programs in Developing Countries: A Meta Regression Analysis”, World Bank, April 2013

- Future changes in Government – these may affect priorities.
- Low level of motivation among Government staff – the project document had foreseen in the introduction of an incentive system, which has not happened.
- The need for meeting allowances – committees will not meet without them and funds were reported to be insufficient. There has been practice of providing meeting allowances until recent past, which has been stopped since starting of 2016, however MoI is making some budgetary provision for this under MEDPA allocations.

Taken together these are significant threats. They include seemingly intractable issues related to Government HR capacity, lack of motivation and transfers, which are a direct threat to effective institutionalisation. The MTR team would like to add to these the weak governance structures at all levels in the Government's own judgement) and high levels of corruption²³ as additional risks to institutionalisation. Supporting the expansion of MEDPA, including a District-based financing mechanism, and ensuring its sustainability across 75 Districts in 5 years' time was a highly ambitious objective. Add to this the creation of 30,000 MEs (40 percent of the number that took three phases to achieve) and the undertaking appears even more formidable. Moreover, the project is expected to achieve this while moving from an implementing to a facilitating role, which is very difficult under the best of circumstances. In the MTE team's experience these roles are seldom combined successfully and a transition entails a fresh project team or a heavy investment in staff capacity building.

There have been no significant changes in either the design or the strategy of the project over this phase.

In conclusion, given the high (though decreasing) levels of poverty and social exclusion in Nepal, MEDEP's goal and outcomes are highly relevant. Institutionalisation of its approach, leading to sustainable delivery of MED services, would bring benefits to poor and excluded groups over an extended period of time. Whether the project as designed and implemented could deliver this was an untested assumption, though it seems plausible. This will be considered in Chapter 5. Combining the ME creation role and facilitation of institutionalisation was a high-risk strategy, to which were added a number of significant external threats.

3. Major Findings and Analysis: Progress, effectiveness, and sustainability

This chapter considers, in section 3.1, progress that has been made on implementation of the project's main interventions, by component. This includes improvements in access to services, identification of issues that need to be addressed and whether MEDEP has successfully taken up a facilitation rather than direct implementation role, as foreseen in the project design. This is the first level in the Theory of Change, "interventions". If interventions have progressed and are appropriate, they can be expected to have contributed to establishment of a sustainable system for delivery of services for new ME creation and growth resilience. The extent to which this has happened or is likely to happen before project completion, including scale of outreach, is considered in section 3.2. This deals with the next level in the Theory of Change and is the key issue the MTE has considered. Section 3.3 addresses the final level of the Theory of Change: the effect on ME creation and impact on poverty reduction. Social impact will be considered as well. Section 3.4 presents an overview of the status of GESI in deferent dimensions of the project, explains how the project has been achieving its GESI targets and how much of its GESI approach in being institutionalized in the MEDPA program by MoI. Section 3.5 looks into the management aspect of the project against its efficiency and effectiveness in delivering the outcomes of the project as a whole.

²³Nepal ranks 130 out of 168 on the Transparency International Ranking, <https://www.transparency.org/country/#NPL>

3.1 Progress on implementing the components/interventions

Component wise progress made by the project by the end of 2015 is being assessed in this section of the report.

3.1.1 Progress Analysis of Component 1

Component 1: Government of Nepal delivers MEDPA sustainability and MIS

i) The Component Aims For:

Component 1 aims at developing the capacity of GoN to deliver MED by outsourcing service delivery to local MED service providers, as well as ensuring that legislation and guidelines for the implementation of MED are in place and updated based on experience. With these capacities, the Ministry of Industry (MoI) and its agencies – Department of Cottage and Small Industries (DCSI) and Cottage and Small Industry Development Board (CSIDB) at the central level and Cottage and Small Industry Offices (CSIO), Cottage and Small Industry Development Board Offices (CSIDBO) and District Enterprise Development Committee/District Development Committees (DEDC/DDCs) at the district level would effectively deliver MED programs within the framework of the MoI implemented MEDPA programme.

The project document's main strategies to achieve this include development of systems/institutional structures and staff capacity. Systems: MEDPA Operational Guidelines detailing the functions of all institutions in the MED delivery system, an appropriate procurement system, an incentive system to increase staff motivation and a mechanisms for the pooling of financial resources in Micro Enterprise Development Funds (MEDF) at the District level. The MEDEP service model was to be simplified to reduce cost. In capacity building: a wide range of efforts targeting Government staff and DDC/DEDC members, including coaching, and establishment of MED courses at Government training institutions.

The MIS was to be upgraded and MEDPA staff trained on its use²⁴. MEDEP was to “move from being an implementer of MED, to becoming a facilitator of the government's effort”²⁵. GoN was to allocate funds to MEDPA, appoint staff where vacancies existed or create new posts where necessary, and create ME units at DCSI and CSIDB, and a Section at MOI, at the national level. This would enable the expansion of MEDPA to all 75 Districts.

The strategy developed by the project follows this closely but did not include simplification of the MEDEP service model.

ii) Major Achievements:

a. Systems and institutions

• The MEDPA Strategic Plan

The MEDPA Strategic Plan (FY 2070/71 - FY 2074/75) with a budget of NRs 4.1 billion (approx. US\$ 42.54 mln) prepared in 2013, in principle formally institutionalized the MEDEP model. GoN has allocated NRs 1 billion in total by the FY 2015/2016. It has increasingly made available a budget for

²⁴ The Project document includes a separate component on this, but the MTE has considered it as part of Component 1.

²⁵ Project document page 30.

MEDPA implementation and its contribution is as planned (table 3.1)²⁶. During the interactions with MoI MoF, MoFALD and NPC high-level officials responsible for MEDPA, it was made clear to the MTE team about GoN's commitment to provide required financial resources for the operationalization of its MEDPA operational plan. These GoN institutions, at the highest levels, seem to be keen on giving continuity to the MEDPA program, upscale it both by resources and target numbers, review relevant policies and strategic plans in due time, and increase the capacity of its implementation management mechanisms at MoI and MoFALD and their respective agencies up to the district level.

- **MEDPA Operational Guidelines at the highest levels only**

The MEDPA Operational Guidelines (2014), developed by MOI with MEDEP's technical inputs was a further step towards institutionalisation. This is the key official document (approved by Ministerial decision) for replicating the MEDEP model across the county. It stipulates the functions of all involved institutions.

Based on experience from implementation, and to better reflect Local Government legislation, the guidelines were revised in 2015 to include, amongst others: GESI responsiveness in planning and implementation; compulsory channelling of GoN funds through District Micro Enterprise Development Funds (MEDF) and institutionalisation of monitoring and evaluation in MEDPA with additional human resources at national and district level.

The revised Guidelines explicitly make provision for ME creation and scale up activities to be implemented by sub-contracting to MEDSPs, and the role of ME associations including District Micro Entrepreneurs Groups Association (DMEGA) and the need to strengthen them are recognized.²⁷ The revised Guidelines include provisions for aligning MED planning at local level with the 14-step bottom-up planning process followed by the local bodies (DDCs, Municipalities and VDCs), provisions of Enterprise Development Units (EDU) at DDCs and involvement of DDC Programme Officers in MED planning and M&E.

The Strategy and Guidelines have provisions for aligning MED planning, execution and monitoring and evaluation with structures and processes of local government bodies (DDC, Municipalities and VDCs). This is a positive situation which assures the involvement of local bodies in supporting MED in the area.

The MEDPA operational guideline does not capture the MED model (which has been claimed to be developed and tested by MEDEP and internalized by MEDPA) to its fullest spirits. The capacity building of GoN and Local Bodies staffs, Outsourcing the services of MEDSPs for up scaling support services, Monitoring etc. are not fully reflected in the guidelines and also in the budget lines of DCSIOs and CSIDB district offices. The guideline is also not very explicit in recognizing and elaborating the advocacy role of MEAs like DEMEGA other than assuring its representation in the DEDCs and other institutional mechanisms. It does not take any responsibility in supporting DEMEGA for their effective contribution in the programme.

The Guidelines continue to include many references to a direct role of MEDEP. The MTE's interviews in the districts indicate that especially at district level, this has created a dependency on MEDEP staff as

²⁶ NRs 102 mln (approx. US\$ 1.2 mln) in 2012/13, NRs 204 mln (approx. US\$ 2.3 mln) in 2013/14, NRs 192 mln (approx. US\$ 2.4 mln) in 2014/15 and 231 mln (approx. 2.3 mln) in 2015/16 (Source: FCGO Reports).

²⁷ Such provisions, among others, include: NMEFEN – Member of MEDPA Steering Committee (MEDPA Operational Guidelines, Section 7 (25.1)), D-MEGA – Member of DEDC (ibid, Section 7 (29.1)), ME Associations – Capacity development provisions (ibid, Section 7 (28.Dha); Capacity strengthening of D-MEGA and NMEFEN and strengthening of ME Networks (ibid, Section 8(Tha))

‘puller of the cart’ (e.g. for hands on support for preparation of meeting minutes, calling meetings, leading MED-SP selection process, etc.).

The guideline does not include instructions for planning and budgeting for MEDPA at district level. There are inconsistencies in allocation of budget for different activities from one district to another. For example some districts have separate budget line for 'scale up support' and some does not.

The guidelines have also made it essential for the MEDSPs to deliver a set target of 'access to finance' by the MEs as a milestone for final payment. This can be expected that the MEDSPs will become more responsible on the aspect of 'Access to Finance'.

- **Local Mechanisms for Planning and Management of MED interventions at DDC, Municipality, and VDCs**

Under MEDPA it has been essential to have local planning and management mechanisms for MED at DDC, Municipality and VDCs in form of Enterprise Development Committees, and Enterprise Development Plans. A practice of developing multiyear MED Strategic Plans at the level of local bodies has been practiced by MEDEP and MEDPA. These institutions and planning tools (DEDC/DEDP, MEDC/MEDP, and VEDC/VEDP) have started showing their potential in mobilizing local interests and resources across the stakeholder at the local level.

MEDEP has supported establishment and operation of District Enterprise Development Committees (DEDC) and Municipality/Village Enterprise Development Committees (M/VEDC). By end of 2015, a total of 63 DEDCs were reported to be functional.

MEDEP has invested NRs 2.09 mln in 2013, NRs 7.30 mln in 2014 and NRs 8.85 mln in 2015 to cover costs related to their meeting expenses, monitoring of MEs, development of District Enterprise Development Strategic Plans (DEDSP) and Municipal/Village Enterprise Development Plans (M/VEDP), MEDPA orientation, exposure visits, orientation on 14 step planning, and joint planning and review.

A total of 40 DEDSP and 112 VEDP were developed in MEDEP districts by the end of 2015, with MEDEP support. This is on track. The Guidelines for formulation of these plans are in place and implemented by the MEDSPs which are contracted to support this. An overview of the achievements of the component 1 against its key outputs indicators are presented in table 1 provided in appendix of this report.

While DEDCs and VEDCs are formally in place, the MTE found that there is great diversity in their effectiveness, as could be expected. Some are committed and well-run, others less so. The low level of finance involved, compared to for instance infrastructure, and reduces interest. Meeting allowances are an important incentive, and without those some committees find it hard to meet. While MEDPA now foresees in these allowances, as well as increased fund allocation for functions such as monitoring and evaluation visits, the MTE heard different views on whether this will be sufficient. There has been a lack of implementation of the Enterprise Development Plans because DDCs and VDCs, and the politicians who influence them, generally do not consider this a priority. MoI is looking for increased budget and clear allocations of resources for DEDC/VEDC/MEDC orientations, preparations of MED Plans at the level of these local bodies and also for exposure visits to facilitate peer learning.

During the interactions with DEDCs, VEDCs and Municipality officials the MTE found that the members of such mechanisms; i) appreciate the potential of such mechanism in MED, ii) appreciate the MEDSP selection process, iii) expect donors and GoN to put more funds for the MED Plans of the area, iv) expect meeting allowances and other incentives (such as observation visits nationally and internationally).

- **MEDF**

Another key element in MEDPA is the Micro Enterprise Development Fund (MEDF), institutionalised through the Operational Guidelines. Its effective and accountable operation is one of the key criteria by which Districts “graduate” from direct MEDEP support to MEDPA and could expect to receive donor funds from the MEDEP budget. It is the single financing mechanism to implement the DEDSP. The effective functioning of the DEDC and its M&E Sub-Committee are also associated with successful operation of the MEDF. By the time of the MTE, Micro Enterprise Development Funds had been established in 53 of 64 MEDEP/MEDPA districts. This is on target. However, there were mixed observations and findings on functionality of the MEDFs mostly related to operational responsibilities and issues related to signatory of the MEDF account (the latter have now been resolved). GoN is nearly the only source of funding for MEDPA through MEDFs. Though the figures included in table 1 seem to show otherwise, they include all funds allocated to MED, not just MEDPA. The MTE’s own findings in the districts indicate that few resources were contributed by other institutions, e.g. DDCs in some cases, and UNDP. The figures may reflect promised allocations rather than actual disbursements, and DDCs and VDCs prefer to keep control over their limited budgets rather than pooling them. The expected DFAT funds have not been forthcoming due to concerns over fiduciary risks.

There are several expected sources of income at MEDF and each of them has different dynamics. The main source is MEDPA allocation from MOI which takes MEDF as a virtual channel to reach to the CSIO or CSIDB district office. These offices also receive larger or similar level of direct budget from MoI for the regular 'skill trainings' that they are delivering classically. In such conditions, MTE feels that the long struggle that MoI and MoFALD went through to agree upon the 'virtual channelling of MEDPA budget' through MEDF, portrayed as a big success does not add any significant value for MEDF. The dispute was on who holds the money, and who signs the check, therefore the theory of 'this virtual transfer' acting as an incentive to local bodies and other to contribute funds in the MEDF does not seem to be valid. During the interviews with the staff of DDC, CSIDBO/DCSIO, and DTCO, MTE gathered that they are not happy with this 'virtual channelling' as the interest was on 'who controls the money', however they have accepted it as the GoN's decision.

Increased level of ownership of DDC, VDC, and Municipalities over the D/M/VEDCs and their respective MED plans certainly is going to be a key factor for funding contribution by these institutions in such mechanisms and tools.

- **Incentive System for GoN staff**

An incentive system for MEDPA implementation by CSIDB and DCSI has not been practiced, as this was not accepted by GoN. It can be argued that this may affect effective implementation as officials at district level see MEDPA as an add-on to their regular duties, however over the period of time the respective GoN offices will gradually accept MEDPA as their regular program given the existence of the MEDPA Strategy and budget allocations, and the incentive issue may not prevail. At present this can be seen as 'raised expectations due to the presence of MEDEP', and existing practices of 'incentives' in few other government agencies and programs. It is interesting for the MTE to notice that the demand for incentive is for MEDPA implementation, but not for the regular training programs of these offices which are financed through DTCO's TSA channel although both programs run through GoN funding only.

- **MEDSP Outsourcing**

The concept and process of outsourcing the services of MEDSPs for ME creation has been properly adopted within MEDPA, the operational guideline also captures this very well. The procurement is done in two levels; i) A pre-selection process for short listing is done at central level for all districts, and ii) RFP call and evaluation of bid documents are done at district level by DEDC.

MEDEP has developed a ToR and system for the pre-selection of MEDSPs (before they can bid) and a selection committee is functioning at the national level. This does not in effect change the procurement of services from MEDSPs, which is regulated by the Public Procurement Act of the GoN. The Act has to be followed. It does not foresee in contracts longer than one year, and given other provisions and delays due to poor planning this means that under MEDPA MED Service Providers (MEDSPs) have been able to implement just for 3 to 5 months a year. This is reported to have resulted in loss of quality.

MTE got mixed opinion about this procurement system among the local and national stakeholders. MEDSPs seem to prefer a local process through single step; the selecting authorities' opinions are divided on this as some favour a fully local controlled system but others are in favour of the current two stage system, and some also argued that the MEDSP selection should be fully done at central level. The logic and counter logics given are; i) the current process takes long time to complete resulting into late contracting of the MEDSPs, ii) the more local process the more political pressure on the tender evaluation process, etc.

The technical documents, procurement process, evaluation criteria and marking systems and formats that has been developed through the support from MEDEP and being used for the MEDSP procurement following the PPA, holds a higher level of satisfaction among the officials taking part in the procurement process. The local vigilance authorities met by the MTE during the field visits also expressed their satisfaction on the MEDSP procurement process and tools. There were some examples of 'returned complaints' by District Administration Offices made by non winning MEDSPs about the selection process. Such rejections were on the ground of the satisfactory reporting of the representative of DAO in the MEDSP selection committees, off course DAO have advised them to go for court case if they are not satisfied.

Orientation and training of MoI staff at central and district level, and DEDC members on the procurement process and tools needs to be a regular activity in MEDPA. This therefore requires 'a regular budget line' under MEDPA, allocation of staff time and commitment from the leadership of the institutions concerned. Training also needs to be institutionalised at NASC and the Local Development Training Academy.

- **MED Units**

Micro Enterprise Development Units (M/EDUs) have been established at the Department of Cottage and Small Industry and the Cottage and Small Industry Development Board as provisioned by the MEDPA Strategy, for central level steering, coordination and for ensuring effective implementation support to the district CSIOffices and CSIDB Offices. The target of formalizing a MED Section within the MOI has not yet been achieved. An Organization and Management (O&M) survey had to be finalized first, by end of 2015, but is not yet completed. Having this section is important to ensure continuity and to influence allocation of funds. MOI did assign dedicated senior officials in the (M) EDU as focal points for MEDEP/MEDPA, so for immediate needs the required human resources are in place although it is a kind of temporary arrangement within the ministry. The fact that an O&M survey has been requested does indicate commitment of the MOI to establishing the Unit, which was confirmed by interviews held.

- **MIS and Data Management**

MEDEP's MIS had grown organically over the years. Its initial focus was on ME creation but it needed to cover a wider range of data related to MEDEP's results measurement framework. It became overly complex, covering 99 indicators, a number of severe technical problems developed, and it did not meet the needs of users in MEDEP and MEDPA. A new Gender and Social Inclusion MIS was designed on the

basis of an evaluability assessment²⁸ reducing the number of indicators to 27. This is a web-based real time information system that aims to support MEDEP and MEDPA management in timely decision making. The new software was expected to be completed in the second quarter of 2015, but this was delayed due to the MIS specialist leaving MEDEP.

The software is still in the testing phase and data migration from the old to the new system is ongoing. The first seven district pilots are expected in the first half of 2016. The software should be installed in 50 MEDPA districts (including 38 MEDEP) by the end of 2016, but this may be over ambitious given the lack of computer operators in the CSIO/CSIDBO offices. The old system remains in use but is largely dysfunctional.

The evaluability assessment found the quality of data was doubtful, and this was confirmed by the MTE team's interviews with staff involved. DMEGAs have been charged with data collection from the MEs and entry into the system, but they have limited capacity to do so. Under the amended Guidelines MEDEP supports to institutionalize MIS software for reporting and information collection through local bodies i.e. VEDC which reports to DEDC and CSIO/CSIDBO. With the starting of FY 2072/73, the MEG, MEGA will start to report the ME related information to VEDC with the support of Enterprise Development Facilitator (EDF) of MED SPs as per VDC's authority at VDC level. Then, MEDSPs with consent of VEDC will report to DEDC and DEDC/Monitoring subcommittee will verify and validate, and forward to CSIO/CSIDBO for data verification.

According to the MEDPA Operational Guideline, MEDSPs will enter the data into the MIS and will submit to the CSIO/CSIDBO office where MIS software is operated. The MIS will be operated by computer operator of CSIO/CSIDBO. MEDPA districts will be technically assisted by the MISA of MEDEP and IT volunteers of DDC for operating MIS software if required²⁹. This includes a number of quality checks which make for a complex procedure. The lack of DMEGA capacity is addressed by allocating the data collection function to MEDSPs, who will have to be contracted to do so. This system is not yet in place and is therefore untested.

b. Capacity strengthening

MEDEP supported an institutional assessment of key stakeholders of MEDPA in 2014³⁰ and a capacity strengthening strategy³¹ was finalized by the beginning of 2015. These documents provide a sound framework for capacity strengthening of MEDPA actors³². This includes capacity strengthening of MoI, CSIOs and CSIDBOs, and the DEDC/DDCs. The Strategy was initially, not translated into a plan with annual targets (and progress reporting against them) as the project received it after approval of its 2015 work plan, which was then not revised. It is therefore difficult to draw conclusions on the progress of capacity strengthening support, though progress reports provide an overview. The 2016 work plan shows

²⁸"Evaluability Assessment, Prepared for MEDEP, Nepal as part of the Methods Lab project, Dr Maren Duvendack*, Dr Hari Pradhan**, January 2014

²⁹"Programme impact assessment, monitoring and evaluation Strategies", 2016

³⁰"Assessment of Institutional Capacity of Government Institutions for implementation of MEDPA", Dec 2014. One of the key recommendations of this assessment include: embedding of the entrepreneurship development training to GoN staff through regular GoN training institutions like Nepal Administrative Staff College, Agriculture and Forestry Training Centres.

³¹Stephan Schmitt-Degenhardt, "Transition to Sustainability: Capacity Development Strategy for MEDEP IV", Feb 2015

³²Such framework include: i) strengthening capacities of individual, organizational and institutional enabling environment; ii) strengthening capacities on core issues – such as accountability, targeting, inclusiveness, etc.; and iii) capacity strengthening on functional and technical capacities

more clearly how the Strategy informed the project's activities. However, in the MTE's view an undertaking such as this requires multi-year rather than annual planning.

Support has been in the form of orientation, training, joint planning exercises, exposure visits. In 2013, MEDEP provided training to officials of DCSI and CSIDB (11 men 30 women) on SIYB (Start and Improve Your Business) and MEDEP Model orientation. Further to these, MEDEP provided support to strengthen the MEUs (Micro-Enterprise Units) of DCSI and CSIDB through joint planning, joint monitoring, and inter-districts exposure visit for learning. Similarly, in 2014 MEDEP provided technical support to MoI to conduct orientations on MEDPA Operational Guidelines and Fiduciary Risk Management to Local Development Officers (LDOs) and planning officers from DDC, Cottage and Small Industry Officers and Accountants from CSIO and CSIDB in five regions involving 437 participants (Women – 44, Men – 393). Joint planning workshops were held for MEDEP and MEDPA and two review workshops were held by DCSI and CSIDB at the central level. Joint planning and review workshops for MEDEP and MEDPA activities were held in 48 districts with participation of DEDC members, MEDEP and MEDPA stakeholders. Training on the existing MIS has also been provided.

This is as planned and appears useful in principle. However, staff at DCSI, CSIDB and their District Offices (e.g. EDFs, Computer Operators) was not allocated as committed to by GoN in the MEDPA Strategy, which severely limited the scope and effectiveness of training. It has resulted in staff having been trained on tasks that were not theirs. Offices have resorted to recruitment of short-term consultants (e.g. EDFs) to fill the gaps, or allocated new tasks to existing staff with heavy existing workloads. MEDEP staff had to take on implementation roles to ensure progress. Recruitment at CSIDB offices is less problematic than at DCSI, as the former has greater freedom in creating new posts as well as 100 existing vacancies. Recruitment was said to be underway at the time of the MTE. At DCSI an O&M survey would be required. Recruitment of staff to operate the MIS will remain a problem due to the lack of candidates with basic qualifications in the districts.

In spite of the investment in capacity building significant differences in commitment to MEDPA can be noted in CSIDB and DCSI and their offices. The organisations had and still have their own ME development programmes, largely consisting of skills training. Many see MEDPA as an additional burden, and as a “project” rather than an institutionalised programme. Good progress has been made in this regard, but could be reversed if additional staffs are not allocated or the level of funding through the MEDFs remains low. “We will just go back to our own programme” one official stated, and others (though not all) echoed this sentiment. At the highest level in MoI, commitment is strong, though, and the opposite intention was expressed, i.e. staff would be recruited eventually and until that time implementation of MEDPA could still go forward.

An opportunity to address staff shortages is the coinciding of formulation of the new MEDPA Strategy by MOI and the National Development Plan (14th Three Year Plan) by the National Planning Commission (NPC). The required policy/legal framework and budgetary resources for establishment of the MED Section and provision of required human resources could be provided for by the Plan. NPC acknowledges contributions of MEDEP/MEDPA towards local economic development and poverty reduction in rural, poor and remote communities with a focus on inclusiveness. Making use of this opportunity will require MEDEP's support to the MOI for preparation and submission of an MED position paper to the Three Year Plan preparation team at NPC.

Transfers of staff are a further constraint. District staff is expected to be transferred every two years, but in fact this often happens much more frequently. The results of capacity strengthening are then lost, and MEDEP has to be engaged in an seemingly unending cycle of training and awareness raising. However, as MEDPA expands to all 75 district, it can be expected that by that time both MoI agencies CSIDB and DCSI will have enough pool of trained/knowledgeable staff to run MEDPA with additionally recruited

MED professionals, so this issue of frequent staff transfer can be considered as a temporary phenomenon. The critical issue here is the continuity of staff training and orientation in the post MEDEP period after 2018 through clear budgetary provisions within MEDPA allocations for staff capacity building., including through NASC and the Local Development Training Academy.

c. Expansion and handing over

One way in which MEDEP and MEDPA prepare for the transition from the former to the latter is by alignment of planning, budgeting, and implementation and review/reporting cycles. Since the start of MEDPA in 2012/13, joint planning and review sessions have been organised for preparation of annual work plans to ensure coherence and consistency throughout the programme districts. As a result, joint Annual Work Plans were prepared in 2013 and 2014. In 2015, as a part of MEDEP's continuous support, two joint planning workshops were held for MEDEP and MEDPA with participation of MEDEP, MoI, DCSI and CSIDB, and two review workshops were held by DCSI and CSIDB at the central level. Joint planning and review workshops for MEDEP and MEDPA activities were held in 48 districts where District Enterprise Development Committee members, MEDEP and MEDPA stakeholders participated. These are positive achievements. The usefulness of this process is affected, though, by the lack of alignment between the GoN planning, budget allocation and review/reporting cycle (which the MEDPA follows), and MEDEP's annual cycle.

Expansion of MEDPA is well on target. Preceded by a MEDEP-like GoN programme in 12 districts from 2009, and named MEDPA in 2013/14, the programme had been expanded to 64 districts by the end of 2015. An additional 5 districts will be included in 2016, leaving 6 districts to be covered as of 2017. MEDEP has supported this expansion by training and coaching, but also by providing hands-on support. The expansion has gone together with MEDPA supporting the creation of 14,851 MEs (partly with MEDEP funds), which is an indication of a good level of effectiveness, were it not for MEDEP's direct involvement. High level officials at MoI expressed the intention to continue the expansion with or without MEDEP support, indicating strong commitment to the programme, though at present staff allocations are insufficient to effectively carry through the expansion.

d. Graduation of Districts

The graduation of districts, meant to result in the withdrawal of MEDEP direct inputs, aligning all essential MED services into the MEDPA framework, and MEDEP contributing ME creation funds to the MEDFs, however, is behind schedule. By end of 2015, a total of 15 MEDEP districts were targeted to have graduated status, but only 8 were declared to have met the criteria. As observed by DDC/DEDCs, the multiple processes and steps (rapid assessments and micro assessments) required for determining the status of programme districts against 10 agreed criteria for graduation, and difficulties in reaching consensus on the outcomes among diverse stakeholders including DFAT and UNDP, have resulted in slow progress. As a project MEDEP has little influence over Districts' ability to meet the criteria. This is the DDC's responsibility.

In conclusion, though there have been some delays, good progress has been made with implementation of activities MEDEP planned to enable GoN institutions to implement MEDPA, both at the level of putting systems in place and capacity building. However, whether the planned activities were appropriate and effective is another matter. The Capacity Development Strategy was not translated into a systematic long-term plan despite that fact that there were at least two 'capacity assessments' commissioned by MEDEP itself has provided some useful recommendations to have a systematic capacity strengthening longer terms plan.

The lack of staff at the DCSI and CSIDB offices and high staff turnover limited the effectiveness of capacity building activities. Insufficient allocation of funds to the MEDFs by DDCs, VDCs and MEDEP weaken the financial basis of the programme. The delays in district graduation indicate DDCs/DEDCs

and CSIDB/DCSI are not ready to accountably operate the funds. Partly due to some of these factors but also to MEDEP's ME creation target, MEDEP continues to be involved in direct implementation to a greater extent than desirable given its institutionalisation and facilitation role. Given these concerns, many of which were beyond MEDEP's control, the Theory of Change may not hold true. This will be considered in section 3.2, where we consider to what extent institutionalisation has been successful.

3.1.2 Progress Analysis of Component 2

Component 2 – Promoting the use of evidence for pro-ME policy

i) The Component Aims For:

Component 2 aims to strengthen the capacity of the GoN in using relevant evidence and dialogue in MED policy making and planning and more research based evidence on MED and its impact on poverty alleviation. This also requires the availability of more research and evidence on MED and its impact on poverty alleviation and therefore a research capacity at key national research/MED institutions.

The strategy included in the project document comprised coaching of MOI to take leadership in and carry out dialogue on issues relevant to MEs, including with ME associations, and through a new dialogue platform, and support to research institutions to carry out ME research and develop commercial strategies and business plans for marketing such research.

The strategy MEDEP developed included advocacy by NMEFEN and DMEGAs in this component. It focused on support, including capacity building, to MoI and the associations to enable them to take leadership and participate in sustainable dialogue, leading to better ME policies and strategies. This was to include development of a dialogue forum and a dialogue/advocacy handbook. Support to research institutions was also foreseen, as well as a Mass Impact Study to provide information on MEs' impact on poverty and economic development as an input to dialogue. Partnerships, alliances and networks were to be developed to influence policies more effectively. One of the expected results was the integration of MED related policies with concerned ministries i.e. MOI, Ministry of Agricultural Development, Ministry of Forest and Soil Conservation and Ministry of Federal Affairs and Local Development.

ii) Major Achievements

a. Influencing Policies

MEDEP IV has contributed to a significant number of policies, both directly and by supporting MoI and advocacy by NMEFEN. It contributed to inclusion of an MED component in the (draft) Industrial Enterprise Act 2069/70 that is yet to be adopted by Parliament and provided feedback to the Monetary Policy 2013 to prioritize MEDEP promoted cooperatives for providing wholesale loans (Monetary Policy 2013, Clause 105). MEDEP efforts to include provisions for credit facilities to MEs and physically disabled people to run self-employment oriented activities through the Rural Self Reliance Fund (RSRF) are reflected in Clause number 105, Page 14, Monetary Policy for Fiscal Year 2013/14.

MEDEP's financial and technical support to NMEFEN has also contributed to drafting of an ME friendly Honey Promotion Policy (waiting for approval from MoAD), which assures quality of Nepali honey and marketing (national as well as international) with additional benefits to MEs such as tax subsidies on equipment. In 2015, MEDEP's support to NMEFEN to conduct dialogue with the Ministry of Agriculture Development (MoAD) resulted in drafting of a Five-Year Strategic Plan of Agro Business Promotion Policy.

With support of MEDEP, NMEFEN has been one of the key members of Riverbed Farming Alliance. A Riverbed Farming Policy has been drafted and is waiting for approval by MOFALD. At the time of the MTE, the Riverbed Farming (RBF) Action Plan was in its final stage. It proposes representation of ME Associations in different structures (local to national levels) and ensures MEs' access to benefits provisioned by different policies such as crop insurance, lease hold farming and subsidy on inputs.

MEDEP supported the Department of Forests (DoF) within the Ministry of Forests and Soil Conservation to assess the status of Pine Tree Thinning Guidelines (PTTG) and identify the potential for sustainably promoting forest-based enterprises. As a result MoFSC decided to reactivate the PTTG 2064 with revisions and develop thinning working procedures. This is one instance where the aim to promote evidence-based policy making was actually achieved.

MEDEP contributed to a compilation of MED relevant sections from different policies, acts, and guidelines, for information of MEs, MEAs and other stakeholders³³. This could be the basis for advocacy and claiming facilities as provisioned by various government programmes and policies, and some MEAs have succeeded in accessing assistance as a result. Full dissemination is still to happen.

b. Support to develop capacity to conduct dialogue

MEDEP supported the development of linkages between NMEFEN and a number of organisations related to specific policies. This included linkages with the District Coffee Cooperatives Union (DCCU), Federation of Nepal Chamber of Commerce and Industry (FNCCI), and District Agriculture Development Office (DADOs) to promote coffee production, mobilise technical inputs, and marketing of coffee products. DMEGAs that included coffee producers were also involved.

A mechanism for identifying issues is included in the NMEFEN communication Strategy/Guideline³⁴. MEGs and MEGAs formulate issues that require dialogue and policy advocacy; such issues are forwarded to DMEGAs and discussed; district level issues are meant to be addressed by DMEGAs through consultations with district level line agencies (e.g. Forests, Agriculture, Water Supply and Sanitation, etc.); issues requiring attention by regional and/or national authorities are forwarded to NMEFEN and MEDEP for initiating dialogue and policy advocacy at the appropriate level; at national level NMEFEN takes up those issues with line ministries and other authorities.

In practice, however, this mechanism is not yet functioning, though DMEGAs and NMEFEN are meeting quarterly. The issues for advocacy have been largely identified by MEDEP, in consultation with NMEFEN and MoI. Lower level MEGAs do not have sufficient capacity to identify significant issues for advocacy, though they have enabled access to services.

Development of an Advocacy Handbook is planned for 2016. Establishment of a Policy Dialogue Platform at national level is also planned for 2016. It is to be one of the functions within the MED Section of MOI, of which establishment is dependent on finalisation of the O&M survey. For now, NMEFEN's membership of the MEDPA Steering Committee provides it with direct access to relevant sector ministries and MED actors at national level.

MEDEP has supported NMEFEN to develop alliances which provide avenues for advocacy. It is a member of MED Committee within FNCCI, member of FNCSI, member of Handicraft Association of Nepal (HAN), and a member of the CSI Fund of GoN.

³³Laghu Udhyamsambandhi Bhibhinna Nitigat Tatha Kanuni Pravadhanharu ko Sangalo, Shrawan 2072; Compilation of Various Policies and Legal Provisions related to Micro Enterprises, Aug 2015 (in Nepali)

³⁴NMEFEN Communication Strategy/Guideline, Dec 2014

NMEFEN (and DMEGA) staff and board members participated in MED policy and advocacy training. In terms of GoN capacity building, in 2013 MEDEP supported an exposure visit of officials to Sri Lanka to enhance their knowledge and exposure through interaction and observation of enterprise development programmes and policies with a focus on Micro and Traditional Enterprises.

Much of the advocacy capacity building has been through coaching and hand-holding and it is not always clear how much MEDEP was directly involved and responsible for the results. There have been no specific activities to build GoN or NMEFEN's capacity to make use of research, or do analysis for evidence-based policy making.

Except for the establishment and operationalization of a policy dialogue platform, progress on the above is on track in terms of implementation of planned activities, and the achievements in terms of policies are significant, even though they have not come through a dialogue platform.

c. Research and research institutions

In 2014, MEDEP completed a study (by engaging an independent consultant firm) on 'Allo Products Diversification, Supply (Value) Chain and Future Potentiality of Expansion' which revealed that Allo (Himalayan nettle) based micro enterprises had contributed to uplifting the livelihoods of the poor, women and indigenous people and had created many jobs in the villages.

Similarly, MEDEP supported compilation and publishing of a micro enterprise development related thesis, dissertations research and studies³⁵, with aim of contributing to evidence-based policy advocacy. MEDEP reports that some of the studies (e.g. two value chain studies) have been used in dialogue.

A Mass Impact Study carried out in 2015³⁶ (at the time of MTE, the final draft report was available). It presents a comparative analysis of socio-economic impact of different commodity and service-based MEs. It makes a number of recommendations on MEDPA policies and programming including a greater focus on growth and development, GESI and strengthening of the ME Associations to ensure sustainability. MEDEP intends to integrate these in its programmes from 2016 onwards, but relevance to broader advocacy seems limited.

Mapping of research and advocacy organisations conducted by MEDEP in 2015 has identified 50 organizations (32 national, 7 Regional and 11 District based) involved in and having potential to work on MED policies research and development. Institutions shortlisted carried out the research for the project. MEDEP still plans to support organisations in strengthening their capacity to conduct research relevant to evidence-based policy advocacy on MED, and market it commercially. Given that the project is more than mid-way, the results are unlikely to be reaped in the project period.

In conclusion, MEDEP has successfully influenced policies relevant to MEs, partly through NMEFEN and MoI. As a result of work with other ministries, there has been some progress on alignment of ME relevant policies, though there is no dedicated coordination platform yet. Relevant research has also been done, though so far mostly not in relation to the policies developed. There has been little progress on developing the capacity of MoI and NMEFEN to make use of research, or to conduct dialogue and advocacy effectively. NMEFEN has no advocacy strategy or plans, but it intends to develop these in 2016. MoI has not yet taken the leadership in dialogue. Rather, MEDEP has. It has been the driving force

³⁵Micro Enterprise Development for Poverty Alleviation, Volume III, 2014; and Micro Enterprise Development in Nepal: Potentials, Achievements and Impacts, 2014.

³⁶Mass Impacts on Entrepreneurs of the Selected Products and Services Promoted by Micro-Enterprise Development Programme, Dec 2015, Development Resource and Training Centre, Lalitpur

in influencing policies, successfully, rather than being a facilitator. Studies that have been done were funded and supervised by MEDEP. Capacity building at research institutions still has to start. These weaknesses in implementation affect the likelihood that the Theory of Change will hold true.

3.1.3 Progress Analysis of Component 3

Component 3 - MEA Deliver Services to Members sustainably

i) The Component Aims For:

This component aims at strengthening the capacity of the Micro Entrepreneurs Associations (MEAs) in which MEs started under MEDEP and MEDPA are organised to deliver support services to MEs that have “graduated” from the MED services in their start-up and early development phase, to enable them to become resilient. Such services include national and district level advocacy, and support in access to markets and market information, formation of cooperatives, creation of Common Facility Centres, training, counselling, finance and technology, including sectoral “toolkits”. The project document specifies that these services should be “easy to market....on a commercial basis”³⁷. The services should generate a “stream of income” and “by the end of MEDEP IV the services provided by the MED associations will all be sustainable”. The focus is on the district and national level, i.e. DMEGAs and the NMEFEN.

The key strategies specified in the project document include a market assessment for services, development of business and advocacy strategies, support to development of a service offer, new service development, capacity strengthening and development of “strategic partnerships with key market organisations like financial institutions and technology centres”³⁸. NMEFEN was to be assisted to support DMEGAs. Support was to include limited funding of professional staff, and to be based on tailored, association-specific offers. Funding was to be gradually reduced.

The project’s strategy as laid down in the revised impact logic for this component and other documents is modelled on this, though the focus is on the district level, correctly given that that is where the MEs are. Business “strategies” have been more concretely interpreted as strategic and business plans, but a service market assessment was not foreseen. Development of advocacy strategies was also not included as capacity was considered insufficient.³⁹ There is a greater emphasis on institutional development, and on marketing of services. Support to NMEFEN in advocacy was in practice moved to Component 2, which covers national level dialogue. An electronic communication platform, also mentioned in the project document, was to be one of the vehicles by which MEs could access information and develop networks.

ii) Major Achievements

a. Funding and business planning

The DMEGAs have been and are heavily dependent on MEDEP financially, with more than the “limited” funding foreseen in the project document provided. Support (financial or technical) was not based on tailor-made offers. Material and financial assistance initially included equipment, furniture and 60 percent of operational costs, staff salaries, and 100 percent of programme cost (service delivery). Subsidies to programme cost are reduced to 60 percent when districts “graduate”. As MEDEP withdraws this will be gradually reduced further to zero, and the MEDPA budget does not foresee in DMEGA grants. It is unclear whether service delivery could be funded, since the new Operational Guidelines expect MEDSPs

³⁷Page 37.

³⁸ Page 38

³⁹ Accountability Initiative Pvt , “Institutional Capacity Assessment of MEA and Sales Outlets”, December 2014

to provide follow up services too. DMEGAs are so far unable to participate in tenders for service delivery since they are part of the DEDC which awards the contracts, though they could in theory seek contracts outside MEDEP or MEDPA. Support to NMEFEN is at similar levels.

Developing business plans was considered a priority under these circumstances, and was also indicated by a Capacity Needs Assessment the project supported NMEFEN to conduct in 2014⁴⁰. The project has supported 20 DMEGAs and NMEFEN to develop plans. Support to the remaining DMEGAs is expected. The business plans usually foresee increased membership fees, recruitment of more MEDEP ME members (currently they number some 31,000), recruitment of other MEs, fees for (most) services, support from the DDC and contracts with other projects or organisations. A membership service guideline with fees was developed by NMEFEN (with MEDEP support) and promoted to DMEGAs in all MEDEP and 12 MEDPA districts in 2015. DMEGAs met by the MTE team were applying them in their business plans.

b. Services

Actual service delivery has been good, with MEDEP reporting that some 29,544 MEs have received services over the past two years. The target is 65 percent of MEA members or of existing MEs in phase IV, or of MEs created, which of the three is not clear. Taking existing active MEs as the basis, which numbered 39,727 by the end of 2015, 75 percent have been reached, so this would be well on target⁴¹. Services included support in labelling, branding, licensing, quality control, market promotion, market linkages, trade fairs, and business to business linkages. Outreach specific to resilience and graduation support (e.g. the kind of services MEDEP pays for) also on track.

As indicated above, service delivery has been funded by MEDEP. MEs have so far not paid for services, with some exceptions, and there is little sign of the “commercial” approach foreseen in the project document. DMEGAs usually hire EDFs or other subject experts to implement their contracts with MEDEP. They do not have the internal capacity to do so.

An electronic communication platform was developed in 2015, through NMEFEN. It will be tested in 2016. It comprises a Smartphone app which will enable MEs to access information related to, amongst others, markets (e.g. on prices, buyers and suppliers), technologies, FSPs, and policies. NMEFEN and DMEGAs can use the platform to communicate with ME members, who can also provide feedback and suggestions, including on policy issues. Management of the platform is expected to be funded from 5 percent of the DMEGA membership fee and outside subscriptions.

DMEGAs have played an important role in data collection and entry for the MIS, hiring staff for this purpose using MEDEP funds. With reduced funding this has come under threat and under the new Operational Guidelines this will be outsourced to MEDSPs. This is appropriate, as there is little incentive or rationale for the DMEGAs to perform a role that is of little benefit to them.

There has been no other new service development, though identification by NMEFEN (with MEDEP support) of improved technologies in 7 sectors could contribute to this in 2016.

c. Advocacy

DMEGAs are represented on the DEDCs, which in principle provide a dialogue forum and opportunity for advocacy. DMEGA capacity building in this area is foreseen in the project strategy. DMEGA staff and

⁴⁰ Assessment of institutional capacity of Government institutions for the implementation of MEDPA, 2014

⁴¹ MEDEP data in “MTE multiple information based on checklist in Inception report”, prepared by MEDEP.

board members participated in MED policy and advocacy training, but as this has not had an impact yet it is unlikely to have been sufficient. This was confirmed by interviews in the districts.

As indicated in the section on Component 2, a mechanism for bringing advocacy issues up from the MEAs to the DMEGAs and if necessary NMEFEN has been designed but it is not yet functioning. Without adequate capacity to identify important issues for dialogue, to conduct consultations with members, and develop and implement an advocacy strategy DMEGAs are unable to fulfil the advocacy function, which is usually the core role of business membership organisations. That there is interest in this role is indicated by some DMEGAs having included it in their business plans.

The members of DEMEGA consulted by the MTE during the field visits do realise the need and importance for advocacy, they are not sure about their technical capacities to do so without support from professional persons, funding for the same in sustainable manner is an unanswered question for them.

d. Strengthening DMEGA membership base, organisational capacity and systems

DMEGAs have been increasing their membership base, partly as a result of more active recruitment⁴² but also because MEDEP and MEDPA are supporting creation of more MEs. From 2014 to 2015 membership went up by some 9,000. In principle this is expected to collect more membership fees by DMEGAs, however physical observation of the books of accounts of DMEGA While DMEGAs were exclusively providing services to MEs created by MEDEP and MEDPA, this policy has changed and other MEs are being targeted as well, with membership-fee based services. Some 1,500 MEs have signed up. This is a positive development as it reduces the exclusivity of the associations and could further increase the income base. In the coming year MEDEP plans to provide more support to recruitment.

The membership service guideline developed by NMEFEN also included membership procedures, e.g. the use of membership and service application forms, ID cards, and membership certificates. These are starting to be applied.

Organizational Development training was conducted for 200 selected Board members and staff of 44 DMEGAs covering issues such as organizational structures and policies (including GESI) and good governance. DMEGA and NMEFEN staff were also included in training on marketing. Capacity building has been informed by the project capacity building strategy⁴³, but as for other institutions in the system there is no long-term DMEGA/NMEFEN capacity building plan.

On the basis of meetings with the DMEGAs the MTE team judges that they have benefitted enormously from intensive handholding and coaching by MEDEP staff. Much of their activity is closely guided by the project.

In conclusion, MEDEP has invested significantly in the DMEGAs and NMEFEN, as an element of the service delivery system. The membership base is increasing, and outreach in terms of services is large. However, the advocacy function of the DMEGAs, which should be their core business, has not come off the ground. Other functions are heavily dependent on MEDEP support. Efforts to change this by the development of business plans are in line with the Capacity Development Strategy and in principle appropriate, but have come very late. As for MEDEP's expected transition from implementation to facilitation, the project has not actually been doing the DMEGAs work, which is positive, but the level of

⁴²As suggested in Stephan Schmitt-Degenhardt, "Transition to Sustainability, Capacity Development Strategy for MEDEP IV", 2014

⁴³Stephan Schmitt-Degenhardt, "Transition to Sustainability, Capacity Development Strategy for MEDEP IV", 2014

funding it has been providing cannot be characterized as facilitation. That its strategy will result in sustainable delivery of services by DMEGAs, as foreseen in the Theory of Change, is doubtful.

3.1.4 Progress Analysis of Component 4

Component 4: MEDSPs are able to deliver MED sustainably

i) The Component Aims For:

The aim of this component is sustainable delivery of MED services by MED Service providers (largely NGOs). This entails strengthening their capacity for service delivery and marketing. MEDSPs had already been developed in previous phases but their number was not sufficient. Historically many of the current MEDSP organizations are established by either former MEDEP staff or EDFs who have worked in other agencies on MED. This component will also help the Government of Nepal to meet the MEDPA tendering processes to acquire the services of MEDSPs. Component 1 and 4 are linked as component 4 will also contribute to improve the capacity of government to plan, procure and monitor service providers for the delivery of MED.

The strategy foreseen in the project document is capacity building on the MEDEP service model; in particular, for creation of MEs and follow up monitoring and support until they graduate to support from DMEGAs. This would enable large numbers of competitive MEDSPs to crowd in to bid for implementing MEDPA. A key element of the strategy was development and marketing of courses and a professional profile for EDFs (who are hired by MEDSPs to actually deliver the services) at training institutions. The capacity of the National Entrepreneurship Development Centre (NEDC), the MEDSPs' apex body also established earlier to provide training and bidding support to MEDFs was also to be strengthened.

The strategy the project developed closely followed this. Capacity building was to take the form of coaching, mentoring, workshops, and training.

ii) Major Achievements

a. Crowding in of MEDSPs and EDFs

As the availability of sufficient number of MEDSP bidders has been noted as a problem in MEDEP phase III, this was partly due to the shortage of trained EDFs, which also affected service facilitation by DMEGAs and the ability of DCSI and CSIDB to engage qualified staff.

MEDEP had already developed a 51 days course, which was taken up by training institutions. It was, however, insufficient to result in well-qualified EDFs who could pass a test at the National Skills Testing Board. The project therefore developed a 10 months training for level 2 qualifications, and a 3-year diploma course for Technical School Leaving Certificate (level 3 of certification)) which are strategically designed to meet the need of EDFs. A skill testing and certification process for qualified level 1 (or experienced EDF practitioners) has been also developed for the career advancement of the EDFs by CTEVT/NSTB.

As a result the number of EDFs is increasing in the market. Private sector training institutes under the Centre for Technical Education and Technical Training (CTEVT) affiliation are coming up in different parts of the country (even in district like Kalikot) and providing EDF training opportunities to local youth. It has been noted that a single former EDF has established five EDF training centres as private venture in different part of the mid and far west region. The Industrial Entrepreneurship Development Institute (IEDI under MoI) is also offering the courses and the National Skills Testing Board of CTEVT is certifying the EDFs. Demand for the courses is good, with most students paying tuition themselves, and

the training institutes have the capacity to meet it. Rolling out the new diploma course will require MEDEP technical and initial financial support, including for quality control.

The courses are inclusive. Of 157 students in courses in 2015, women numbered 102, Dalit 5, Indigenous Nationalities 71, Madheshi 25, and Muslim 4. Though this is not fully reflective of the target group, training providers depend on demand for the courses to achieve this.

Although compared to the 2018 target certification is somewhat delayed the gap in the required and currently available number of EDFs is not very significant. The main issue is not in implementation but in submitting bids. The Districts require three bids from MEDSPs and that it is difficult if some flexibility in the bidding process is not introduced (allowing one individual EDF to be part of two or more bids). The intervention is on track.

This is confirmed by the growth in terms of number of MEDSPs bidding organizations, which indicates an increase. The list of successful MEDSPs in the bidding also shows that in the last three years at least 5-7 MEDSPs have been providing their services in two to five districts during one FY, which means that MEDSPs are emerging with higher delivery capacity. Data provided by MEDEP shows that the number of MEDSPs taking part in the bidding for MED services under MEDPA and MEDEP has increased by 34% from 2013 to 2015. During the 2013 bidding cycle 206 MEDSPs have taken part, grown to 277 taking part during 2015 procurement cycle in both MEDEP and MEDPA biddings (Table 4).

The increase in the number of MEDSPs could have been more, given the large numbers of NGOs operating in the districts, but MEDEP has used the same MEDSPs for the delivery of its ME creation target in recent years. Experience counts in selection of MEDSPs, and getting this experience is only possible through MEDEP or MEDPA contracts.

In addition to development of EDF training (and some financial support to delivery), newly selected MEDSPs were provided orientation on the MEDEP service model, and MEDSPs that had implemented services were given refresher trainings. Coaching and mentoring was a continuous aspect of MEDEP's involvement.

b. Procurement of MEDSP services

Procurement of MEDSP services is practiced by MEDEP and adopted by MEDPA. The concept and process of outsourcing of such services through the Quality and Cost Based Selection (QCBS) method has been practiced and internalized by MEDPA. The MEDPA operational guidelines have captured the concept, process and tools for running the bidding process and evaluating the bids from MEDSPs.

The procurement follows the Public Procurement Act (PPA) of GoN. The procurement process is run on an annual basis and takes place at two levels. First, the Expression of Interest process is run by the MoI for all districts, and district wise short lists are prepared to invite MEDSPs for detailed technical and financial proposals. These proposals are evaluated in two steps (first technical and second financial) by a subcommittee of the DEDC in each district. The evaluation process and marking tools used seem to be robust and effective.

The CSIO/CSIDBO and other direct stakeholders have different opinions about this process. All agree that the evaluation system is robust and effective and leaves no space for any kind of bias to influence the evaluation. Some stakeholders feel that the two stage selection process is effective in 'shock absorbing' any political interference in the selection process, some think that the selection of MEDSPs should be totally done by the centre, and some also voice that the selection process should be done at district level for both stages.

In the MTE team's view the current procurement process is in principle effective overall. However, the following implementation issues should be noted:

- Orientation of the CSIO/CSIDBO staff on the procurement process and also orientation of the DEDC subcommittee on the evaluation process and marking tools will be required on regular basis as there will change of GoN staff involved in the selection process.
- Late release of GoN Budget and spending authorizations delays the procurement of MEDSPs resulting in a short implementation period for the service providers, which was reported by some stakeholders interviewed to have an adverse effect on quality of the services (not all services delivered and shorter periods of time between them). MEDEP has tried to address this by supporting MEDPA to start the procurement process earlier, which is already resulting in longer implementation periods. It is advocating for starting the process even in the preceding year. A multiyear contract with MEDSPs could be another solution.
- As already noted above, the availability of sufficient EDFs (on exclusive availability basis) for at least three proposals in one district (15-20 EDFs per district) is a challenge, while the job available only for MEDEP/MEDPA ME creation work is 50 percent of the time for 5-6 EDFs.
- The MEDSPs are facing difficulty in receiving the payment of the last instalment (10% withheld amount) as there has been difficulty in hiring consultants for the final monitoring. Low budget, uncertain timing of the task, scattered work, small volume of work seems a main reason for lack of interest from potential service providers.

The per capita cost of ME creation is estimated about 20,000 NRs, and the successful bid amounts vary from about 12,500 NRs to 22,500 NRs. The cost has been going down due to increasing competition. It has been noted that in some cases the bid amount is less in the hill and mountain districts, although the cost of operation in mountain districts will be much higher than in Tarai districts. This may be due to greater competition.

C. National Entrepreneurship Development Center

The MEDSPs' umbrella organisation NEDC is meant to be a resource centre for entrepreneurship development programmes and member MEDSPs and to provide capacity development to MEDSPs. Governance issues led to a cessation in the partnership between MEDEP and NEDC in 2014, but this has been resolved. NEDC has conducted training for CSIDB staff, developed software to manage an EDF inventory, and MEDEP supports development of a strategic plan. NEDC's income is from membership fees (38 members), fees for facilitation EDF certification, MEDEP contracts, MEDFs' payment for services (ultimately from MEDEP), and contracts with other programmes. MEDEP subsidies have been gradually reduced to between 30 and 40 percent and the organisation is actively looking for other clients.

In conclusion, progress in terms of implementation has been good on this component. More EDFs and MEDSPs are available for implementation, but there are some issues related to contracting and payment that need to be addressed. Developments at the NEDC are promising. Likely reasons for good progress include, in the MTE's view, that service providers are non-government and have a clear incentive to perform as long as funds are available, and the project's strategy to build a system for EDF training rather than fulfilling this function itself. On the strength of the progress made it may be expected that the institutionalisation level in the Theory of Change can be achieved.

3.1.5 Progress Analysis of Component 5

Component 5 – Improving access to finance for micro enterprises

i) The Component Aims For:

This component aims to improve access of microenterprises to financial services from formal financial services providers (FSPs) and cooperatives. The change it facilitates is a sustainable system that delivers financial services to MEs, comprising sustainable partnerships between financial services providers and entrepreneurs and their associations, and more cooperatives that provide financial services. This builds on MEDEP's experience in earlier phases. Cooperatives were found to be especially suitable in more remote areas where the incentives for FSPs to operate are weak due to high costs.

The strategies as outlined in the project document include development of partnerships between NMEFEN and FSPs, which were to result in the latter targeting MEDEP and MEDPA MEs with appropriate financial products. New products were to be developed if necessary. The system was to include certification of MEs by MOI. The capacity of NMEFEN and DMEGAs to help ME groups form cooperatives was to be developed, resulting in new cooperatives offering savings and credit services. NMEFEN was to raise funds for FSPs and cooperatives, and link cooperatives to wholesale credit sources. NMEFEN was to generate a profit from increasing access to financial services as a service provided to members. Financial literacy training was to be developed, to be delivered by NMEFEN and DMEGAs.

ii) Major Achievements

a. Efficiency of Financial Service Providers

The project strategy largely follows this: apart from developing the certification system (this is appropriate, FSPs should assess credit worthiness themselves) and fundraising by NMEFEN for FSPs (also appropriately, financial institutions should do these themselves too). More importantly, the strategy does not include specific interventions to institutionalise further development of FSP partnerships and cooperatives in MEDPA or through NMEFEN, and it does not foresee NMEFEN generating a profit from access to financial services.

The target group for credit are existing MEs and the 40 percent of newly formed MEs not started by the hard-core poor. The latter are not considered creditworthy by providers and MEDEP therefore supports them with Common Facility Centres, equipment and material inputs. Following a period of profitability they can graduate to loans.

The FSPs mostly use a Grameen style lending methodology, but in remote areas operate “self-reliant groups” which require less supervision. Several use branchless banking (through local agents) for greater outreach. Interest rates are variously said to be between 10 and 20 or 10 and 16 percent. There was no development of new products specifically for MEDEP MEs. Reaching these clients proved to be a matter of targeting and outreach rather than calling for new products. Some of the partners are considering expanding e-banking (mobile banking) to increase outreach but so far this has not included credit operations (but transfers and payments).

To share the perceived risk of lending to the poorest as well as the cost of outreach, project support included operational subsidies. This is a common facilitative approach in microfinance.

The FSPs also provide financial literacy training. Some reported they did so already before their partnerships with the project, others use a package developed by MEDEP, which contracted this work to NMEFEN, as planned. MEDEP provided 120 EDFs with financial literacy training by contracting

NMEFEN and plans to train more. EDFs can provide this service through DMEGAs and MEDSPs (if contracted to do so).

The project has developed an intervention in insurance not foreseen in the project document. The rationale is to reduce vulnerability to natural disasters or other shocks.

b. Financial Services to MEs included in Monetary Policy

MEDEP and NMEFEN advocacy to the Central bank contributed to measures promoting financial services to MEs included in the 2013/14 Monetary Policy, which mentions MEDEP specifically. This and a financial mapping study were the basis for development of national-level partnerships with 6 (originally 7) microfinance providers operational in 2014 and an additional 5 in 2015. These were formalised in an MOU between the MOI (signing also for the project) and the institutions, witnessed by NMEFEN. It covers MEDEP and MEDPA areas. MEDEP offices also developed partnerships with regional MFIs which were found to be more responsive to local demand.

c. Linkage between FSPs and DEMEGA

The main role of NMEFEN and DMEGAs is linking FSPs to MEs. In practice the involvement of NMEFEN has been limited (it being at the national level), and FSPs have been largely linked to MEGs through MEDEP and DMEGAs. MEDEP has started negotiating agreements between DMEGAs and FSPs that aim at expanding lending, also beyond project completion. The involvement of DCSI and CSIDB, mentioned in the MOU in one breath with MEDEP, has been limited. Apart from awareness raising workshops and exposure visits there has been no capacity building for them or NMEFEN to continue or further expand partnerships.

d. Access to loan by MEs

The number of MEs that accessed loans overall (FSPs and cooperatives) is 52 percent of the target while for first-time loans it is 67 percent. Given that MEDEP is mid-way, this can be considered on target. Separate data provided to the MTE indicate that FSPs account for 76 percent of the loans, though not all were provided under the FSP partnerships. This was achieved in spite of initial delays due to the need to negotiate the MOU after proclamation of the Monetary Policy, the time it took to get branch offices on board and the lending methodology (MEs in groups receive loans consecutively rather than at the same time). The final target can be expected to be achieved. The high percentage of MEs with a bank account indicates increasing integration into the financial services market.

FSP outreach to women and disadvantaged groups is similar to MEDEP targets overall, with 77 percent women, 20 percent Dalits and 45 percent indigenous groups. This is a good achievement, especially given FSPs' need to be financially sustainable.

Some major issues

The MTE identified the following issues that limit further outreach and effectiveness:

- The wide dispersal and remoteness of MEs results in most clients being in towns or at a short distance from roads. Most partner FSPs have declined to lend to more remote groups.
- FSPs are reluctant to use mobile banking for credit disbursement and repayments, as they consider interaction with clients to be key to maintaining high repayment rates, and the technology is not available.
- The number of participating FSPs is still relatively small, which limits outreach.

- There are indications that access to finance is quite high already. The project's mapping showed 44 percent in the target Districts borrowing from FSPs, 22 percent from cooperatives⁴⁴. Some FSPs consider the market to be close to saturation. This applies more to their limited areas of operation than to remoter MEs as confirmed by an independent study which gives Nepal a score of 2 out of 5 on market penetration (5 being saturated). This implies the focus should be increasing outreach to under-served areas and improving service quality⁴⁵.
- Interest rates are considered to be high by MEs and some stakeholders. They are in line with common microfinance practice, though. The available interest rate varies between 6-22% at individual lending level. The market share of FSPs with lower interest rates seems comparatively less of those having higher interest rate. This is possible mainly because of the flexible lending policies of the FSPs that have higher interest rates.
- The loan processing method and lending conditions of the FSP varies from one to another. Though not established, the MTE perceived that 'lower the interest rate complex the lending process and limited outreach'. Where as in the case of higher interest rate the FSPs have less complex lending process, and they expand their outreach to improve their business opportunity.
- Most MEs are not well or at all integrated into value chains and therefore have limited market access. This weakens their viability. FSPs suggested this could be partly addressed by their being able to lend, under their partnerships with MEDEP, to players in value chains other than producers, e.g. input providers, aggregators, processors, large buyers.
- A market segment that remains underserved is made up of the so-called missing middle MEs: those that require larger loans to grow further, but for which FSPs require collateral, which they do not have. This is in spite of the Central Bank's monetary policy providing for non-collateralised loans up to a higher amount (700,000) than before as a result of MEDEP advocacy.

e. Promotion of Cooperatives

Some 300 cooperatives were already in place as a result of previous phases. Under Phase IV cooperatives were formed out of MEGs by DMEGAs contracted by the project which organised the necessary training and support to business plan development. NMEFEN played a coordinating role. Official procedures (registration, certification) were handled by the Cooperative Division offices. Cooperatives were also linked to the RSRF and other wholesale lenders such as the Women Entrepreneurship Development Fund. Assistance included "logistical support", i.e. furniture, computers etc. Some cooperatives have other functions, e.g. in marketing. Involvement of and capacity building at DCSI and CSIDB has been limited to "awareness raising".

Cooperative formation already exceeds the project target. Their total number (including from previous phases) was 329 by the end of 2015. Twenty (in this phase) have accessed wholesale loans from the RSRF or other sources, which is on target. MEGs or individual MEs are also accessing loans from other cooperatives. As indicated above, in terms of MEs receiving the project is on track and 23 percent of loans are from cooperatives. The scale of outreach is therefore still lower than of the partner FSPs. The main reason is that it takes time (one to two years) before a cooperative is sufficiently well-established to meet the wholesale lenders' criteria. Outreach to women and vulnerable groups are similar to the FSPs'.

As a result of the Monetary Policy referred to earlier an agreement is in place with the Central Bank under which ME cooperatives have priority to receive wholesale loans at an effective interest rate of just 2 percent from the Rural Self-Reliance Fund (RSRF). In addition, NMEFEN is one of the members in the Central Committee of the Women Entrepreneurship Development Fund. This has contributed to a

⁴⁴ MEDEP, "Assessment of access to Finance in MEDPA and MEDEP including financial mapping", August 2014

⁴⁵ Foundation Planet Finance, "MIMOSA; Microfinance Index of Market Outreach and Saturation", 2013
<http://mimosaindex.org/>

conducive environment for further development of cooperatives that offer savings and credit services. Other types of organisations, such as associations or NGOs are by law not allowed to access wholesale loans.

Issues related to cooperatives:

- A direct cost of cooperative formation is some NRS 40,000, and the process takes time. Partnering with existing cooperatives to absorb MEDEP MEs could reach to greater outreach faster and at lower cost, though in some areas there may be no alternative to establishing new cooperatives.
- Interest rates are considered high, at between 6 to 22 percent depending on the source, but are in line with the microfinance market.
- Formation of cooperatives by MEDPA is at a very low level (just one, due to insufficient ME Group members) and it has little capacity and few resources to do so.

f. Insurance

MEDEP has promoted produce insurance in tandem with raising awareness of GoN's provision to subsidise premiums for agriculture and livestock products by 75 percent. Partnership arrangements with FSPs also included a requirement to have all loans insured. As a result 2,580 borrowers were insured while 199 MEs insured their produce.

In conclusion, the project is on track in terms of MEs receiving loans, and outreach has increased since the project's start. FSPs have greater scale of outreach than cooperatives, but the latter reach remoter areas. This validates the project's strategy, and in these terms the Theory of Change can be expected to be realised. MEDEP has, however, largely been implementing this component itself rather than facilitating implementation by MEDPA. The main concern is therefore whether greater outreach the targets are feasible beyond MEDEP, given the lack of capacity at MEDPA. This will be considered in the next section.

3.2 Progress on establishing a sustainable system for delivery of the MEDEP model–effectiveness and sustainability

Have MEDEPs interventions resulted in a sustainable system for delivery of services for MED, or are they likely to do so, as predicted by the Theory of Change MEDEP is based on? Issues of scale and sustainability are key to this question and are the focus of this section.

Has **Component 1** resulted in a sustainable system and capacity at relevant GoN institutions to manage delivery of MED at scale, or is this likely to be in place by the end of the project?

The scale of MEDPA has been expanding, to 64 districts, and the MEDPA Strategy foresees expansion to all 75 districts. Funds have been allocated by GoN. MOI officials interviewed confirmed their commitment to nation-wide coverage, “even if MEDEP were to withdraw now”. This provides a sound basis for further progress and the expansion target is likely to be achieved by the end of the project.

MEDPA created more than 14,000 MEs since MEDEP IV's start, which is significant. Further scale in terms of outreach to the target group depends on a large number of players and factors. Within GoN the key factors are:

- Availability of funds
- Capacity and commitment of the DCSI and CSIDB at national and district level
- Level of interest in MED at DDCs and VDCs

GoN has channelled funds into the established MEDFs, but MEDEP has not, due to unsatisfactory or inconclusive results of the various assessments of fiduciary risks it has done at the district level. Other donors contributing to the Fund is, in the MTE team's view, unlikely. Few consider direct support to ME creation an approach that is likely to result in impact on a large scale in Nepal, and work with value chain and market systems development approaches instead, or on the business enabling environment. Those that do use approaches similar to MEDEP's have their own "models" and their own programmes, which they can be expected to, want to continue. MEDPA's scale of outreach would therefore remain relatively limited. Using the limited information on specific allocations of the MEDPA budget, it can be estimated to amount to 6,588 new MEs per year, so around 87 per district per year⁴⁶.

The capacity at the DCSI and CSIDB District Offices is inadequate, in particular due to staff shortages. Given that MEDEP staff have contributed to direct implementation of MEDPA to fill the gaps, scale is also likely to remain limited on this account, unless GoN creates new posts and recruits staff. The same holds good at the national level. As reported in the previous chapter, commitment is mixed, mostly due to a lack of ownership over MEDPA, though indications are that this is gradually improving. The lack of a staff incentive system is a contributing factor.

The level of interest in MEDPA at VDCs and DDCs, as noted earlier, is also mixed. Availability of more funds could improve this. Whether the fact that there have been no elections for local government bodies, and VDC and DDC members are therefore less accountable to the people they serve, is a factor is unclear. It is precisely local political party representatives who are said to be less interested in MED given the small amounts of money involved.

In this context, it also required to keep in mind that in the next two to three years of time the political context of Nepal is expected to pass through several change process like 'operationalization of federal structure of the state, holding local, provincial and general elections, restructuring of state organs under federal structure etc. This changing scenario will have some effect over the pace of the project, however as MEDPA is a national program, it is also expected to be benefited from the 'restructuring plan of MoI under federal structure' together with its other programs. At this juncture MEDEP should be flexible enough to make adjustments under the guidance of the project steering committee to cope-up with the new circumstances.

Commitment at both the national but especially the district level is likely to be affected adversely if the current situation in which MEDEP does not contribute as planned to the MEDFs were to continue. In the first place, small funds mean less recognition and influence. Secondly, if the project and the donor who support MEDPA are seen not to have sufficient confidence in the programme to channel their funds through it, MEDPA as a programme will lose credibility and the confidence of those who charged with implementing it. This would affect scale as well as sustainability.

While there is therefore potential for more scale, the constraints are significant. Without more funds and capable staff the current scale is likely to be the maximum that can be expected. Withdrawal of MEDEP from direct support to MEDPA would reduce it.

With regard to sustainability much of the above applies. A sound regulatory and policy basis has been laid for sustainability of MEDPA, in the shape of the Strategy and Operational Guidelines, and a budget has been allocated by GoN. Development of a new Strategy for the coming 5 years, and the possibility to

⁴⁶Based on MEDEP's 2015 annual progress report, MEDPA budget under component 1, and an average cost of 20,000 NRS per new ME, based on data provided by MEDEP to the MTE.

include MEDPA in the next National Development Plan provide an opportunity to strengthen this. In this respect MEDPA has been institutionalised and is sustainable.

However, in a democracy relevance and effectiveness of Government programmes does to some extent at least underpin sustainability, though it may take a long time for this causal link to do its work. It was reported to the MTE team that the new National Development Plan is likely to focus on economic development, which could mean a shift in priorities. Poverty reduction through growth could be seen as more effective than poverty alleviation through direct assistance. Making a case for MEDPA in those new terms is therefore likely to be important, or funding could be reduced.

Lack of effectiveness (which also means lack of relevance) is, however, the main threat to sustainability. The MTE team suggests that it may have to be accepted that MEDPA will not be as effective as MEDEP is, given MEDEP's human, financial and logistical resources, and the different regulations it works under. However, without adequate staffing, without MEDEP's direct implementation support to fill the gaps, and without MEDEP's continuous capacity building for new and newly transferred staff, an acceptable level of effectiveness will not be maintained beyond the project period.

Also with regard to sustainability GoN recruiting the necessary staff is therefore a first priority. With regard to capacity building: this need to become an ongoing function in the system, not a project function, as there will be a need for it beyond 2018. MEDEP has well understood this with respect to the training of EDFs, which has become the function of various training institutes. The project's strategy to develop an MED course at NASC, planned for this year, is similarly key to MEDPA sustainability. Integrating MED in standard NASC courses and at the MOFALD Local Development Training Academy, and at the Industrial Entrepreneurship Development Institutes (IEDI) for existing staff would further enhance sustainability. MEDPA budget has to be allocated for staff training.

Under MEDPA effectiveness of the DEDCs and VEDCs could be reduced as a result of budget reductions for monitoring and other functions, though it is encouraging that a budget has been foreseen, including for meeting allowances, for the next financial year.

A functional MIS that provides no more than the necessary information, and management capable of using this information, is also essential to sustainability. This is not yet in place, though good progress has been made on developing the software. The planned arrangements for data collection seem overly complex (and therefore costly). Given institutional weaknesses, they are unlikely to work.

Under **component 2** (evidence based policy making) progress has been made in terms of a better enabling environment for MEs. The signs of systemic change in which MOI and NMEFEN take part in sustainable dialogue based on research are still limited. Neither MOI nor NMEFEN have the required expertise. MOI drawing on MEDEP's CTA for this function is one symptom of this. So is the continuous technical support provided to NMEFEN, though more progress has been made there in NMEFEN taking a more active role and linking it to other private sector bodies. MEDEP has remained in the leadership position.

There is no doubt about the relevance of dialogue for development of a vibrant ME sector. However, the question is whether there is an effective "market" for evidence based dialogue. Are NMEFEN and MOI able to pay for research? Are institutions able to supply it? Once supplied, are NMEFEN and MOI able to use it in an effective manner?

There are few indications that the answer to these questions is positive. The payment question is the most basic, and so far MEDEP has been funding all research. NMEFEN and MOI's capacity to pay is minimal. This will remain a donor dependent market and users of research will therefore need the capacity to access funds. Since dialogue has taken place without significant research, this may not be one of their

priorities. As for research institutions, the project's assessment indicated that some are able to carry out MED-related research. Research geared towards advocacy is, however, a specialised area which may require strengthening. Developing business strategies and plans for research institutions as proposed in the project document is no doubt a good idea, but the MTE team believes this is beyond the scope of a project like MEDEP (e.g. it has not been necessary for EDF training either)

Better integration and coordination among ministries would enhance the scale impact of dialogue and resulting policies. While there has been some progress in relation to specific policies (which are useful) a dedicated mechanism for coordination is not in place.

Have MEDEPs interventions under **Component 3** resulted in a sustainable system for delivery of services at scale to MEs or are this likely to be in place by the end of the project?

DMEGAs are increasing in number (in MEDPA districts) and their membership base is growing. With currently more than 31,000 members, by the end of the project membership could include some 60,000 MEs, depending on numbers of new MEs created, the success of enhanced recruitment efforts among programme and other MEs and the DMEGAs' effectiveness. The scale of outreach is therefore large and has the potential to grow further beyond MEDEP's completion.

This is already, and would be even more, an impressive achievement. It offers a great opportunity to give poor entrepreneurs from vulnerable groups a "voice" that can be heard in dialogue forums at the national and district level. It would also enable the associations to reach many with the services needed to strengthen and possibly grow their enterprises.

While the second has materialised as a result of MEDEP funding, the first has not, at least not at the district level. Advocacy is the core function of business associations, and, based on for instance Local Economic Development experience globally, there are likely to be many local issues the DMEGAs could tackle. This could range from allocation of DDC funds to local regulations and governance. Unlike business services, advocacy does need to cost much. This function not being developed therefore represents a missed opportunity.

Does this affect the sustainability of the DMEGAs? It is likely to affect their relevance in the district economy and vis-à-vis other key players, GoN and the private sector. MEs may be more likely to give priority to access to services, but this could also be affected as a result of weak or no advocacy, e.g. for funds for services. More generally, service delivery has been dependent on MEDEP and a similar level of funding cannot be expected once it withdraws. If the DMEGAs have neither an effective advocacy role nor services that meet the needs of their members, they will not be relevant and sustainable. An indication of this is that the numbers of member MEs may be growing but that "only few renew their membership" and only a minority is satisfied with the results of their membership⁴⁷.

Realistic business strategies and plans could partly redress lack of sustainability and ensure continued service delivery. MEDEP is supporting DMEGAs in their development. This and the reduction in subsidies seem to be the main elements of the project's exit strategy, though this has not been explicitly formulated. However, there has been no market assessment to base the business plans on, which weakens their feasibility. Judging from experience so far, MEs' willingness to pay for services, especially when they were always free, is likely to be minimal. The DMEGA Boards and executives seem ill-prepared for the transition to more financial independence. Some reported they did not realise this was to happen "so

⁴⁷Stephan Schmitt-Degenhardt, "Transition to Sustainability, Capacity Development Strategy for MEDEP IV", 2014, page 29

soon”. Some show little of the vision or entrepreneurship that will be required to implement the business plans, though others do.

NMEFEN is in a similar position, though dependence on MEDEP funds is less and the leadership appear committed to raising income. It sees advocacy as the organisation’s core function, though networking among and services to DMEGAs remain part of its plans.

What happens over the coming year will indicate whether the plans are realistic, will be implemented and can have an impact. For many the plans will come too late as they will take time to bear fruit.

The project document’s strategy proposed “limited” funding and sharing some of the costs of services”, for the DMEGAs and NMEFEN and a commercial approach from the start. This has not been happened. The MTE team judges that document’s aim of “commercial” sustainability of a wide range of services was to start with unrealistic. However, good practice in support to Business Membership Organisation includes:

“As a general rule, financial assistance to BMOs (Business Membership Organisation) should not exceed 20 to 30 percent of the beneficiaries' annual budget and 30 to 50 percent with regard to co-financing the start-up phase of new activities..... High dependency on grants makes (a BMO) vulnerable and undermines its position as an independent organization”⁴⁸.

This has not been applied, and with the best of intentions MEDEP has created a dependency that will be hard to overcome.

Does this mean the DMEGAs can be expected to fail? Some of the Mets interlocutors in the Districts answered this question in the affirmative. The MTE team noted that where MEDEP funding has been, or is expected to be reduced, especially service delivery staff is leaving or plan to do so. With reduction in salaries of staff, these may follow suit.

Is sustainable delivery of MED services at scale in place or likely to be so (**component 4**)?

The previous section demonstrated how the capacity to deliver MED services has been increasing in scale, both in terms of EDFs and MEDSPs. Whether this has resulted in a greater scale of service delivery will be considered in section 5.3, on ME creation (figures on delivery and creation are the same).

In principle there could be potential for greater scale. This would depend on the availability of funds because delivery is fully dependent on MEDPA and MEDEP. Funds from the MEDEP and MEDPA budgets combined are currently increasing slowly only through the GoN contribution, much more expansion cannot be expected, apart from geographical coverage. When MEDEP funding comes to an end, scale will be reduced, as also indicated under component 1. The market for MEDSPs will contract significantly.

Availability of funds affects sustainability too. Even at current levels, lack of enough work volume for MEDSPs makes the question of their sustainability challenging. The market for MEDEP’s service model is by nature limited. It is also insecure, as income depends on winning tenders. MEDSPs are not able to provide full-time jobs throughout the year for the EDFs and other staff that they need. This creates problems in the retention experienced staff. At individual level the EDFs may also find difficulty in

⁴⁸Strohmayer, R. et. al., “Building the capacity of Business Membership Organisations”, World Bank SME Department, no year, page 64

sticking to the EDF role as they receive short term contract only (3-5 months a year). A smaller market would exacerbate these constraints.

A further important concern is that GoN staff for outsourcing, supporting and monitoring the services is not in place. This will affect the functioning of the MEDSP market, as well as the quality of its outcomes. So far MEDEP staff have provided direct support when necessary, but this will also not last beyond 2018. The project document speaks of MEDSPs having become “commercial operations”⁴⁹. However, a study on the institutional capacity of NEDC and MEDSPs for MEDEP in 2014⁵⁰ identified the structural mismatch between the 'NGO construct' and 'private sector business model' of operation of these entities. The intention was that “by providing MED services the promoters will have professional engagement for financial benefits”. On the contrary the NGO's regulatory acts do not allow the board members to make financial/professional gain from the operation of such entities. This leads towards losing interest of the promoters (who in most of the cases are the experienced EDFs), and in the long run “the board” could become non-functional or indifferent to what the organization is doing.

The same study also found that some of the MEDSPs have been able to go beyond MEDEP/MEDPA and become successful in mobilizing resources for different types of projects and services (including in MED) from other donor agencies. This is positive and the MTE confirmed it. However, the financial sustainability of the organizations themselves remains uncertain. The institutional capacity study suggested exploring the possibility of promoting commercial private sector organizations/firms to take up the role of MEDSPs, and also consider helping the people in the NGOs to convert to them to, or to start private firms as MEDSPs. Although conceptually the bidding is open for both NGOs and private sector agencies, it is very rare to see significant number of “private for profit” organizations participating in the bidding process and winning the bids. There are very few such examples with almost 95 percent of the MEDSPs being NGOs. The study's suggestions have not been taken up by MEDEP, possibly influenced by a reported preference of UNDP for NGOs. The MTE believes this to be misplaced as commercial providers have stronger incentives to deliver.

The study includes many useful suggestion and recommendations in relation to improving the capacity of MEDSPs. Any significant actions taken by MEDEP based on these are not clearly visible and the question about the sustainability of MEDSPs remains.

NEDC could potentially help address the above issues, with MEDEP advice, by developing a clear vision and plan on how the MED and related services market system could work sustainably, especially beyond 2018. This would have to be commonly agreed by MEDSPs involved and interested in MEDEP/MEDPA activities.

One of MEDEPs interventions where it has truly considered the market system for MED, and looked beyond a direct support solution to a constraint is the training of EDFs. Instead of MEDEP training them this is now institutionalised on a sustainable basis, independent from MEDEP or MEDPA funding. This is a significant achievement, and MEDEP should apply the thinking on which it is based and lesson learned to other parts of the system. Of course the contraction of the MEDEP model market will also affect the demand for EDFs, but these have a broader set of skills that has proven to be in demand at organisations that do not use the model. As long as there will be employment possibilities in the market it is most likely that EDF training institutes will remain in the market and possibly more will enter it.

⁴⁹ Page 42

⁵⁰ Review of the institutional capacity of National Entrepreneurship Development Centre (NEDC) and Micro-Enterprise Development Service Providers (MED-SPs), 2014

The revision, updating and improving the curricula of the EDF courses would be required periodically. Coordinating this could be a function of the MoI MED section.

Finally, have MEDEPs an intervention under Component 5 resulted in a sustainable system for delivery of financial services at scale, or is this likely to be in place by the end of the project?

In section 3.1.5 it was demonstrated that the scale of outreach of financial services to MEs is expanding, as a result of partnerships with FSPs and developing cooperatives. The potential for further scale is in theory significant. The financial mapping study identified some 253 financial services providers, and MEDEP MEs, currently 40,000 “active” and MEDPA MEs are organised in groups which could be developed into cooperatives.

However, a plausible and sustainable strategy for reaching scale is as yet not defined. MOUs between DMEGAs and FSPs to expand the number of ME clients are in principle valuable, but the sustainability of DMEGAs is questionable. Further partnerships with FSPs are not planned. Scale is expected to be reached by additional FSPs “crowding in”, i.e. starting to target MEs because it has shown to be a good business opportunity. This is not happening yet, though it is an encouraging sign that one of the existing partners is seeking expanding its agreement with MEDEP to all 75 Districts. The Central Bank’s policies promoting lending to MEs could play a role but unless incentives for FSPs are strong expansion and sustainability of lending to MEs will remain limited.

What are the incentives from FSP’s point of view?

- MEs are already organised in groups and there is no need to provide them with skills training (as some FSPs do). This is a cost saving.
- The substantial investment MEDEP has made in developing MEs means they are less likely to fail, which reduces risk.
- Repayment rates so far are very high, close to, or at 100 percent⁵¹.
- Some FSPs stated their service was already profitable in spite of high costs, though others found this would take several years to achieve.

These are good indications that current FSP partners are likely to continue serving MEDEP MEs. This was confirmed by those interviewed. Concerns are:

- The number of FSP partners is likely to be too small to continue to reach scale beyond 2018, and currently NMEFEN, DCSI and CSIDB do not have the capacity to continue to facilitate expansion. Their involvement so far has been limited. Developing partnerships is not part of the MEDPA Operational Guidelines.
- There are probably limits to the extent to which FSPs can expand their coverage profitably to remote and dispersed MEs without technological innovation such as mobile lending⁵².
- FSPs targeting MEDEP and MEDPA MEs narrows their market (and therefore commercial viability of the services) and creates an unnecessary exclusion.
- The doubtful sustainability of DMEGAs raises the question who will link FSPs to MEGs following project completion.

⁵¹The more telling portfolio at risk rates were not available.

⁵²See for instance http://www.ifc.org/wps/wcm/connect/region_ext_content/regions/sub-saharan+africa/news/wizzit_southafrica

For cooperatives replication is planned (more cooperatives formed in the same way). This is relatively cost-intensive, paid for by MEDEP, and not foreseen under MEDPA's Operational Guidelines and budget. MEDPA has formed few cooperatives and its capacity to do more is limited. Having MEs lend from existing cooperatives, or becoming part of them, could be an alternative in some areas, but even this would need to become a function of one of the players in the MEDEP system and would need to be funded.

Once cooperatives are functioning their sustainability is likely to be good, given that members benefit through savings and credit services. Interest rates are not significantly lower than those of FSPs, but repayment rates are high at close to or at 100 percent.

For insurance the most plausible scale strategy is to keep including it in loan contracts, as is being done. Here too the lack of technological innovation is a limit on outreach⁵³.

In conclusion, while the regulatory and policy basis for the MEDPA system are sound, there are significant weaknesses in implementation that were found to threaten sustainability and scale. Limited funding through the MEDFs and lack of capable GoN staff are the most critical. The latter was identified as an influencing factor (risk) in the Theory of Change. The second is the result of the interplay between weak governance (identified as a risk to the Theory of Change by the MTE) and concerns of the donor which had not been foreseen.

Outsourcing of services for MED is currently functioning, though some implementation issues need to be addressed. Continued scale and sustainability depend on DCSI and CSIDB staff being in place and on the continued availability, and level of funding since the services are fully financed by MEDEP and MEDPA. Given the limited funds in MEDFs and that MEDEP funding will come to an end, there is a risk to the longer term sustainability of the MEDSPs as organisations, and therefore service provision. The Theory of Change in the project document insufficiently foresaw the contraction of the market and that NGOs are not actually for-profit businesses. For-profit providers would have stronger incentives to look beyond MEDPA for additional clients.

Current and potential scale of the DMEGAs and their outreach are large. Their sustainability is doubtful and a nation-wide, effective system for service delivery cannot be expected by the end of the project. This is not due to an external risk to the Theory of Change but to the aim of commercial sustainability of services itself being unrealistic. The high levels of funding and lack of focus on advocacy have meanwhile increased the vulnerability of the DMEGAs. The MTE team expects that, depending on various factors, including good business plans, development of the advocacy function, (limited) funding from the MEDFs or DDCs and entrepreneurial leadership, some will fail, some will be reduced to a bare minimum of services paid for from membership fees, and some will flourish by raising funds from different sources.

In terms of providing access to credit that is likely to be sustainable the system is functional at present and delivering benefits. What will have been achieved by the end of the project is likely to remain in place. However, expansion is dependent on MEDEP and whether MEDPA will be able to continue this will require clear allocation of this function, capacity building and funds. These have so far not been provided and a system for managing and expanding access to credit beyond MEDEP's completion is not in place. This is at least in part due to this having been insufficiently specified as an aim and in the Theory of Change in the project document, and MEDEP's strategy having further de-emphasized it.

⁵³See <http://www.bbc.com/news/world-africa-35942844>

Evidence-based policy making is unlikely to be in place by the end of the project. It is doubtful that research for ME policy making and advocacy would survive beyond the project unless donor funds can be accessed for this purpose. The Theory of Change assumed a market for research and evidence based policy making. Advocacy for MEs by NMEFEN, however, may continue if MEDEP takes a purely facilitative and capacity building role.

While, therefore, MEDEP achievements have been positive in many areas, there are major concerns with regard to the final result that can be expected. This is in part due to an over-ambitious project design, logical assumptions in the Theory of Change that did not hold true, high levels of risk that did not sufficiently inform design, and weaknesses in project interventions and implementation. In the MTE's view the inclusion of creation of a large number of MEs by MEDEP itself was a design error that has severely affected MEDEP's ability to facilitate the establishment of a sustainable MED system at scale.

Could the service delivery system work without some of its elements? This depends on what one expects from it. If one aims at ME creation, growth and resilience, the key elements of the system are DCSI and CSIDB, to outsource services and continue expanding access to credit, the MEDSPs and FSPs/cooperatives to deliver services, and the MEDFs and DDC/DEDCs to ensure the availability of funding. While the MTE agrees advocacy, and therefore DMEGAs and NMEFEN, is important, if these organisations fail MEs can be created and assisted to grow without them.

3.3 Impact trend

The final goal of the programme is to contribute to poverty reduction and employment generation in Nepal through Micro Enterprise Development. MEDPA, MEDEP and Local Bodies together are expected to create 73,000 MEs, with targets set for inclusion of vulnerable groups. This chapter considers the extent to which this is being achieved. This is the final level of the Theory of Change. Positive findings here do not, however, indicate that the sustainable system for service delivery has been achieved, which, as concluded in the previous section is not the case? Rather, they are the result of direct implementation by MEDEP, MEDEP implementation support to MEDPA and of MEDPA managing to outsource to MEDSPs, which are the strongest component of the delivery system.

The table 6 in appendix A, shows results against the key indicators MEDEP assesses in accordance with its results measurement framework. Not all data were available to the MTE, in particular from MEDPA. Further analysis on the impact trend as MTE have noted are discussed below.

3.3.1 ME creation, jobs generated, sustainability

Total ME creation by the end of year 2015 is approximately 45 percent of the total target of 73,000. Considering MEDEP, MEDPA and Local Bodies separately, the achievements are 48, 55 and 5 percent respectively. Local Bodies refers, though, to ME creation funded by them, not by them. The low achievement reflects low financial contributions as already noted above. If their and MEDPA's progress is considered together this amounts to 41 percent of the combined target. Overall progress has been good, especially considering the effects of the 2015 earthquake and blockade in the border with India for a long period.

According to MEDEP all those who go through the programme of service delivery start MEs, which is an unusual achievement. Data on ME creation therefore reflect access to services.

Focus Group Discussion and interviews with entrepreneurs conducted by the MTE confirmed that MEDEP support was instrumental in starting the MEs.

Job creation is on track, at 51 percent of the target. This includes the entrepreneurs, i.e. few MEs create additional jobs.

As in any MED programme, not all MEs that are started survive. Of course this applies to enterprises generally, whether started with a programme's support or not. As reported, nearly 19,000 MEs have received services to become resilient and scale up. The table 7 in appendix A, shows survival rates since 1998. The higher rates in later years do not necessarily reflect an increase in effectiveness and impact, but rather that MEs created recently are more likely to be still in business, while with the passing of time more fail, as could be expected. The data indicate that after a period of 10 years, some 50 percent have survived (discounting semi-active MEs). This is a remarkable achievement, indicating both the effectiveness of start-up and resilience support. It compares for instance to small business survival rates in much better conditions (in the US) of around 50 percent after the first 5 years and a third after 10 years⁵⁴. Comparable data from MEDPA are not available.

MEDEP defines resilient MEs as those still in businesses at least 2 years after "graduation", without MEDEP support. A study done in 2014 defined resilience more precisely as "the ability of a business to protect itself from untoward unexpected events and risks and to continue the business in changing business environment and surroundings"⁵⁵. It developed 16 indicators and assessed enterprises against them. It concluded that 8 percent of the MEs were "resilient" while 42 percent had potential to be so. This would imply that longer-term sustainability of 92 percent of the enterprises is doubtful. The above data indicate that in fact half the enterprises do survive for 10 years or more. One of the study's weaknesses is the absence of a comparison with non-MEDEP MEs owned by members of the same target groups.

The project document states that of the 73,000 MEs created in this phase 60,000 should be resilient. This was of course unfeasible given that it takes time for MEs to reach this stage and to for this to be demonstrable. The MTE understands that the project is proposing to reduce this target to 20,000, which is reasonable⁵⁶. Project projections indicate this will be achieved. If, more simply, ME survival is considered it is likely that some 90 percent of the MEs will still be in business by the end of Phase IV.

3.3.2 Inclusiveness

The table below provides data on the level of poverty of those who created enterprises with MEDEP support. Nearly all fall below the poverty line (97 percent) and the majority (54%) falls under hard core poor category. The MTE considers this an excellent achievement in targeting. MEDPA data are not available to allow a comparison.

Poverty status	Rate
Hard Core Poor	53.87
Non Hard Core Poor	43.49
Lower Middle	2.51
Middle	0.07
Well Off	0.03
Others	0.03

Source: MEDEP MIS

⁵⁴ SBA Office of Advocacy, https://www.sba.gov/sites/default/files/FAQ_March_2014_0.pdf

⁵⁵ Institute for Policy Research and Development, "Assessment of Effectiveness of MEDEP's Support to Make Micro Entrepreneurs More Resilient through Job Creation and Livelihoods Improved", February 2014, page 58

⁵⁶ MEDEP Excel sheet Results Chain_Impact_Outcome_Output_MEDEP IV Phase

One way in which MEDEP supports the creation and survival of MEs of the hard-core poor specifically is through establishment of Common Facility Centres. DDCs, VDCs and other ministries contribute to funding. In 2013 MEDEP supported MEs with 29 new CFC against the target of 25 CFC and scale up support for 23 existing CFCs while target was 45 CFC. It is not possible to compare survival rates of MEs in and out CFCs but the recent mass impact study and the MTE's own findings indicate they are overall functioning well and that entrepreneurs consider them important to their success.⁵⁷

Gender equality and social inclusion (GESI) are measured by looking at the representation of men, women, and deprived populations of programme districts, who lack access to available economic opportunity and resources. MEDEP and MEDPA have clear targets for social inclusion. ME creation should be 30 percent by Dalits, Indigenous Nationalities 40 percent, other castes 30 percent, unemployed youths (16-30 years) 40 percent, Madhesi 40 percent. Women should account for 70 percent. MEDEP uses standard of UN Gender Inequality Index to measure the result for women. The targets have been institutionalised in the MEDPA Operational Guidelines. As shown in Table 8 both MEDPA and MEDEP have exceeded the 70% target of women among the MEs created by 78% and 76% respectively. However both achieved 40% target of indigenous. On Dalit target of 30% MEDPA achieved 28% and MEDEP 24%.

Despite targeting these vulnerable groups and women being a big challenge in the Nepalese context, MEDEP and MEDPA are overall on target, as demonstrated by the data in the table below. There are some shortfalls in targeting Dalits (MEDEP) and Madheshi (both MEDEP and MEDPA but especially the latter). The Mass Impact Study also noted this. This may be in part due to the district coverage. Interviews conducted by the MTE indicated, though, that many members of the poorest and vulnerable groups simply cannot afford not to work but participate in training. This was also noted by a 2014 impact study⁵⁸. On the other hand, inclusion of women exceeds the target, which is a significant achievement.

3.3.3 Income

In accordance with the DCED Standard for results measurement, MEDEP assesses and reports on total additional net income created by the MEs. The results are in the table below. Enterprises have on average experienced more than a doubling of income. This is impressive. The figure for 2015 is low as data are not (yet) available.

MEs Income Gain since Project Start (MEDEP Only)

Year	Production Cost (Rs)	Sales Revenue (Rs)	Profit (Rs)	Gain %
2013	187,603,169	476,396,504	288,793,335	154
2014	80,912,035	278,322,603	197,410,568	244
2015	14,007,725	28,270,055	14,262,330	102

Source: MEDEP MIS

⁵⁷ Development Resource and Training Centre, "Mass impacts on entrepreneurs of the selected products and services promoted by MEDEP", December 2014

⁵⁸ (No author), "Impact study on Empowerment of Women, Dalits, Indigenous Nationalities and other hardcore poor through MEDEP", December 2015

The MTE notes, though, that enterprise financial data are notoriously unreliable. That this present actual net income (which means subtracting income lost from other activities) may also be doubtful. What does seem clear is that, on average, enterprises did increase their incomes significantly.

While earlier impact studies have found similarly high increases in income, some have attempted to calculate what is attributable to MEDEP, e.g., by comparison with a control group and taking into account overall trends in income (as also required by the DCED Standard). The most recent study to do so estimated that a 56 percent increase on average could be attributed to the programme⁵⁹. This better reflects MEDEP's impact on incomes, and is still an impressive result. The study also found increases in savings and other assets.

An impact study conducted in 2010 found that as a result of income increases 73 percent of entrepreneurs moved out of poverty⁶⁰. The recent Mass Impact Study found an even greater impact with more than 90 percent of the households with active MEs moving out of poverty.

Focus Group Discussions with MEs under the MTE confirmed significant impact in incomes, due to having started an ME.

The averages reported do, however, mask considerable variation, with hard-core poor, women and vulnerable groups having increased their incomes less than other groups, and larger percentages not having increased their incomes. The referenced impact studies make detailed recommendation on addressing this.

3.3.4 Social and other impact

Considerable social impact and impact on quality of life has been demonstrated, by the 2014 Impact Study on Empowerment and the recent Mass Impact Study. This is not part of MEDEP's Theory of Change, but is an effect hoped for by the project donors.

The studies found, in brief, that:

- Women have a stronger role in enterprise related decision making.
- Food security and consumption has improved due to higher incomes.
- Women have been able to increase their network and become members of different groups.
- Women and other groups have enhanced confidence due to access to information and exposure, and greater participation in local groups and networks.
- Status has increased, in particular of women, as a result of higher incomes, a larger contribution to household income, and ability to work with outsiders.
- Women have a greater say in decisions both at family and community levels, including on how to spend income in the household.
- Spending on children's health care and education has increased due to higher incomes and awareness of the significance of these services.
- There have been small changes in discriminatory norms and practices on the basis of caste and gender, mostly due to social change in Nepal, strengthened by higher incomes and status.
- There is a strong increase in participation in VDC and DDC meetings.
- Capacity to claim services and right from government offices has increased.

⁵⁹ (No author), "Impact study on Empowerment of Women, Dalits, Indigenous Nationalities and other hardcore poor through MEDEP", December 2015

⁶⁰ Impact Assessment of Micro Enterprise Development Programme, Dec 2010

The impact studies have also found that the creation of MEs that use local resources has a multiplier effect: on employment creation and more opportunities to earn locally, which further contribute to social and economic empowerment.

These are important findings, which demonstrate that the impact of ME creation goes well beyond income and jobs for those who run them. While the study covered MEs created by MEDEP in earlier phases there is no indication that the impact will be different in the present phase or for MEDPA. Also in this case, however, the study noted considerable variation in impact among social groups, and made recommendations to address them.

The MTE also notes that many of the decision-making positions in the MEDSPs, NEDC, NMEFEN and DMEGAs are occupied by women and some cases socially excluded groups. This can be partly attributed to the training and awareness raising done by MEDEP. As already noted in section 5.1, target group members have been trained and found employment as EDFs. The table below shows the make-up of the group of EDFs certified so far. Many work in their own communities, which can be expected to have a further empowering effect.

In conclusion, MEDEP and MEDPA are making good progress against their ME creation targets. Impact on jobs and incomes can be expected to be good. Further impact on social and quality of life indicators has been demonstrated. MEDEP has reached deprived segments of the population and with a programme that does not provide just short-term relief but that provides people with a capacity that is self-sustaining and empowering. Differences in impact remain, with the most disadvantaged overall benefitting less. There remains the questions like 'even if many people are assisted and assisted well, is this really the most effective way of addressing poverty alleviation? Is it value for money? How should it be adapted giving the changing context and some of the new challenges in Nepal? Limited scope, limited allocated time for the MTE, and limited availability of the relevant data have been the limiting factors for detail analysis around these questions by the MTE.

3.4 An overview on GESI within the project

Gender and Social Inclusion is one of the key implementation strategies of MEDEP at all intervention levels of the project. MTE have looked GESI in MEDEP at different levels;

- at ME creation level:
- At scale up support level
- at DEMEGA level
- at institutionalization level within MEDPA

MEDEP targets socially excluded groups as its primary beneficiaries. The socially excluded groups are among poor and people living below the poverty line that comprises of women – 70 percent, Dalits – 30 percent, Indigenous Nationalities 40 percent, Youths (16 to 40 years) – 60 percent and Madheshi – 40 percent. The ME creation data from MEDEP and MEDPA indicate that GESI has been effectively taken care and the basic criteria for GESI is being duly met by the project.

GESI disaggregated data of scale up support was not available at the time of MTE both at MEDEP and MEDPA, however the participants of FGD at CFCs conducted by the MTE have mentioned that the focus and coverage of MEDEP and MEDPA in terms of Gender and Social Inclusion is clear and the selection process of MEs for scale up support is also very participatory and satisfactory on GESI coverage. This was clearly evident among the participants of the FGDs conducted by the MTE team at CFC level, where

almost 80% of the participants were from women, dalit, indigenous/Janajati groups except in the case of one or two places where the total target community were from other categories.

Out of 713 EDFs 541 are available for MEDEP and MEDPA of which 311 women, 230 men, 161 IN, 127 dalit, 2 Muslim and other 251. MEDPA have collaborated with the private sector EDF training institutes for GESI considerations in the EDF trainees' selection, and also provided few fellowships for economically challenged trainees from different disadvantaged groups. Table below presents the percentage of EDFs from different disadvantaged groups who are providing their services under MEDEP and MEDPA contracts.

Group	Number of EDF	Percentage
Total	541	100
Women	311	57.5
Men	230	42.5
Dalit	127	23.5
Indigenous	161	30
Muslim	2	0.4
Other	251	46

It is envisaged that the demand for EDFs is going to increase significantly in next two to three years. The EDF training institutes from private sector do have that interest and capacity to meet the future need for EDFs, however in absence of any incentive mechanisms the inclusion of disadvantaged groups among the participants of EDF courses may not necessarily maintained.

The table below reflect the GESI disaggregated data of certified EDFs that are available in the current market.

Make up of Certified EDFs

Group	Women	Men	Total
Dalit	115	31	146
Janajatis	146	61	207
Madheshi	38	69	107
BCTN	161	146	307
Total	460	307	767

Source: data provided by MEDEP

The MEDEP has set norms for the representation of women, dalit, Janajatis/Indigenous people in the MEAs (especially at DMEGA), and the DMEGA bi-laws also incorporates such provision. MEDEP has advised all association and committees must have appropriate women and social group representation by ensuring women, dalit and indigenous people occupy 60%, 21% and 36 percent respectively of decision making position in all DMEGA across the country. The table below shows the GESI representation status of the DMEGAs, which meets the set target percentage for GESI at the decision making level. The active and effective involvement of these representatives is relative to the local situation of empowerment of these groups, which was distinctly visible during the interactions with DMEGA across the districts visited by MTE team.

FSP outreach to women and disadvantaged groups is similar to MEDEP targets overall, with 77 percent women, 20 percent Dalits and 45 percent indigenous groups.

CFC facilities in one hand seem to be effective in helping the MEs improve their productivity and quality, but in other hand does not meet the basic standards in relation to; water and sanitation facilities in the CFC, enough storage and working space, and child care facilities (as a matter of standard specification, but may vary according to the local needs of the affiliated MEs at the CFC). Such conditions have linkage with assurance of GESI related needs of the MEs in particular for women entrepreneurs who work in the CFC.

GESI status in DMEGA

GESI in Decision Making Position (either chair, secretary, or treasurer)	DMEGA (%)
Women in decision making position	62%
Dalit in decision making position	21%
Indigenous Nationality in decision making position	48%
GESI in Executive Committees	
Women in Executive Committee	59%
Dalits in Executive Committee	19%
Indigenous Nationality in Executive Committee	47%

Source: MEDEP Data Base

Out of 38 MEDEP districts only 15 districts are in Tarai area comprising Madhesi population. AS per CBS 2011 data, the total population of these 15 districts accounts only 36% of the total population of the 38 MEDEP districts. Out of the total population of these 15 Tarai districts all are not from Madhesi origin, a good percentage of the population here are also from hill origin. So in the districts where less than 30% are from Madhesi origin, the target of 40% Madhesi among the MEs created by MEDEP is not realistic. Unless a higher percentage of the ME creation target is allocated in these districts, the 40% target is not going to be achieved by MEDEP. MEDEP is allocating about 220 ME creation target each year per district (2014-2017), it may not be possible for MEDEP to reduce this already very small annual target from other districts and increase the target in fifteen Tarai districts. However, it appears that by 2017 MEDEP will have allocated about 40% of the total ME creation target in these 15 Tarai districts.

The operational guideline of MEDPA has incorporated:

- The GESI targeting criteria and allocation percentages to women, dalit, Indigenous, groups, and Madhesi. At the implementation level the ME creation data of MEDEP and MEDPA both give the impression that these criteria are being complied effectively.
- the policy of priority marking in the evaluation of the tender bids of MEDSPs in the case of women EDF is proposed is also being practiced in both MEDEP and MEDPA.
- Integration of one day GESI training into Entrepreneurship Development Training curriculum. From 2015, it has been applied to all MEDEP and MEDPA districts.
- The DEDC has representatives from all the social groups and organizations including Dalits, Indigenous Nationalities, women Coordination Committee. The membership of the DEDCs is about 20 people, in which only the women development officer and one nominated women members are there. Most of the representatives in the DEDC are ex-officio members therefore the presence of Women member in DEDCs largely depends on who is designated by the respective agencies sending their representatives in DEDC.
- The operational guidelines of MEDPA gives emphasis on GESI consideration in selecting the target groups for ME creation, the revised operational guidelines include the percentage of different target groups that the project targeting should aim for. Transforming 'targeting approach' into practise is not an easy task, however MEDPA and MEDEP are making it happen. GESI concept has been incorporated in the EDF – curriculum.

3.5 Project implementation set-up and management

MEDEP is implemented by MoI, which has appointed a National Project Director (NPD) supported by the MoI's Micro-Enterprise Unit. They are responsible for overseeing overall implementation of the project, as well as of MEDPA. MTE interviews indicated a high level of commitment and knowledge of the project, especially with the NPD. Project management and senior staff are in frequent contact with the NPD, who is involved in planning, reviewing progress and facilitating relations with other ministries. Actual implementation is by the project team, which is set-up along a three tier organizational model:

- A Central Office, known as National Programme Support Office, in Kathmandu
- 8 Area Programme Support Offices (APSOs) located in Dhangadhi, Surkhet, Dang, Pokhara, Kathmandu, Hetauda, Udayapur and Biratnagar
- District Focal Points stationed in MEDEP districts, covering MEDEP as well as MEDPA districts, where either a Government Support Specialist (GSS) or a Market Development Specialist (MDS) are assigned. Supervised by the APSOs, the GSS and MDS provide their services to more than one district.

The project is headed by a National Project Manager (NPM). Within the National Programme Support Office, the structure reflects assigned responsibilities along the five Components of the Programme, which are headed by Component Managers. GESI/Institutional Development is treated as crosscutting to all components. Monitoring and Results Management (the project's internal system) and MIS are operating distinctly as key function of management and have staff assigned in the APSOs as well.

As all the components have their own outcomes, outputs and result indicators, the main focus of the components is on delivering 'their' results. Thus at times the components appear to be operating in silos, within a focused domain. Discussions with staff confirmed this creates overlaps, duplication of efforts, and difficulty in keeping track of the information and knowledge created. There are, however, also positive instances of synergies, e.g. where component managers work together to strengthen the different roles of NMEFEN.

GSS and MDS staff functions in a matrix system, reporting to the APSO manager (micro enterprise development specialist) as well as relevant component managers. Two reporting lines have contributed to some confusion (as reported by district staff), especially at the APSOs, about the activities staff are expected to undertake. The roles of GSS and MDS is crucial for facilitating transition from MEDEP to MEDPA at district level, however currently their 'technical inputs' to the 'distantly supported districts' are limited. Though the GSS and MDS are supposed to be 'expert positions' with technical skills, however over the years they are providing 'generalists' services. This has implications on how the project is catering to the capacity strengthening needs of the MED actors in the districts in technical areas (e.g. market analysis and development).

The complex nature of the work related to supporting institutionalization demands a different set of "skill mix" within the project team than that in the previous phases: for instance a proper understanding of the GoN operating system, planning budgeting, Public Finance Management (PFM) process, GoN organizational culture and practices, the political process, and good practice in facilitation and capacity building. It also requires a higher level of "professional power" to be accepted by GoN stakeholders.

The MTE found MEDEPs current skill mix in the team is overall more focused towards the management of ME creation and less on institutionalization. Interviews with staff indicate this may be due to: i) the "comfort zone effect" (you are comfortable doing what you have been doing since long and prefer to do what you are comfortable with); ii) Lack of understanding and role clarity for institutionalization support,

and mentoring, and iii) the team does not sufficiently possess the required skills and competencies to support institutionalization. In addition, the high target for ME creation diverts the team from its core institutionalization task. There has been little investment in staff development to enable them to fulfill this task.

A Chief Technical Advisor (CTA) has been seconded to the MoI to provide policy and implementation guidance to MEDPA and liaise between MEDPA and the project. The current CTA is a high-level expert of MED in the country and he also brings in a long legacy of his involvement as NPM of the project. He was supposed to be housed at the MOI⁶¹, but is still physically located within MEDEP, due to “lack of space”, in spite of his efforts to move. This reduces his effectiveness in the role foreseen. Since he commands great respect in the project, it may also affect the functioning of the team.

A Senior Institutionalization Specialist (International) was foreseen in the project document but not assigned because of objections of GoN. This has affected the project’s effectiveness in its core task.

The project’s MIS was already discussed in sections 5.1 and 5.2. It is only partly functional and is a database of MEs (creation, scaling up support, etc.) rather than providing a real time picture of the activities of the project as a whole. Data on MEDPA are not available, apart from the most basic. At NPSO level insufficient is done to analyze data to create knowledge products and provide feedback to management and service providers. In its present form the MIS does not adequately inform project management and decision making.

The project document foresaw the MIS would be complemented by a Monitoring and Results Management (MRM) system based on the Standard of the Donor Committee for Enterprise Development (DCED). The DCED standard is for enterprise development programme. MEDEP IV is an institutional development programme that aims at putting in place an enterprise development system. These are two different things and the project document should not have included the requirement to follow the DCED Standard. Moreover, putting in place a Monitoring and Results Measurement system that meets the Standard requires extensive use of international, DCED specialized expertise. While external M&E expertise was used, it took half the project period to develop the basics of the system.

The principles of the Standard, however, apply to development interventions generally: Clear impact logic for the entire programme and results chains and measurement plans for interventions. These have been largely finalized, but indicators (including those in the project’s results measurement or logical framework) do not adequately reflect the institutionalization objective. The system has not yet had an effect on intervention (re)design.

The project has not maintained a trajectory of various reviews and studies. Several good studies have been undertaken by MEDEP in the past, but it is not always clear how they have informed design of the project’s activities. The Capacity strengthening needs assessment and the Strategy, referenced several times in Chapter 3, for instance, it has not resulted in a concrete plan, and however some of its recommendations are being captured by the AWP of 2016 now.

Common management tools and practices (e.g. work planning, regular team meetings, budgeting and tracking of expenditure) are in place. Annual meetings of the entire team are probably insufficient to maintain a sense of common purpose, review progress, revise interventions, and address common challenges.

⁶¹ By the time of finalization of this report the CTA has already moved to MoI, which has led to the starting of MED section within the ministry.

A steering mechanism, in the form of an inter-ministerial Project Board which also includes the private sector, UNDP and DFAT, is in place and functioning.

UNDP's role comprises "programme assurance" and largely administration and finance support services. A Programme Analyst was assigned to the first function. At DFAT two staff has been assigned. As DFAT has no function in MEDEP apart from engagement in the steering mechanism, the balance between UNDP and DFAT oversight appears awry. In the MTE's view this is symptomatic of a lack of confidence between the two, which has resulted in weak strategic guidance, an emphasis on detailed directing of the project in its operations, minute reviews and commenting on reports (rather than providing a strategic response), etc.

This is partly rooted in UNDP's and DFAT's "vision" for the project and its strategy for achieving it not appearing to coincide, in terms of for instance the importance of ME creation and what can be reasonably expected from GoN and other partners. Disagreements about the feasibility of the MEDFs as recipient of DFAT funds, and the importance of the MEDFs as a key element in the MEDPA structure, after what the MTE finds was an intensive and lengthy series of assessments, is just one instance of this. This has had a clear impact on the project team and its work. The project document seemed its only safe ground, and it has felt disinclined to depart from it, even if it found there were better ways of doing things. ME creation in particular was a low-risk area. This has been reinforced by programme assurance, which has held the project to targets rather than stimulating innovation, out of the box thinking, and entrepreneurship.

It has also been a factor in what the MTE found to be an inward looking culture in the project, in which self-criticism and having an open mind for outside criticism or new approaches is not being nurtured. Again, this has affected the creativity and innovativeness of MEDEP's experienced staff.

Weak relationships with and lack of learning from other MED and private sector development projects is a further issue in this constellation of factors. Projects noted they had sought cooperation with MEDEP but without success. MEDEP was invited to join an informal forum on market systems development but declined, reportedly because UNDP was not in favor. MEDEP is turned inward on itself. This has left its work largely uninformed by progress in the enterprise development field.

4. Overall Conclusions

Some of the major conclusions of MTE over the strength and areas for improvements are summarised in this section which are mainly derived through the analysis of the achievements of the projects, consultations with various stakeholders at community, district and central level, This list is not exhaustive on itself, and may repeat some arguments from previous section of the report.

4.1 Major Success and Strengths of the Project

i) ME Creation

This is one of the success areas of the project. Both MEDPA and MEDEP are in track of achieving the ME creations target. However, the progress on the target achievement on the local bodies side (11000 ME creation) is not possible to achieve in the remaining period of the project.

ii) EDF Training

This is one highly success area of the project. Attribution of this achievement should not be limited to MEDP-IV rather a good result emerged through a longer period of efforts starting from the early days of

MEDEP. A flexible prototype of EDF training delivery capacity has emerged from the private sector, which on itself is another strong factor of this success. MEDPA can bank on this strength, however the EDF training institutes (now they have their association as well) or their apex association should be taken as a stakeholder in the future discourse of MEDPA.

iii) MEDSPs crowding in

Substantial number of MEDSPs (in NGO form) has emerged and is showing interest to serve for MEDPA, and MEDEP. Now the issue is not whether enough number of MEDSPs are available to fulfil the number of required MEDSPs to take part in the process, but the issue is how to sustain them working in the MED sector so that the interest, expertise, and number of active organizations do not decline because of lack of adequate business opportunities in the market.

iv) Outsourcing for MED services

MEDPA have accepted and practicing the 'outsourcing of MED services' of the MEDSPs through a competitive bidding process. The revised operational guidelines of MEDPA now also include the provision of outsourcing the scale-up support to the MEs through MEDSPs. This is a very positive initiative that MoI have taken, as this is comparatively new it is yet to be made a regular practice at the field level.

v) Strong Ownership of MoI

MEDPA is a unique example of GoN taking over the concept and model of a donor funded project into a regular GoN funded project. Although, the history of MED type of intervention goes back to late eighties within the DCSIO and CSIDB, however that was limited to a one shot short term training without any linkage to start-up enterprises by the participants. The governments strong ownership over the program is reflected not only putting the required policy, strategies and institutional mechanisms in place at different levels, but also in its act of allocating incremental resources to the project.

vi) Local Mechanisms for MED (DEDC/DEDP, VEDC/VEDP)

The local mechanisms to work on the planning, implementation, monitoring and facilitation at the district and VDC level are already in place in most of the project districts. As per the MEDPA guidelines formation of DEDC, MEDC and VEDC and have respective level periodic plans for Enterprise Development is required. Such mechanisms seem to be effective in sensitization and mobilization of local stakeholders and concerned agencies, draw increased level of interest and commitment on MED in their respective areas. They have also started demonstrating the potential of attracting the interest from other locally active development agencies working in the sector both from GoN and NGO/INGO sector.

The MTE noted that MEDEP have supported VEDP development process in 112 VDCs; however the data shows that 299 VDCs have already allocated resources for MED activities in the VDC. This is an indication of upcoming interest and commitment of VDCs on MED activities. During the field visit MTE interacted with VEDCs with/without VEDP and VDC officials with VEDP but with/without VEDCs. There seem to be a growing demand for the support in establishing the VEDC and also to develop the VEDPs. This is something new at Municipality level, however in those new municipalities where MEDEP, MEDPA were functional the former VDC officials now working for the municipality are very much interested to take-up MED activities and solicit for technical support.

vii) Strong Apex bodies at National Level :

Apex organizations of MEAs, MEDSPs, and EDF training institutes have emerged with strong possibilities of working as resource centres on MED. These entities are going to be good assets for the future implementation of MEDPA. NMEFEN, NEDC have already proven their ability to work on research and capacity building related activities under MEDEP in the past. A linkage between these apex

institutions and the MEDSPs, EDF training agencies, and DMEGAs may be a good functional support system to rely on.

4.2 Areas of Improvements

i) The MEDEP service model

Is more MEs creation still required? Or should existing MEs be supported to grow instead? Or should larger enterprises be supported that create many jobs? For many of the poorest and most vulnerable starting an ME, from scratch or on the basis of an existing activity is the only option as MEs that grow to the extent that they offer jobs to many are exceptional, and large enterprises do not locate in rural and remote areas. While the many of the MEs may remain at the “income generation level” and the large majority stay small, MEs started by the poor can and do grow and do create jobs. The MEDEP model supports this too.

The contribution in terms of economic growth may be limited, but in terms of poverty alleviation it is high. Cash income for many of the poorest of the poor is still a need, and can make a real difference in the life quality of the family. This is sufficient justification to continue to support the MEDEP model with public funds and to develop an effective and sustainable delivery system for the services.

While “linkages to markets” are a feature of the model, this is not sufficient and often not effective. MEs are, or should be part of value chains, without which they will remain at a subsistence level.

ii) Coverage of current services

Although by the end of this project MEDPA will be covering all 75 districts, the actual coverage in terms of individual beneficiary is quite small. At present MEDEP and MEDPA interventions are limited to 4-5 VDCs in each district of coverage, with less than 250 ME creation target. At the VDC level a target of 30-50 ME creation is noted at this point of time from both MEDPA and MEDEP. Considering the 23% population under the poverty line, in dire need for supports from the state for their subsistence, GoN need a serious thinking towards increasing input for MEDPA (as it has been taken one of the key interventions of GoN as an instrument to address poverty in the rural area for PBL) for increased ME creation targets across the country. GoN also need to make its efforts in bringing donor support for its increased coverage through MEDPA.

iii) Weak DMEGAs

The ME associations, in particular at district and national level does not need any further justification for their existence as they have the role in organizing the MEs, advocating for enabling policy and program environment for the members MEs.

By nature of membership composition and legitimacy, these associations are not 'professional service provider' agencies but they are more of a kind of 'interest and advocacy groups' with very limited managerial capacities.

Based on the discussions and interviews with DMEGA, MEDEP and NMEFEN officials, MTE had the opinion of:

- Within MEDEP, DMEGAs are being used as professional service providing agencies, heavily funded for professional activities which are beyond the managerial capacity of the office bearers. Many of them are completely dependent on the hired staffs, without understanding of what they are managing, and what they are accountable for? And, it is not their fault, as they have limited educational and management exposure and capabilities.

- The sustainability measures considered for these associations (such as higher collection of membership fee through enlarged membership, members contributions, fee for services to members, and 'winning service providing tenders' etc...). These options appear as hypothetical ideas only, the analysis and evidence based logic to believe that these options are; i) legitimate in the context of 'NGO identity' of the associations, and ii) hold viability from managerial, economic and professional capability point of view, are largely not convincing.
- The over dependency on MEDEPs funding, advice, and technical aspects, close technical support and direct monitoring from MEDEP have never allowed the associations to foresee themselves at a situation of 'without MEDEP' until very recently. This late realization of the need to stand alone without MEDEP has created a panic mindset among the leaders of these associations both at National and District level.
- At ME, MEG and MEGA level some level of interest and commitment to support for the sustainability of the associations has been also visible during the FGDs and interviews undertaken by the MTE. This is highly positive but may not be sufficient alone, and needs a clearly developed convincing plan of action to materialize such interest and commitments.
- In MEDPA (operational guidelines) positioning of associations interms of their role, operation and sustainability, and also any support provision for them are 'not explicit' 'not enough'.
- Although the 'GESI' criteria's are being followed by these associations, the level of assertiveness and active role in decision making demonstrated by the representatives under 'GESI' category need significant improvement. Although, some selective examples of emerging cases like 'Kasha Pariyar' ⁶² can be found in the chair of DEMEGA in Sindhuli Ms. Rita Bogati among those met by the MTE during the field visits.
- Considering the weak analysis and viability logics of the 'Sustainability Strategies' considered for these associations, MTE felt that MEDEPs' understanding and expertise on the management, sustainability and legitimacy aspect of 'Advocacy and Interest Groups' is either limited or overshadowed by the practice of using them as 'service delivery agencies'.

iv) Institutionalization of Capacity for 'Capacity Building'

Although the planned capacity building activities are being delivered, the recommendations of the capacity assessment studies are gradually being undertaken, the extent of envisioning of the ongoing future capacity development needs within MEDPA has not been captured by the operational guidelines, and budget allocation practices within MoI and its line agencies. The focus should be institutionalizing the CB strategy and MoIs capacity in 'building capacity' of the stakeholders within MEDPA in future sustainably. Episodic capacity building interventions may not necessarily result into a sustainable system for 'capacity Building'. There are already good examples like inclusion of MED in the curriculum of NASC courses through facilitation of MEDEP and MoI.

v) Institutionalization of Scale up support

One of the salient features of 'MED Model' of MEDEP is the scale up support in different forms to the selected and needy MEs, mainly from GESI groups. The concept, process and delivery mechanisms are already proven by the MEDEP practice in the field. This has been further refined to bring in MEDSPs to deliver such scale up support. However, the extent of such support interms of number of MEs who receive it is very low (in particular in MEDPA). IF the Operational Guideline of MEDPA be more explicit in the form, process and mode of availing such services to the MEs, have clear guidelines on making budgetary provisions for, and also set a fixed percentage of target MEs to receive such support.

⁶² She is the former Chair of NMEFEN, and a very active, exemplary leader of MEs created by MEDEP in the past.

vi) GESI policy and Guidelines

In general, the project is delivering 'GESI' in its interventions. However, from institutionalization point of view the GESI directives and provisions in the 'operational Guidelines' of MEDPA is very limited to the extent of targeting for the ME creation only. Issues like 'GESI' still need very fixative directions to be followed and monitored.

vii) MIS and Data Base

This is another area which needs a serious consideration. The full fledged functionality of the new MIS has not yet been achieved. The future plan of how MEDPA MIS will be managed from the view point of; i) by whom? at what level, ii) its viability from capacity, timeliness and quality perspective, iii) availability of resources, is not very clear at this point of time both at the end of MEDEP and MoI. The monitoring tools and systems are in place and captured by the operational guidelines.

viii) District Graduation

This has been one complex area of management within MEDEP. The achievement on the graduation criteria's are always and all are not under control of the project and MoI as well. Many of the conditions are dependent on the 'systems' at DDC level. The 'concept of pooling funds' in the MEDF, and DDC/DEDCs capacity to manage the MEDF seems a leading consideration towards 'District Graduation'. In absence of a full spectrum coverage of the range of activities that are currently being delivered by MEDEP in the districts by MEDPA intervention with adequate financial resources either from MEDPA allocations, and or through local contributions, the graduation does not make any difference to the districts. The absence of a clear elaboration of what sort of activities needed to be performed at district and below level, by whom and how such activities are going to be financed, the concept and purpose of 'district graduation' is going to be unclear. During the MTE, it was decided between UNDP and DFAT that DFAT's resources will not be channelled through MEDF, the relevance of 'district graduation' holds less meaning, but the issue of at what point MEDEP shall withdraw from the district remains unanswered.

ix) MEDF

This has been a contentious area of discussion between the donor, MoI and UNDP, each having their one stands and interpretations, and expectations. Based on the discussions with different stakeholders at central and district level MTE had the following opinion on this issue:

- MEDF has the potential of drawing interest of local bodies and other local developmental partners and agencies on the DEDP increasing the chances of receiving support for the DEDP (less on budget but more on program support or target sharing basis).
- The PFM situation at the local bodies' level holds scepticism among development partners and PFM experts for its higher level of fiduciary risks.
- Functional MEDF with basic resources to fund the operation of DEDC, program monitoring, and support the VDCs for VEDP process may act as a centrifugal force for the effective and sustainable functioning of DEDC at the districts.
- The current provision of 'virtual channelling' of MEDEP budget allocation through MEDF does not seem to be adding any significant value to MEDF, although a very high level of efforts and resources has been spent in resolving this issue by MoI and MEDEP with all good intentions and expectations. On the contrary MTE felt that a situation of 'permanent dissatisfaction and confusion' among the staffs of DDC, MoI district agencies, and DTCO has been created even if they do not have any ill intentions.

x) MEDPA Implementation Planning and budgeting

The joint planning between MEDPA and MEDEP is a good practice which can result into capacity building of MoI district agencies, DEDC and DDC on MED. MEDPA follows the standard planning and

budgeting practice of GoN, recently adopted to follow the 14 step decentralized planning process practiced by GoN and local bodies. However, MTE felt that there is a need to have more elaborated and uniform planning process and budgeting tools to make sure that; i) the program planning across the districts are in coherence with the MED strategy, Policy and operational guidelines, ii) the district plans are inclusive of all required activities for the project and adequate budgets are allocated for.

xi) MEDEP Management

MEDEPs internal management structure is divided at three levels; i) UNDP Level, ii) Project Level, and APSO level (extended up to district level). MTE have felt that there are issues that need to be addressed by the project at all three levels;

- Considering the size and design complexities of the project the level of dedicated managerial capacity put in by UNDP at its country office level appear to be inadequate to fulfil the oversight and technical backstopping needs of the project, reporting and communication needs and demands from the donor, and coordination and communication needs of MOI, in addition to UNDPs own internal management functions.
- At the National Program Support Level a feeling of standard and systematic project management that has functioning systems and appropriate skill mix needs to be reflected. Based on the observations during the MTE, The MTE felt that the standards of management efficiency which has to be reflected in terms of coherence in deliberations, coordinated actions, promptness and completeness of information's, preparedness of various activities of the project, mutual complementarity among the team members still has enough room for improvements. The MTE also felt that the team may not have enough skill mix to support the institutionalization process, rather have more command of the 'service delivery management of MED'.
- MEDEP produces annual progress reports which are substantially elaborative on the achievement status. However, these reports could be improved more to be specific, categorical, and clear in terms of its content by aligning the reports in line with the AWP. The reports should provide a comparative and cumulative overview of the results with visible synergy and coherence with the project document.
- The financial reports provided to the MTE, do not provide enough information to figure out what has been planned under which component, and activities and what has been achieved. With the level of available financial data of the project it was not possible to see the trend and financial efficiency of the project. How much resource has been spent on different aspects of the project such as project management, Institutionalization, Capacity building, and program related activities.
- The component wise divided management structure appear to be in one hand allowing staff to focus on one track and produce results, but on the other hand also puts the project in an operational situation of different 'silos' making the coherence, coordination and complementarity more complex.
- At APSO level, they feel themselves in a situation of trapped between too many bosses to report and cater the demands from each of them. The scattered staffing in different districts from APSO, sometime creates problems in communication, coordination and monitoring due to very few professional staff at APSO level.
- At individual level, all the project staffs consulted are highly committed, motivated and dedicated people, ready to go out of the way to support the MTE in every manner. They hold the range of expertise on MED from a very high level to the smallest level of practicality of the sector, probably a benefit of long term experience in the MED sector in MEDEP and elsewhere.

5. Future directions – Recommendations

5.1 Strengthening Support on Institutionalization

This is the core area of operation of the project; therefore this should be given primary focus in the remaining period of the project. Despite the fact that so many activities have been delivered by the project in the area of institutionalization, a lot is being planned in 2016 AWP, the MTE felt that the progress on 'Institutionalization' still require highly concentrated efforts. Therefore, MTE's recommendations on these aspects are as follows:

5.1.1 MED Service Model Improvement

A tested MED service Model has been the basis of MEDPA design; however there are still various aspects that need to be further captured by the model being used by MEDPA. Some of the aspects are discussed in other sections related to 'outsourcing', role of associations and their sustainability in relevant recommendations. However, more specifically the MTE recommends that 'value chain development concept' should be included in the model following internationally tested approaches of facilitation. Capacity Building Plan should include interventions on 'Value chain development' to create the capacity of MEDSPs to deliver it, and DCSI/CSIDB's capacity to manage. MEDPA budget should include the delivery of value chain development.

Another area of improvement in the MED model is inclusiveness and targeting, MTE recommends that, MoI supported by the CTA and UNDP should provide a management response to the recommendations in the 2014 impact study and mass impact study, and MEDPA should respond to this with proposed concrete measures to respond to the management response and then implement, with facilitative support from MEDEP.

5.1.2 Shift focus from Delivery to Institutionalization

The project is well on track with direct support to ME creation, but its main aim of a sustainable system for delivery of services for creation, resilience and growth of MEs is not being adequately realised. There are many reasons, some well beyond the project's control. A key factor, however, is the combination of an implementation and a facilitation or institutionalisation role. These are difficult to combine in practice, especially with an ambitious target for ME creation and a team that is experienced in delivery against such targets rather than facilitation. Supporting institutionalisation of the MEDPA across the country is a similarly ambitious target.

The MTE feels that to allow MEDEP focus on its core role of supporting institutionalization from 2017 onwards the ME creation part of MEDEP should be transferred to MEDPA. This will allow MEDEP with additional resources and capacity to work more rigorously on the institutionalization part. The Annual Work Plan of 2017 should incorporate the new plans (additional Plans) like; i) The two CB plans (as discussed in 5.1.4 below), and ii) Institutionalization Support and Monitoring Plan (as discussed in 5.4.5 below).

The MTE's main recommendation is therefore as follows:

- Design, with support from an external consultant, a simple and transparent strategy and plan to withdraw MEDEP from its role in ME creation within a period of 3 to 6 months, and to refocus it on institutionalisation. Involve MoI and other players in the service delivery system in this process to come to a shared understanding. This should be effective from 2017 AWP.

- As the local level MED plans and D/V/MEDC mechanisms have started showing their potential in mobilizing the resources and commitment of the local bodies, MTE feels that MEDEP scale up its support for the VEDP development process, as this will contribute in not only local resource mobilization but also in institutionalization of the MED service model at local institution level.
- Reallocate funds in the first place to institutionalisation of MEDPA, including to an increase in appropriate staff, an international institution building expert, external technical expertise and intensive staff capacity building on approaches to facilitation and institutionalisation. Contracting a firm as “co-facilitator” could in part be an alternative to many more staff.
- If a revised budget still provides space, provide for more ME creation by MEDPA, and have MEDPA set realistic targets which are matched to the capacity in and requirements of the Districts. This is, however, not a priority.
- Ensure full alignment of annual planning between MEDPA and MEDEP, following the GoN rather than the UNDP planning cycle. There should be no separate MEDEP plan, but the joint plan should clearly identify MEDEP’s activities and targets in institutionalisation. MEDEP should have sets of its 'support plans' to allow monitoring its results and outputs.

5.1.3 Review MEDPA Operational Guidelines

A next round of review and revision of MEDPA operation guidelines is required. Some of the key areas (not limited to) for review suggested by MTE are:

- i. Elaboration of the concept of ME Associations, their functions, linkage with MEDPA, and their sustainability is needed. It should be taken into consideration that they should not be turned into service delivery professional organizations but focus on their nature of 'interest group's advocacy associations'.
- ii. Incorporating a separate elaborative section on 'GESI' to assure that it becomes integral strategy of MEDPA at every point of action, not only limited to ME creation level.
- iii. Incorporating a separate section on 'Planning and Budgeting' at MoI, CSIDB, DCSI, District offices, and Local Body (D/M/VEDC) level. This section should assure consistency in planning and budgeting across the board, in particular the district planning and budgeting should be more clearly guided with templates for planning with budget sub headings, the scale of operation may vary according to the needs of the district.
- iv. Ensure the MEDPA budget explicitly provides for all functions that are allocated to different actors in the system, e.g. the monitoring and evaluation function of the DEDCs. Some functions (e.g. those of DMEGAs) have no specific budget allocations as well, which is left to the discretion of DDCs/DEDC.
- v. The Monitoring, MIS/Database Management aspect needs more clarity in terms of role and responsibility.
- vi. As procurement of MEDSPs is very significant part of the MED model being adopted by MEDPA, a separate section on the steps and process of MEDSP procurement for services like ME creation, Scale up Support, and M&E would be helpful for delivery management agencies of MoI both at central and district level.
- vii. A separate section on Capacity Building (Human Resource) should be included with a rolling CB approach that MEDPA would require deliver at different level, this should be also clearly lined with the budget subheadings at different levels. This should include the MEDSPs, and MEAs as well.

- viii. Further clarify roles, if not in a new version of the Guidelines (which have just been approved) then in additional procedures.
- ix. Taking MEDEP's representation out of the system/process and Institutions provisioned by the guidelines, but create some space for any future support agency (strictly in distance facilitation role, not in direct function role within the system structures).

This should be planned together with MoI, CSIDB, and DCSI, and worked out together. A facilitated review process should be carried out with hands-on input from MEDEP component managers together with GON and MEA stakeholders.

5.1.4 Work on Institutionalization of Capacity Development

A systematic Capacity building Plan for the remaining duration of MEDEP, and a long term Capacity Building Strategic Plan for MEDPA needs to be developed. The first one to be done immediately on which MEDEP should work for the rest of the project period. This plan will focus on 'one time' type of activities and directly help the MoI and its agencies in preparing themselves to take over the capacity building interventions for MEDPA in future. There should be clear logical linkage between the first CB plan and the 2nd plan to justify the needs of the proposed activities and where they contribute in the 2nd Plan. The 2nd Plan is to help MoI to incorporate the CB plan into their annual program of MEDEP, which will be part of the operational guideline as well.

While working on the above two CB plans, currently proposed CB activities should be reconsidered for their appropriateness and effectiveness in the new context. Both the CB plans need to target MoI and its Line Agencies, MEDSPs, ME Associations (Central and districts), and DDC/DEDCs.

The Capacity Building plan should be clearly disaggregated in three categories; i) HR development (MoI, Department, and District level, ii) Logistics Capacity Development, and iii) System Development from both activities and budget point of view. The HR development strategy should be based on 'Cascading Model': higher level builds the capacity of the lower level.

Capacity building for GoN staff generally should be institutionalised given staff transfers, turnover, and recruitment of new staff.

- Include MED training in NASC curriculum (already planned for 2016), using external expertise. This should not be just a dedicated MED course, but also integrated into existing courses, so that officials such as Local Development Officers in the districts are informed of the basic principles of MED and MEDPA.
- Similarly include MED in courses at the MOFALD Local Development Training Academy.
- Develop a 1 week programme on MED at IEDI for capacity building of existing staff (delivery funded from MEDPA budget).
- MEDEP should withdraw from the continuous “awareness raising/orientation” of newly transferred staff at all levels. This should be done by MEDPA (DCSI/CSIDB). MEDEP could develop a set presentation and have this included in the 1 week programme at IEDI.
- Develop and implement a concrete long-term capacity building plan with annual targets for all the actors involved, in all districts, based on the Capacity Building Strategy that is already available.

5.1.5 Support MOI on new MED strategy and 14th Periodic Plan of GoN

A new 5 year MED strategy needs to be developed, while the 14th National Development Plan is also being drafted. These could provide further institutionalization to MEDPA within the planning and

budgeting system of GoN. Tapping on this opportunity MEDEP should take the following immediate actions:

- Provide MOI with technical assistance for revision and updating of the MEDPA Strategy for the next five years. This should include policy related, structural/institutional arrangements (e.g. MED section at MOI) and human resource/capacity development.
- Provide support to the MOI for preparation and submission of MED position paper to the Three Year Plan preparation team at NPC.

5.2 Strengthening Associations and MEDSPs for Sustainability

5.2.1 ME Associations at district level

As discussed in section 4.2 (iii) above, the ME associations need special focus for strengthening their capacity and sustainability (mainly at DMEGA level). It may be useful to organize an intensive workshop (may be 2-3 days working sessions with some preparations on issue/discussion papers) with experts in 'NGO associations and networks', representatives of the associations, MoI and MEDEP with the objective of; i) reviewing the status and issues related to the sustainable functioning of DMEGAs, and ii) discuss and explore viable (and legitimate) options for the sustainability of the associations, and iii) develop short term and long term intervention plans for strengthening and sustaining the associations.

- DMEGAs capacity building should be carefully designed considering; i) their new defined role in MEDPA, iii) new sustainability strategy developed through the process described above, and iii) the potential (and limits of learning) of the individual members in leadership role.
- Design an exit strategy over which DMEGAs feel ownership, including gradual phasing out of subsidies over the remaining project period. Development of the strategy should include involvement of NMEFEN.
- In the new MEDPA Strategy and forthcoming MEDPA budgets, make provision for DMEGAs to fulfil the functions allocated to them in the MEDPA Guidelines through a non competitive conditional grant basis.
- Include in the capacity building plan development of leadership's capacity to advocate at the village and district level for better services, regulation and their implementation, funding. Support this role technically (handholding, mentoring, not replacing) for a set period of time (one year).
- Support DMEGAs to develop a basic 'advocacy strategies' that can be used by all DMEGAs. NMEFEN should be involved in this process.

5.2.2 Associations at national level

National level associations like NMEFEN (association of MEs), NEDC (Association of MEDSPs), and EDF training Institutions Apex organizations should be taken onboard as implementing partner by MEDPA. During MEDEP's remaining period MoI should be supported in; i) recognizing the potential of these associations, ii) making their role clear and accepted within MEDPA plan and included in the operational guidelines with more clarity, iii) budgetary provisions should be made for the activities that are planned to be delivered by these association. Whereas, in the meantime MEDEP should support them for; i) building their capacity in supporting their respective members, ii) developing their sustainability strategy and business plans

5.2.3 Strengthening MEDSPs

- Strengthening capacity of MEDSPs focused to the bid winners only have a risk of limited the numbers of capable bidders in the market. Therefore, a more open approach needs to be taken while delivering generic capacity building activities of MEDSPs on MED Service Model. Such opportunities should be availed also to experienced MEDSPs who are not holding any current contract with MEDEP or MEDPA.
- Delivery of value chain development services also needs to be included in the capacity building activities for MEDSPs and EDFs. Clarifying their role in addition to ME creation including technical follow-up, cooperative formation, scaling up services and monitoring, and providing data for the MIS needs to be made more specific and focused.
- Entry of private sector MEDSPs into the competitions should be explored and promoted by MEDEP and MEDPA as the current NGO mode of most of the MEDSPs create some threat for their sustainability. There are examples of NGOs are being replaced by private sector organizations as service providers (by the same groups of individuals) in employment and skill training sector projects of ADB, WB, SDC and DFID, in which only private sector service providers are allowed to take part in the tendering process.
- The tender evaluation process should be revised to look for MED experience at human resource level but not at organizational level. More emphasis should be given on project management capacity, financial integrity and experience in the economic/community empowerment related interventions at organizational level. This will allow more credible organizations without specific MED experiences but with strong management capacity to take part in the bidding process.
- Individual EDFs should be allowed to be part of more than two bids at a time, so that interested organizations in the bidding process will not be constrained because of non availability of different sets of individual EDFs to propose in the bid.

MEDEP should take an approach of gradual withdrawal of any subsidies to these associations through a mutually agreed plan. Advocacy is the key function of these association but not MEDEPs role; however MEDEP can contribute by creating evidences for advocacy and building advocacy capacity of the associations. The horizon of the associations should be widened to include MEs in general but not limited to the MEs created by MEDEP or MEDPA.

Considering the time needed to work on these issues, this recommendation should be considered as immediate term and to be completed by the end of the project period.

5.3 Clarity on MEDF issues

The MEDF has not yet received significant donor funds. This affects not only MEDEP and MEDPA's credibility but also of the donor (DFAT in this case) and will reduce incentives for actors like DDCs and DEDCs to be involved. In this connection MTE recommends the following:

- Carry out a joint review of MEDF modality, operational issues and analyze fiduciary risks with an independent team of experts, fielded by GoN, DFAT as current donor and UNDP as technical assistance provider. This may contribute to finding solutions agreeable to all involved parties, or at least a conclusion that has been reached in a transparent manner. This review should take PFM

perspective rather accounting perspective. The formal informal incentives at institutional and individual levels associated with the operation of MEDF should be also analyzed.

District graduation remains relevant whether DFAT contributes to the MEDFs or not. Accountable management of the MEDFs is in the interest of all who contribute to it, however the current approach of 'graduation assessment from 'HACT compliance' perspective only needs to be reviewed from its cost effectiveness as well as its inclusiveness and ability to assess the non systemic dimensions (human dimensions, and practicalities) at district level. A more simplified assessment system⁶³ may be designed for this purpose encompassing the key graduation indicators. MEDEP needs to be clear when to exit from the district leaving behind a functional MEDPA MED Service Delivery System in the district. District Graduation should be seen from this point of view.

5.4 Improving Project Management

5.4.1 Review and Revise the Project Document

- i) As a matter of priority develop an unambiguous shared “vision” between UNDP and DFAT on the main outcome expected of MEDEP, the strategy to achieve it, and the process of redirecting the project. It may be good to bring in MoI in this process at a later stage.
- ii) Revise the project document through a thorough appraisal process to the extent the recommendations of MTE are accepted by MoI, DFAT and UNDP and reached to a consensus to take the project to a new direction. External independent consultants should be engaged for this purpose. The consultants should have experience of Nepal on MED, Associations (of NGOs, and Private Sector service provider), Work culture of GoN bureaucracy, and GoN managed economic activity base projects.
- iii) Advocacy and dialogue as a component: Advocacy as a function of the system the project is developing (rather than as a temporary task of the project itself) is a function of the NMEFEN and DMEGAs on the one hand and MOI, as dialogue partner, on the other. Component 1 and 3 also deal with these institutions and there is insufficient justification for a separate component. The work with research institutions has not even begun yet while studies have already been conducted. The market for research is limited and donor dependent.
 - Integrate work on MOI policy making and leadership in initiating dialogue into Component 1, and work on advocacy with NMEFEN and DMEGAs into Component 3.
 - Discontinue plans to support research institutions or to make their work a “commercial” undertaking.
 - Commission research only in relation to issues identified by the associations and MOI themselves, on demand.

⁶³ The Minimum Condition and Performance Measure (MCPM) audits of local bodies practiced are one examples of simplified 'assessment methods' of Local Bodies capacity and performance in managing the block grants and the planning, budgeting, monitoring, and PFM capacities of the local bodies.

5.4.2 MIS

MIS procedures are unnecessarily complex. Data it generates are not being used in management of MEDPA. It does not include the other work DCSI and CSIDB do, which reduces its relevance to them. The quality of data will remain an issue and data collection is costly.

- Simplify data collection and verification procedures, and reduce the frequency of data collection (e.g. on a six-monthly basis), but introduce spot checks to check quality.
- Stop collecting data after 3 years (the normal period for MEDPA inputs) and instead do sample surveys (outsourced) to assess how MEs are doing⁶⁴.
- Include modules that cover other DCSI and CSIDB management needs.
- Carry out training on use of the software in all districts.
- Train MEDEP and MEDPA staff on the use of the data, especially at the management level, and put regular reviews of the results in place
- Explore the viability and practicality of outsourcing the MIS management through out to a professional consulting firm with a multiyear contract.

5.4.3 Project MRM and DCED standard

The basic elements of the DCED standard for MRM, impact logics (results chains) and measurement plans are relevant to management of the project and have been largely designed, though their use in project management is still insufficient. Indicators (including those for the logical framework or result measurement framework) do not adequately reflect the project's institutionalisation objective.

- The project should complete the basic elements of the MRM system, with better indicators for institutionalisation, with the support of an expert, and start using them.
- No other parts of the system need to be developed, apart from a log of main activities, which will help in progress reporting.
- Project management and staff should be trained on the use of the system and its results, so that it will actually improve decision making.

5.4.4 Find solution for MEDPA tendering and contract management issues:

MEDPA tendering and payment procedures have resulted in a short effective period for MED contract implementation and therefore a loss in quality, while for some MEDSP functions (e.g. monitoring) year on year contracts are disruptive. MEDSPs suffer from long delays in final payments.

- Find ways to ensure adequate time is available for MEDSPs to deliver quality services through advance planning (already in progress) and ways to award multi-year contracts.
- Consider third party monitoring throughout the MED cycle through contracts with national level consulting firms, as already practiced by some other GoN programmes⁶⁵. The periodic monitoring feedbacks can be linked with the milestone payments and final payments as well.

⁶⁴Many other GoN projects do sample based 'Sustainability and Functionality Surveys' mainly in water and sanitation sector, other employment and skill sector projects conduct tracer surveys of their past beneficiaries on sample basis.

⁶⁵Rural Water and Sanitation Improvement Project of GoN funded by WB uses a system of third party monitoring which is linked with milestone payment.

5.4.5 Institutionalization Support Monitoring Plan

MEDEP together with MoI, and its central line agencies, DFAT and UNDP develop a comprehensive work plan on 'Institutionalization Support' including the CB plan. A step by step, activity by activity 'institutionalization result milestones' should be also developed to monitor the progress. These plans should be developed and operationalized as soon as possible but no later than end of 2016. The plan should have clear marking of the responsible component and individual staff of MEDEP, so that it could be also used as performance indicator of the staff and components.

5.4.6 UNDP and DFAT Coordination and Communications

The role of UNDP as implementing organisation should be improved by, appointing a full-time dedicated staff member with high level expertise in MED and institution building to support the project and support UNDP in other areas of MED, in addition to the current Programme Analyst UNDP should consider to add a dedicated full time staff to look after the day to day desk work related to MEDEP, so that the program analyst can have more space and time to closely support the CTA team at MoI and MEDEP project management team.

As a first step to moving the programme forward, the quality of coordination and communication between DFAT and UNDP should be improved through:

- Using the revised project document as a flexible guideline, not a straightjacket, stimulate innovation, entrepreneurship and learning in the project team, and reduce the preoccupation with meeting targets.
- Taking measures to improve their working relationship on the basis of a common understanding of their respective roles. Short out any teething problems in between, if needed use an externally facilitated team building exercise including senior members of MEDEP team.
- Avoiding making conflicting statements to and demands on the project.
- Take a more strategic rather than management role in their support to the project. This should be especially so for DFAT, which could refocus on the policy level, where it could make an important contribution.
- Quality management with value addition from the vast global experience of UNDP is what includes among the logic behind the donor's support to MEDEP, UNDP should be careful in delivery up to the standard of this expectation for its own reputation as well as donors satisfaction.
- UNDP should take measures in improving the quality of the progress and financial reports of MEDEP to make them clearer, synchronised with Project Document and AWP. The reports should provide clear, consolidated data on progress to give a clear comparative and cumulative view.

5.4.7 One Year Extension for MEDEP

Considering the extent of exiting and additional tasks that need to be completed by MEDEP in particular on the 'institutionalization aspect' which is very crucial for the effective takeover of the 'MED Service Model' by MEDPA, MTE recommends for an extension of one year for MEDPA, continuing under the UNDP management. This is also taking into consideration of the various disturbances that the project has faced during last two years period. The commitment and intensions of UNDP to deliver what it has promised are clear and this should be appreciated by giving them some more time to complete what they intend to complete. The MTE feels that with revised and focused approach on 'Institutionalization' another three years time including suggested one year extension will allow MEDEP sufficient time to make remarkable achievements on this front.

6. Beyond MEDEP

There may be a rationale for a short extension of MEDEP IV (see the above recommendations) but the project should not be followed by a MEDEP V. If the recommendations for the remainder of the project are implemented, by the project completion date or at most a year later a workable MED service delivery system should be in place, though it will not be able to optimally fulfil all the functions foreseen in the project document. If this is accomplished, MEDEP IV will have fulfilled its mission. If the system is not in place, due to factors beyond the project's control (e.g. GoN does not create the necessary post and recruit staff), DFAT and UNDP should leave it to the actors concerned to address this on their own. At least at the national GoN level sufficient political will seems to be in place to make MEDPA work. If it is not in place because of factors internal to the project, its design and interventions as implemented, more of the same is unlikely to help.

The MTE team has noted many different suggestions for a follow-on project to MEDEP. It has no definite views on these or alternative development options in the sector beyond MEDEP IV for the following reasons:

- These should be considered in the context of the 14th Plan, which is still being formulated.
- It requires an in-depth assessment, including of development needs and existing and planned activities of other donors and projects. Given the complex nature of MEDEP the team has not been in a position to conduct such an assessment and making recommendations without it would be irresponsible.

It therefore recommends the fielding of a mission that conducts an assessment and identification exercise once the draft 14th Plan is available.

One further recommendation is that, In the interest of scale of impact and sustainability, this mission should consider approaches to poverty reduction through private sector development that are not based on direct support to enterprises, and not limited to MEDEP or MEDPA created enterprises. Approaches in local economic development, value chain and market systems development have demonstrated that the poor can be integrated in and benefit from better performing market systems, reaching larger numbers and contributing more to economic development than direct support approaches such as MEDEP⁶⁶. The view that such approaches are incompatible with a focus on the poor is erroneous. They also benefit the non-poor, as well as large firms (which create jobs), but an exclusive focus on the poor generally does not lead to their integration in the mainstream economy.

In Nepal several donors and projects use these approaches (e.g. Samarth, GIZ's Include, SDC). Public institutions are, however, not the appropriate agents to implement them, as they require high levels of specialised expertise, flexible procedures, and results are indirect and take time to be achieved, which is politically unattractive. However, building a Nepalese capacity in these fields in the private sector could be an area where more assistance would be useful, and which could contribute to GoN's objective to reduce poverty and have Nepal graduate to a middle-income country.

The thinking process on 'beyond MEDEP' should ideally take into consideration of the following contexts:

⁶⁶The BEAM Exchange is the web-based community of knowledge and practice for poverty reduction through market systems development: <https://beamexchange.org/about-beam/>

- i) The long intervention of MEDEP from direct ME creation to helping the government to take over the ME creation task has created a strong institutional competence within UNDP about working in the domain of developing local economy. A good understanding of developing local level economic activities can be taken as strength for working on economic interventions at higher level as well.
- ii) The large number of MEs created through MEDEP and MEDPA has also created a large pool of 'Potential MEs' to take their efforts at higher level from a subsistence level to 'growth level' through an enabling environment of technical support and effective access to financial resources, and also that UNDP have a good linkage and mutual trust with these groups.
- iii) As stated above, the GONs aim to 'graduate Nepal as middle income country' by 2022 demands a very strategic and focused intervention to create sustainable economic growth not only at micro level but also at Meso, and Macro level. It is obvious that the next periodic plans of Nepal (the current 14th three year plan and beyond) will target for significant and sustainable economic growth in the country, and also reduce the 'remittance dependency' of the economy through a redirected focus on increase local productivity through improved efficiency of 'Meso level economic activities'.
- iv) As MEDPA is now taking over the micro level economic empowerment approach which has been tested and proved by MEDEP, it will be more logical for UNDP to focus its technical support to the government in developing the small and medium enterprise sector (SME) as a next level for the potential MEs created through MEDEP and MEDPA in the past as well as in the future.

The 'SME sector' development is much talked area in Nepal, however in last ten years or so this sector either has not been able to show significant achievements or its reach has been limited to few highly urban areas and in the retail sector only. Despite SME being a priority lending area for the commercial banks, this has not evolved as an area of substantial lending from the commercial banks, and has not been able to meet the minimum lending limits set by Nepal Rastra Bank for them on SME sector. This means a potential but unused resource for this sector is available in the national money market, waiting for a 'technical and managerial' thrust in organizing, planning and facilitating the SME promotion intervention in the country. So far, inadequate policy framework, lack of effective policy environment for 'SME' promotion, no or insufficient technical and financial support for SME, and absence of a strong regulatory mechanism for monitoring the 'capital market' for its contribution on sustainable and productive SME sector development seems to be the key characteristics of the 'SME sector development' issue in the country.

Therefore, an assessment/identification mission may, among the other options suggested above, consider the 'SME' promotion and development as a niche area which can be considered as an opportunity to take up as beyond MEDEP, but keeping linkage and continuity with what it has gained from MEDEP's experiences. However, further deeper research and analysis of this niche area would be required to make it as a strong case.

Exploring the possibility of collaboration with Banker's Association to further study the possibility of working on 'SME' would be the first step towards this. UNDP may think of organizing a national workshop on this issue through a professional planning and facilitation.

7. Lessons learned

- I. In the MTE's view the main lesson learned from the experience so far is that combining facilitation and direct implementation roles in a project is not workable. The two roles are contradictory and should not be combined. Experience in market systems development programmes that use a facilitative approach confirms this.
- II. A further lesson is that certain minimal conditions need to be in place for successful institutionalisation, most importantly, people to institutionalise *with* or *in*. Without such conditions being in place, sustainable results will not be achieved. It is then advisable to postpone the effort until they are in place.
- III. A focused and clear targeting guidelines at all input levels of a project can be useful approach for mainstreaming GESI. GoN agencies do take care of GESI targeting through such clear provisions in project implementation guidelines and policies.
- IV. Finally, the MTE would like to highlight the project's good practice in bringing about systemic change by institutionalising the training of Enterprise Development Facilitators, largely through private training providers. This is a good example of a project function being taken up by independent market players, which demonstrates the kind of thinking that the remainder of the project should be based on.

Appendix- A: Data Tables

Table 1 Progress against key output indicators Component 1

Indicator	Progress up to end 2014	2015 Target/ Milestone	Achieved in 2015	Cumulative progress up to end 2015	Cumulative Target for end of project
Government of Nepal delivers MEDPA sustainably (Component 1)					
Annual central Government resources for micro enterprise development (million NRs)	782	At least 200 mln	230 mln	1012 mln	
Total annual resources other than MEDPA's leveraged in MEDF at DDC level (million NRS)	14.7	At least 8 mln from DDC and VDCs	14.38 mln	29.08 mln	
Number of DEDSPs developed	33	8	7	40	75
Number of DDCs having MEDF for micro enterprise development	15 ⁶⁷	40	37	53	75
Number of VDCs having separate budget for micro enterprise development	157	50	142	299	
Total budget of VDCs for micro enterprise development (million NRS)	12.7	32 mln (estimated)	35.25 mln	47.95	
Number of VEDPs developed	85	52	27	112	
Number of MEDEP graduated districts	0	15	8	8	38
The existing micro-enterprise unit (MEU) at the MOI is upgraded to micro-enterprise section (MED Section)	MEU in MoI	MED Section established	Not yet established		MED Section established and functional
GoN' higher level coordinating mechanisms are in place	1 Steering Committee (SC) 1 Implementation Committee (IC) Joint Reviews	2 meetings of SC 3 meetings of IC One planned	1 Mtg (in 2014) No mtgs held No annual reviews held One done		

⁶⁷ As the erstwhile MEDPA Guidelines was revised to include new operational modalities for MEDF, so previously established 38 MEDFs were closed and new 15 MEDFs were established according to the provisions of revised MEDPA Guidelines (2014).

Table 2 Progress against key output indicators component 2

Indicator	Progress up to end 2014	2015 Target/ Milestone	Progress up to end 2015	Cumulative progress up to end 2015	Cumulative Target for end of project
Promoting the use of evidence for pro-ME policy (Component 2)					
MED policy related meetings at national and local level	None	Quarterly meetings by DMEGAs and NMEFEN	Quarterly meetings by DMEGAs and NMEFEN		
Policies, Acts and Regulations guidelines developed to replicate MEDEP model under MEDPA	10	5	5	20	
Capturing wider range change (mass impact)	Non	5 (Sectoral Commodities)	5	5	

Table 3 Progress against key output indicators component 4

Indicator	Progress up to end 2014	2015 Target/ Milestone	Achieved in 2015	Cumulative progress up to end 2015	Cumulative target for end of project
Micro Enterprise Development service providers deliver MED sustainably (Component 4)					
Development of New Course Revised Existing Curriculum on MED through CTEVT	N/A	N/A	N/A	2	5
MED <u>Knowledge Management</u> Centre in Place	0	0	0	0	1
No of EDF certified for MED	629 (includes previous phases)	200	138	767	1,205
Number of MEDSPs eligible for MEDPA Model Implementation (<i>each year</i>)	206	192	251	N/A	225

Table 4 Increasing Trend in the Number of MED SPs bidding

Organization	2013/14	2014/15	2015/16
Number of MED SPs bidder – DCSI	101	118	144
Number of MED SPs bidder – CSIDB	105	129	133
Total	206	247	277

Source: MEDEP

Table 5 Progress against key output indicators component 5

Output indicator	Progress up to 2014	2015 Milestone	2015 Progress	Cumulative progress up to 2015	Cumulative Target for end of project
Improving access to finance for micro-entrepreneurs (Component 5)					
Number of cooperatives established to promote access to finance for MEs	56	55 (50 MEDEP, 5 MEDPA)	47	103	97
Number of poor entrepreneurs who increase their access to financial services - <u>active borrowers</u> ⁶⁸ (sex and social group disaggregated)	6894	6,000 (4,000 MEDEP, 2,000 MEDPA)	5,413	12,307	23,493
% of entrepreneurs having own savings/ account in a Financial Service Provider (sex and social group disaggregated)	50% of the existing MEs	60% of existing MEs	70% of the existing MEs.	70% of existing MEs	60% of existing MEs
Capacity enhanced (trainings, logistics) of cooperatives to promote access to finance for MEs	112	50	43	155	100
Number of cooperatives received soft loan	15	5	5	20	30
Number of MEs who received loan for the first time (sex and social group disaggregated)	2,009	5,516 ⁶⁹	2,822	4,831	7,169

⁶⁸ The project actually measures loan disbursements, not active borrowers.

⁶⁹ 40% of the total new micro-entrepreneurs (13,789) targeted to create in 2015 will receive loan for the first time.

Table 6 Table Progress on main outcome indicators

Indicator	Progress up to end 2014	2015 Target/ Milestone	Progress in 2015	Cumulative progress up to end 2015	Cumulative Target for end of project
Vulnerable groups have improved access to economic opportunities and adequate social protection (UNDAF Outcome)					
Jobs created attributable to micro entrepreneurship development (including micro-entrepreneurs means both direct and indirect, GESI disaggregated)	N/A	N/A	N/A	38,053	75,000
Number of graduation /resilient MEs GESI disaggregation	N/A	N/A	N/A	N/A	20,000 (revised target still to be approved)
Number of ME created by MEDPA, MEDEP and Local Bodies	20,725 (9,061 MEDEP, 11,664 MEDPA) ⁷⁰	11,802 (MEDEP 5,320, MEDPA 6,482, Local Bodies N/A)	12,070 (5,423 MEDEP, 6,139 MEDPA, 508 local bodies)	32,795	73,000, 30,000 for MEDEP, 32,000 MEDPA, 11,000 Local Bodies

⁷⁰ Due to a delay in finalizing and approving the MEDPA Operational Guidelines, MoI/DCSI/CSIDB delayed in implementing MEDPA of 2013. MEDEP has reported in its annual report of 2013 that MEDPA did not create any MEs. This is in contradiction with the Mid-term Review of MEDPA conducted by GoN in 2015 which reported MEDPA created 4,324 MEs in 2013. The MTE has not been able to resolve this.

Table 7 ME Survival over time

SN	Year	Existing ME	Active ME	Semi Active ME	Business Survival In terms of Active ME	Business survival rate in terms of (Active + Semi active) ME
1	1998	16	2	-	12.50	12.50
2	1999	382	170	32	44.50	52.88
3	2000	921	438	133	47.56	62.00
4	2001	1,047	576	109	55.01	65.43
5	2002	1,938	891	404	45.98	66.82
6	2003	427	288	37	67.45	76.11
7	2004	796	409	133	51.38	68.09
8	2005	3,886	1,962	687	50.49	68.17
9	2006	3,890	1,750	762	44.99	64.58
10	2007	5,544	2,684	1,049	48.41	67.33
11	2008	6,493	2,993	1,519	46.10	69.49
12	2009	6,225	3,121	1,216	50.14	69.67
13	2010	4,821	3,103	466	64.36	74.03
14	2011	1,742	1,509	86	86.62	91.56
15	2012	4,260	3,370	359	79.11	87.54
16	2013	8,017	7,387	252	92.14	95.29
17	2014	4,344	4,277	21	98.46	98.94
18	2015	4,807	4,797	7	99.79	99.94

Source: Prepared by MEDEP

Table 8 Comparison of achievement of Gender & Social Inclusion Versus Target

Gender/Social Inclusion	Target stated in the Project Document (%)	MEDEP (%)	MEDPA (%)	Local Bodies (%)
Women	70	76	78	88
Men	30	24	22	12
Dalit	30	24	28	27
IN(Aadibasi and janajatis)	40	40	40	48
Madheshi	40	23	6	20
Youths (16-40)	60	60	N/A	N/A
Others (B/C)	30	36	25	25

Source: MEDEP MIS

TERMS OF REFERENCE

1. BACKGROUND AND CONTEXT

MEDEP was developed to support the Government of Nepal in its poverty reduction and employment generation efforts by supporting micro-entrepreneurs in Nepal. Australian Government is the main donor for supporting micro entrepreneurship development in Nepal. The programme was initiated in 1998 and is currently in its phase IV (2013-2018). Phase I ran from 1998 – 2004, phase II from 2004 – 2008, phase III from 2008 – 2013. Over these phases, MEDEP has provided entrepreneurship development training; technical skills; access to finance; testing and transfer of appropriate technology; business counselling and market linkages to micro-entrepreneurs that later became a model for micro-entrepreneur creation and promotion in Nepal. Furthermore, the programme has also successfully provided policy advocacy for the promotion of micro, small enterprises, and support to draft appropriate policies, acts, regulations and guidelines.

During its seventeen years of implementation, MEDEP has realized numerous results. The following are some of the notable ones:

- Within a period of 17 years, it has created 75,000 micro-entrepreneurs and over 79,000 jobs for the rural poor especially women, youth and made the effort to ensure that the socially excluded are equitably benefitting from the program. 80% of entrepreneurs created were still in business and 73.1% of benefited households have moved out of poverty. MEDEP entrepreneurs experienced 512.5% increase in Per Capita Income (Source : Independent MEDEP Impact Study 2010)
- The Government is taking full ownership of the MEDEP model and implementation modality in implementing the Micro Enterprise Development for Poverty Alleviation (MEDPA) programme, with commitments to expand MEDPA to all 75 districts and has started resource allocation from its own budget for implementing MEDPA in 64 districts (FY 2015/16). So far the Government has allocated about US \$ 10 million for replicating MEDEP to 64 districts.
- In order to replicate MEDEP model in 75 districts, MEDEP supported the government to prepare the MEDPA Five Year Strategic Plan (2070/71 – 2074/75 or 2013/14 – 2017/18) and the MEDPA Operational Guidelines with its first revision 2015.
- MEDPA model is also being internalized in local government bodies such as Village Development Committees (VDCs), municipalities and District Development Committees (DDCs) since 2008/09. DDCs of 36 districts contributed their matching funds about \$1. 2 m in micro-enterprise development fund (MEDF) established in DDCs.
- MEDEP has provided substantive inputs to both the Micro-enterprise Development and Microfinance Policies 2008 and the Industrial Policy 2010. Based on MEDEP's experience, GoN has incorporated micro-enterprise development into its Three Year Plan Approach Paper (2013/2014 – 2015/16) as an integral part of its poverty reduction strategy.
- MEDEP provided substantive inputs into the establishment of the Micro-enterprise Unit (MEU) at the MoI and such MEU in all 30 DDCs of districts. It has established networks and forums of micro-entrepreneurs to strengthen them as in groups and associations at all levels: the National Micro-entrepreneurs Federation of Nepal⁷¹ (NMEFEN), the District Micro-entrepreneurs Groups

⁷¹ A federated body of District Micro-entrepreneur Group Associations (DMEGAs)

Associations (DMEGAs), the Micro-entrepreneurs Groups Association (MEGAs) at the rural Market Centres (RMCs), and the Micro-entrepreneurs Groups (MEGs) at the community level

- MEDEP has established proficient Micro-Enterprise Development Service Providers- MEDSPs, (synonym called Business Development Service Providers Organizations –BDSPOs) at district level, and an apex body at national level that brings them together called the National Entrepreneurship Development Centre (NEDC).
- MEDEP has innovatively combined social inclusion approach in addressing issues of socioeconomic inequalities and poverty, thereby contributing to address root causes of conflicts. Working with poor, women and socially excluded is clearly a main contribution in addressing problems that arise from the linkages between poverty, gender and human's security. Thus MEDEP was successfully implemented during Maoist conflict period working in the conflict and has considerably contributed to post-conflict economic recovery and social cohesion, through bringing changes in their livelihoods and income (Source: MEDEP peace impact study, 2012).

MEDEP Phase IV started in August 2013 and runs until July 2018. MEDEP Phase IV is mainly a DFAT supported programme operating at a national level with a budget of USD 33 million. The objectives of MEDEP phase IV are:

- To support the Government to take over the delivery of MED activities through MEDPA programme;
- To build the capacity of GoN and the private sector including NGOs (MED service providers) to sustainably deliver MED;
- To strengthen the capacity of micro-entrepreneurs associations to sustainably provide members with a number of business development services such as access to markets; access to finance; improved technologies and advocacy.

To achieve its objectives MEDEP IV delivers the following Outputs:

Output 1) A sustainable delivery system for Micro-Entrepreneurship Development in Nepal with at least 73,000 new micro-entrepreneurs created in 5 years, 60,000 of which are resilient, targeting women - 70%, Dalits – 30%, Indigenous Nationalities (Aadibasi – Janajatis) – 40%

Output 2) Micro-entrepreneurs' sustainably access to a number of business development services such as social mobilisation for enterprise development, access to technical skills, access to markets; access to finance; improved technologies and advocacy mobilizing micro-entrepreneurs associations and MED service providers (on a cost-recovery basis).

While earlier phases of the programme focused on providing direct support to micro entrepreneurs, the current phase includes a strong focus on building the capacity of the GoN and NGOs to create a sustainable system for supporting micro-entrepreneurs in Nepal, such as the development and implementation of policies supporting access to markets, finance and business development services. The role of the MEDEP has changed from being an implementer to becoming a facilitator.

In this context MEDEP has graduated into a national program and has been internalized by the GON. In operational terms, this means that GON will replicate MEDEP model in all 75 districts under GON's programmatic and budgetary framework; under the MED-PA. The GON has requested MEDEP (and international development partners) for technical and capital assistance for executing MED-PA. Thus, MEDEP has been trying to realign itself to one that provides Technical Assistance to GON's MED-PA for five years until 2018. By then, it is envisaged that technical assistance is no longer required by the GON to implement the MED-PA as the Government will be fully capable of implementing the Program.

Given the objectives of phase IV leading to handing over MEDEP to the GoN, the challenge is to ensure that the MEDEP model is maintained and adopted by MEDPA. A smooth handover and continuation of the MEDEP model requires sufficient capacity within the GoN and other institutions involved in making MEDEP a success. Two capacity assessment and development reports have been conducted and published in 2009 & 2012 which provide clear recommendations for developing capacity among key stakeholders.

2. RATIONALE

The Mid Term Evaluation (MTE) is planned towards the end of 2015 in order to identify potential project design problems, assess progress towards the achievement of objectives, identify and document lessons learned and make recommendations regarding specific corrective actions necessary to improve project performance in the remaining years.

MTE is beneficial for project implementation as they provide an independent in-depth review of implementation progress and provide guidance to address challenges and further enhance implementation.

Findings for the mid-term evaluation will provide a basis for decision-making on actions to be taken for the remaining years of the programme and for the donors to contemplate on support in the sector beyond this phase.

3. PURPOSE AND OBJECTIVE

The evaluation is being undertaken at the midpoint of project implementation and will pave the way for improved project delivery for the remaining project duration.

The specific objectives of this midterm evaluation are;

- Firstly, to provide the project stakeholders with an independent review of the status, performance of the MEDEP Phase IV as compared to the project document, identify and assess the results and impacts as to their sustainability. This will include assessing whether progress is satisfactory in establishing a sustainable delivery system for Micro Entrepreneurship Development in Nepal which is entirely owned and run by the Government, but making use of public and private expertise. Based on the progress made by the Project, the consultants will recommend whether, as outlined in the Project document, it is ready to handover MEDEP to government to streamline with MEDPA.
- Secondly, to assess the context related to the political economy, identify and describe the lessons learned, summarize the experiences gained, technically and managerially, and propose amendments (if any) required in the project design, implementation arrangements and/or institutional linkages in order to effectively and sustainably contribute to the livelihood improvement in the target areas.

Program Duration being assessed: August 2013 – December 2015

Program: MEDEP Phase IV

Geo coverage: National and covering 38 MEDEP/MEDPA districts (attached annex for name of districts)

Available information on MEDEP-MEDPA: The MTE team will review the relevant documents (see Annex) and will make use of the MIS data base for MEDEP beneficiary analysis like total number of micro entrepreneurs (MEs) created, number of potential MEs who received entrepreneurship development training and technical skill trainings, status of MEs, sales/production of MEs, Income change and moved out of poverty status, etc.

Suggested list of target groups and stakeholders to be consulted, which can be further updated by the MTR evaluation team as per need

- Targeted beneficiaries – Micro entrepreneurs, including Women, Youth, Dalit, Janajatis and Madhesi from poor and marginalized population.
- National level stakeholders – MOI - MEDEP and MEDPA government officials, MoFALD, CSIDB/DCSI, PB members and UNDP/MEDEP
- Other donors mainly DFID, GIZ, DANIDA and World Bank to seek their views on MEDEP and MEDPA and the institutionalization process.
- District level partners - Local Government, Local Development Fund, Department of Cottage Industries, District Chamber of Commerce and Industry, district chapters of Federation of Nepal Cottage and Small Industries (FNCSI), district Enterprise Development Committee (DEDC) members
- Micro-enterprise forums and networks - NMEFEN, DMEGAs, MEGAs, and the MEGs at the community level
- Service providers – MEDSPs, NEDC

Cross cutting Issues - The extent to which appropriate programming and budgeting supporting gender equality and social inclusion, human rights-based, good governance, Disaster Risk Reduction, Environmental safeguards, result oriented and conflict sensitivity was maintained on respective livelihood results as intended

4. EVALUATION CRITERIA'S AND QUESTIONS

The evaluation will be based on the standard OECD Development Assistance Committee (DAC) evaluation criteria (relevance, effectiveness, efficiency, impact and sustainability) and United Nations Evaluation Group (UNEG) HR/GE guidance

(<http://www.uneval.org/papersandpubs/documentdetail>).

The suggested **evaluation questions** are below and their rationale will be further refined by the consultant in consultation with Evaluation management group and presented in the 'inception report' (evaluation plan).

- Has this program made reasonable progress? Is it on track? Achieving what it was intended to achieve within the timeframe?
 - ☐ Progress in creating micro-entrepreneurs? Is MEDEP maintaining the quality and inclusivity of the micro-entrepreneurs created in Phase IV?
 - ☐ Quality and inclusivity of the micro-entrepreneurs under MEDPA? Is MEDEP sufficiently supporting MEDPA to create MEs with the same level of quality and inclusivity as MEDEP MEs?
 - ☐ Progress with institutionalization and system building? What is the progress that has been made for the MoI to deliver a MEDEP-style program? (this will include looking at MEDPA) (Think HR, institutional structure, policy, procedures, financial and procurement processes, budget allocations etc.).
 - ☐ Progress on certain selected key elements of the theory of change?
 - That quality Micro Enterprise Development Service Providers MEDSPs) would bid
 - MEDSPs would increase in number and be financially self-sustaining (crowding-in of MEDSPs)
 - That government would develop the skills and capacity to manage sub-contracting.
 - That the Government will develop skill and capacity to coordinate other Private Sector Development (PSD) programs and build additional support for MEDPA

- That building in MEDEP processes/approaches in the MEDPA Operational Guideline will provide surety to quality and inclusive micro-entrepreneurs
 - Progress with developing and implementing a Cash Transfer assurance mechanism that meets HACT quality standards?
- Is the M&E system/framework developed for MEDEP and MEDPA providing sufficient information to track progress?
- Effectiveness of the Programme in strengthening capacities at the national, state, district and below levels to implement ME strategies
- Assessment of progress under the different Programme components
- Review the effectiveness of partnership arrangements of MEDEP and MEDPA with other institutions such as Local Government, Local Development Fund, Department of Cottage Industries, Chamber of Commerce, etc. in developing a sustainable Micro Enterprise Development (MED) system.
- Examine whether MEDEP has been able to move ahead in the right directions in order to
 - (i) Phase out gradually from its managerial responsibilities (as project implementer) and
 - (ii) build the capacities of different stakeholders from Government to non-Government and
 - (iii) ensure sustainability of different institutions
- Is progress showing signs of self-sustaining?
 - Is the current level of GoN support/engagement enough to maintain progress? □Is the political will even at all levels of government?
- Sustainability of the MEDEP approach: How is the transfer to government affecting on selected key aspects of the program / MEDEP approach:
 - GESI indicators, including GESI composition of Entrepreneurship development Facilitators?
 - The full program of support to entrepreneurs as developed by MEDEP – the MEDEP approach of micro-entrepreneurship development
 - Monitoring of support to beneficiaries and sustainability
- What is the progress in establishing and implementing a Micro Enterprise Development Fund (MEDF)?
- What are the reasons for over/under achievement in a certain area?
 - Political economy?
 - Technical capacity?
 - Stakeholders delivering on their responsibilities as required? □Other reasons

Future directions / review outputs

- What should be the focus of the program for the time remaining?
 - What further progress/changes will need to be made? What time frame are we looking at for these future changes? What do we think the chances are for these to be achieved?
 - What are the key technical or operational/management issues that need addressing in the remaining period of MEDEP?
- Is the current management structure appropriate to deliver the intended outcomes?
 - Any obvious bottlenecks?
 - Appropriate resourcing (DFAT, MEDEP, UNDP and GoN) models?
 - Suggestions for improved ways of working?
- Continuing relevance of the program for Nepal?

- What are the development options in the sector post MEDEP IV? What should this look like – nature and duration of assistance?
- What are the possible options for sustaining the Government's efforts (systems, structures, human resources and political will) for consolidating the foundation made in MED after MEDEP IV?

Lessons Learned (in terms of good practices, replication, political transition or conflict context, economic growth; future program opportunities; private sector development and enterprise development, etc.)

5. MID-TERM EVALUATION METHODOLOGY

The evaluation will be conducted primarily to assess the progress. This evaluation will include mixed method design. The evaluation design will include both the qualitative and quantitative methods involving primary and secondary data collection.

A suggestive list of approaches for information review/analysis are as follows and the consultant team are expected to present a more robust methodology, including data sources, in the proposal and the 'inception report':

Desk review of the program document including the RRF and M&E framework with a focus on the outcomes, outputs and targets set for the project, and the Annual progress reports

Specific analysis of existing reports (number of evaluation and assessment reports are available with MEDEP), indicator tracking tools and other monitoring and reporting information systems maintained within the programme. MEDEP has established a data base of all micro entrepreneurs in its existing MIS.

Discussions with UNDP, DFAT, Government of Nepal, and relevant stakeholders to gather diverse views from stakeholders engaged in the programme/projects implementation.

Visit to selected field sites (suggestive 1 Mountain, 2 Hills and 2 Tarai districts to cover all physiographic region of Nepal, covering both MEDEP and MEDPA) and undertake interviews with district government officials, communities and other stakeholders, such as MEDSPs, MEAs who have been involved in implementing activities under the program and/or participated in various program activities, and program's beneficiaries. Focus Group Discussions to be held whenever appropriate.

Discussions with Coordinators, focal persons, based at national and district level who have been directly/indirectly involved in the MEDEP Programme.

Discussions with key donors, PB members and others who are directly, indirectly involved.

Facilitation of group consultations and feedback sessions where feasible.

6. DELIVERABLES/EXPECTED OUTPUTS OF EVALUATION

The Consulting firm will be accountable for producing following Deliverables/Expected outputs

The Consulting firm shall submit:

Evaluation inception report: It should detail the evaluators' understanding of what is being evaluated and why, showing how each evaluation question will be answered by way of: proposed methods; proposed sources of data; and data collection and analysis procedures. The inception report should include a proposed schedule of tasks, activities and deliverables, designating a team member with the lead responsibility for each task or product. The inception report provides the

programme unit and the evaluators with an opportunity to verify that they share the same understanding about the evaluation and clarify any misunderstanding at the outset.

Presentation of inception report to key stakeholders including UNDP, Donor and key Government counterparts

Draft Mid-Term Evaluation report with all major findings and recommendations

Presentation of draft report to stakeholders, including UNDP, Donor and key Government counterparts-

Final Draft Mid-Term Evaluation report incorporating comments received, and including a clear succinct Executive Summary

Final presentation on the Mid-Term Evaluation for the Government of Nepal, Donor and UNDP.

Final Evaluation Report: To be prepared in standard format and submitted to the UNDP after incorporating feedback received on the Draft Report. The Final Report should be accompanied by four digital copies of the processed data files, transcripts and associated materials.

7. EVALUATION ETHICS

The evaluation will be conducted in accordance with the principles outlined in the UNEG "Ethical Guidelines for Evaluation" and evaluators will take necessary measures to protect the rights and confidentiality of informants. All evaluators must be independent and objective, and therefore should not have had any prior involvement in design, implementation, decision-making or financing any of the UNDP/MEDEP interventions contributing to this outcome. In addition, to avoid any conflict of interest, evaluators should not be rendering any service to the implementation agency of the projects and programme to be evaluated for a year following the evaluation.

The evaluation is expected to adhere to a framework supporting human rights-based (HRBA), results-oriented and gender responsive monitoring and evaluation. Towards this purpose, the project evaluation will encompass the principles of gender equality and human rights, ensuring that the evaluation process respects these normative standards, and aims for the progressive realization of same by respecting, protecting and fulfilling obligations of non-discrimination, access to information, and ensuring participation through a combination of consultative and participatory evaluation approaches. For more details on human rights and gender equality in evaluations, please refer to the UNEG Handbook Integrating Human Rights and Gender Equality in Evaluation – Towards UNEG Guidance.

8. IMPLEMENTATION ARRANGEMENTS

The figure below outlines a proposed management structure of an evaluation. The logic of this structure is that all key stakeholders are engaged in the evaluation, there is government ownership of the evaluation process and the findings, there is a quality assurance mechanism in place to oversee the entire work, and that there is an appointed person to manage the exercise.

Evaluation Commissioners: The key role of the evaluation commissioners will be the following:

- Determine which outcomes and projects will be evaluated and when. This is done at the CPAP level when the Evaluation Plan for the Country Program is developed, approved and uploaded in UNDP's online Evaluation Resource Center (ERC)
- Safeguard the independence of the exercise;
- Establish appropriate institutional arrangement to manage evaluation;
- Ensure adequate resources;
- Draw from evaluation findings to improve quality of program, strategic decision making, and future programming

Evaluation Steering Committee (or Reference Group): The key role of the Evaluation Steering Committee (ESC) will be the following:

- This is the primary decision-making entity for the evaluation as it consists of members of the evaluation commissioners and other key stakeholders
- Endorse the TOR for the evaluation
- Oversee progress and conduct of the evaluation
- Review the evaluation products, provide feedback and ensure final draft meets quality standards □Endorse the final evaluation report
- Endorse the communication plan for the dissemination of evaluation findings. Communication plan to be prepared by evaluation task manager.
- Review and endorse management response to the evaluation

Evaluation Management Group (EMG): This group will support the Evaluation Manager for the day-to-day management of the evaluation process. More specifically, it will:

- Prepare the terms of reference for the evaluation in consultation with the Evaluation Steering Committee (ESC);
- Ensure the quality and independence of the evaluation in alignment with UNEG Norms and Standards and Ethical Guidelines;
- Support the Evaluation Manager for the day-to-day implementation of the evaluation activities and management of the evaluation budget;
- Hire the team of external consultants
- Ensure participation of relevant stakeholders;
- Review and provide substantive comments to the inception report, including the work plan, analytical framework, methodology, and evaluation matrix;
- Substantive feedback on the draft and final evaluation reports, for quality assurance purposes, and to ensure that the evaluation findings and conclusions are relevant and recommendations are implementable;
- Inform the Evaluation Steering Committee on progress;
- Prepare management response to the evaluation for ESC's review
- Contribute to the dissemination of the evaluation findings and follow-up on the management response.

Evaluation Task Manager: Evaluation task manager will work as the Secretariat of the EMG.

Evaluation team: This team has to be a third party firm/group/individuals who have never been involved in any part of the project/program design or implementation. Their tasks will be as per the TOR and contractual agreement:

- Understand the TOR (and show they do) through evaluation proposal, inception report, full methodology; day-to-day management of process; keeping the manager informed; draft/final report and briefing to the key stakeholders;
- keep to standards and ethical principles in line with UNEG Norms and Standards and Ethical Guidelines;
- deliver the products agreed to the right standard and quality;
- account for what the team has done (and spent)

9. TIME FRAME

The duration of the evaluation will be two and half months starting from January 2015, including field visits, travel time, consultations, desktop research and debriefing of the findings to UNDP and the Government of Nepal. The following indicative time line is suggested for evaluation

process (to be verified and amended by the consultant team based on the findings of the inception report):

Deliverables	Timeline
Desk Review : Review of documents and materials	2 nd week of January 2016
Briefing of Evaluators: Briefing of consultant with UNDP/MEDEP/MOI/MoFALD /CSIDB/DCSI and Donor on expectations and working arrangements, sharing of documents/data, contact details, etc. with the consultant	2 nd & 3 rd week of January 2016
Draft Inception Report submission and presentation (which should include a proposed detailed evaluation design)	3 rd week of January 2016
Finalizing the inception report (including the evaluation design, evaluation questions as per OECD DAC evaluation criteria)	4 th week of January 2016
Field work Meetings, Interviews, FGDs, data analysis ,visits to selected project sites	2 nd and 3 rd week of February 2016
Preparation of draft report	4 th week of February 2016
Submission of draft report to Programme Board	End of February 2016
Stakeholders meeting for presentation of the draft report and review of the draft report (for quality assurance)	1 st week of March 2016
Finalizing the evaluation reports	2 nd week of March 2016
Submission of final report and other evaluation products	End of 2 nd week of March 2016

PART – B: COST ESTIMATE/ REMUNERATION

As per UNDP/MEDEP’s Guidelines and Norms. It is expected that the consulting firm will propose the total cost of the entire assignment.

PART – C: QUALIFICATION REQUIRED (ACADEMIC AND WORKING EXPERIENCES IN THE RELEVANT FIELDS)

A team consisting of one International consultant as the Team Leader and three national evaluation consultants including a Deputy Team Leader will conduct the evaluation. They will be recruited through a consulting firm.

Basic Requirement of the Consulting Firm

The consulting firm that would be interested to submit proposal should possess the following qualifications and experiences to be eligible for the assignment:

The proposer should possess the following qualifications to be eligible for the assignment:

- Should have demonstrated evidence of conducting and managing complex and multimillion dollars evaluations, studies and assessments of large projects (minimum of 5) on institutional and social development.
- Should be in existence or registered for at least 5 years as of the date of submission of the proposal.
- Signed (original) and dated (latest) CVs of experts who meet the academic and professional experiences mentioned above.
- Should have international work experience (experience in South Asia in general and Nepal in particular is desirable)

Evaluation team

The evaluation team will be comprised of one international expert (team leader) and three national experts (including one deputy team leader). The composition of the evaluation team and their general job descriptions are described below:

A DFAT consultant will also join the field mission with the evaluation team for DFAT's internal reporting purposes.

(i) Evaluation Team Leader (International Consultant): 35 days

Responsible for the overall design of the evaluation and coordination of the evaluation team. She/he will be responsible for the overall quality of the evaluation and timely submission of the deliverables of the evaluation. She/he will lead the team, lead the desk review analyses, lead the discussions in the meetings, assign clear roles / responsibilities / deliverable for each of the team member, draft sections of the report and finalise the reports compiling inputs from the other team members, prepare presentations and present the findings of the report to different stakeholders. In addition to leading the team, she/he will specifically focus on evaluating the key result areas especially on sustainability part.

Education:

- Master's degree(s) or higher in management, economics, social science, development studies, public policy, or other related fields.

Experience/Expertise -

- At least seven years of experience in project planning, evaluation/assessment. The candidate should show demonstrated evidence of project evaluation involving multiple stakeholders, Previous experience in evaluating at least two three other comprehensive, multi-years, multi-million-dollar social development projects.
- Extensive experience acting as team leader for complex evaluations and proven ability to manage a diverse evaluation team.
- Sound technical knowledge in at least one of the following- institutional capacity development, social development, private sector development and good understanding of all.
- Previous work in gender and social inclusion issues will be a distinct advantage
- Excellent drafting of professional and standard reports and communication skills; excellent editorial capacity
- Ability to work under pressure in a multicultural and complex environment
- Work experience in and knowledge of Nepal would be an advantage
- Excellent command of written and spoken English is essential

(ii) Deputy Team Leader: Institutional development Expert with preferably some expertise and experience in enterprise development (National consultant): 50 days

The incumbent will act as the Deputy Team Leader and support the TL in managing the review. S/he will be responsible to assess the institutionalization and system building aspect of MEDEP-MEDPA implementation (such as human resources, institutional structure, policy, procedures, financial/procurement processes and capacity to manage sub-contracting). This may also include looking at the partnership and collaborative approach to a Micro Enterprise Development (MED) system building promoted by MEDEP. The consultant will also review the MEDEP capacity development efforts of its partners specifically the Government of Nepal (MoI and its' agencies) and private sector (MEAs and MED SPs) at the national and sub-national level. S/he will be responsible for drafting, reviewing and editing different chapters in the related areas and also as assigned by the team leader, and assisting the team to ensure the overall quality and timely submission of the evaluation reports and presentations.

Education: Master's Degree or higher from recognized university/Institution in institutional development, economics, public administration or related fields.

Expertise/Experience:

- A minimum of seven years of experience in conducting evaluations especially on institutional development added advantage if some of these are in private sector development, and enterprise development.
- At least seven years of institution strengthening, capacity building, public policy development and partnership building with government at local and national levels.

- Experience in capacity development of society groups or community based organization
- Good understanding of Nepal's public administration
- Familiarity and knowledge of private sector development specifically focused on microenterprise development.

(iii) Social Development Expert with expertise/experience in Gender Equality and Social Inclusion (GESI) (National Consultant): 40 days

Responsible for assessing whether/how institutionalization and internalization has affected the quality and inclusivity of the micro-entrepreneurs created and the business development services being provided to the micro-entrepreneurs; are the services being provided in a whole package? The consultant will also be responsible for analyzing the progress, issues and challenges of the economic and socio-political empowerment of women, youth and socially excluded people for a Micro Enterprise Development (MED) program implemented through the Government system. S/he will also analyze effectiveness of the Programme in strengthening GESI capacities at the national, state, district and below levels to implement ME strategies.

Education: Master's degree(s) or higher in social development and gender studies or other related fields with relevant experience.

Experience/Experience:

At least 7 years of experience in project plan, monitoring, assessments and evaluation at national level focusing on social development and gender equality and social inclusion.

S/he should be familiar with UNDP, DFAT and Government of Nepal's GESI policies and programming with a proven track record on gender mainstreaming.

S/he should have understanding and knowledge of the legal, policy and institutional issues governing micro-enterprises and inclusive growth.

S/he should have an exposure to the concepts and approaches of public-private partnership and entrepreneurs development.

(IV) Data Analyst (National consultant) 30 days

Responsible for reviewing and analyzing data and progress, issues and challenges of the information management system which is cross cutting in many results areas of MEDEP IV. The consultant will assess the MEDEP's /MEDPA MIS data and primary data, identify Institutional capacity strength to report MEDEP and MEDPA results effectively and efficiently. The consultant will assist the team to ensure the overall quality and timely submission of the evaluation reports and presentations.

Education: Master's Degree from recognized university/Institution in statistics or Information Technology, or other related field of studies.

Expertise/ Experience: At least 7 years of experience in Statistical Tools Application, Data Management, Data Analysis and technical skills for producing facts and figures.

Generic UNDP Competencies

- Functional Competencies of individual Consultants:
- Good understanding of programme evaluation particularly of private sector development
- Strong analytical skills
- Strong inter-personal communication skills
- Good understanding of gender and social inclusion analyses and issues in enterprise development

- In-depth conceptual and practical knowledge of enterprise development, governance and development issues
- Proven track record of leading teams Corporate Competencies:
- Demonstrates integrity by modelling the UN's values and ethical standards
- Promotes the vision, mission, and strategic goals of UNDP
- Displays cultural, gender, religion, race, nationality and age sensitivity and adaptability
- Treats all people fairly without favouritism
- Fulfils all obligations to gender sensitivity and zero tolerance for sexual harassment Management and Leadership
- Ability to effectively lead a multi-cultural team of national consultants
- Builds strong relationships with clients, focuses on impact and result for the client and responds positively to feedback
- Consistently approaches work with energy and a positive, constructive attitude
- Demonstrates excellent oral and written communication skills
- Demonstrates openness to change and ability to manage complexities

Annex 2 – MTE evaluation questions and framework

Evaluation Matrix for Mid Term Evaluation of MEDEP IV (2013 – 2018)					
Evaluation Criteria	Evaluation Questions	Evaluation Sub-questions	Indicators	Methodology	Data sources
Overall Assessment - Programme Progress Assessment, Monitoring, Policy Advocacy and Coordination					
	What progress has been made in creating micro entrepreneurs and strengthening existing micro entrepreneurs?	<ul style="list-style-type: none"> Progress in creating micro-entrepreneurs by MEDEP and MEDPA? 	<ul style="list-style-type: none"> Numbers created versus targets, for MEDPA, Local Bodies and MEDEP 	<ul style="list-style-type: none"> Review of MEDEP MIS Review of MEDEP and MEDPA project documents, annual plans and progress reviews 	<ul style="list-style-type: none"> MIS Annual Plans and Progress Reports Assessment/St udy reports
		<ul style="list-style-type: none"> Is MEDEP maintaining the quality and inclusivity of the micro-entrepreneurs created in Phase IV? 	<ul style="list-style-type: none"> % from various vulnerable groups (GESI indicators) Business survival rates after 2 years Sales/profits 	<ul style="list-style-type: none"> Review of MIS data/information Review of GESI strategy, annual plans, progress reports and study/assessment reports (if any) 	<ul style="list-style-type: none"> MIS Annual Plans and Progress Reports Assessment/St udy reports
		<ul style="list-style-type: none"> Quality and inclusivity of the micro-entrepreneurs under MEDPA? 	<ul style="list-style-type: none"> % from various vulnerable groups (GESI indicators) Business survival rates after 2 years Sales/profits 	<ul style="list-style-type: none"> Review of MIS data/information Review of MEDPA GESI strategy, targets, annual plans, progress reports and study/assessment reports (if any) 	<ul style="list-style-type: none"> MIS Annual Plans and Progress Reports Assessment/St udy reports
		<ul style="list-style-type: none"> How is the transfer to Government affecting numbers, quality and inclusivity of micro entrepreneurs? 	<ul style="list-style-type: none"> Comparison of target vs. achievements with reference to annual plans over the last three years 	<ul style="list-style-type: none"> Comparison of findings on MEDEP and MEDPA Kisi and Interviews with MEDEP/MEDPA stakeholders 	<ul style="list-style-type: none"> MIS Interviews with project staff, MEDPA staff, DDCs, DEDCs, NMEFEN, DMEGA
		<ul style="list-style-type: none"> Progress in ensuring resilience of micro entrepreneurs? 	<ul style="list-style-type: none"> Longer-term business survival rates (more than 2 years) Sales/profits 	<ul style="list-style-type: none"> Analysis of MIS Data Qualitative information from field observations, FGDs and interviews with 	<ul style="list-style-type: none"> MIS

				local stakeholders	
	What progress has been made in enabling potential and existing entrepreneurs to access MED services?	<ul style="list-style-type: none"> Progress in increasing access to MED services (including finance)? 	<ul style="list-style-type: none"> Number of MEs who used various services, under MEDEP and MEDPA, NMEFEN, DMEGA, Financial Service Providers, Cooperatives Number of new Districts where services have become available 	<ul style="list-style-type: none"> Analysis of MIS data and progress reports FGDs and interviews with local stakeholders 	<ul style="list-style-type: none"> MIS Project reports Field notes of MTE team
		<ul style="list-style-type: none"> Which MED services? 	<ul style="list-style-type: none"> Current portfolio of services Has it been reviewed and revised as planned, on the basis of a study? What services are actually being accessed (compared to the “official” portfolio)? 	<ul style="list-style-type: none"> Review of project documents, strategies and official guidelines on ‘official’ portfolio of MED services Interviews with various types of service providers FGDs with target groups 	<ul style="list-style-type: none"> MIS Manuals on services Report on review of services
		<ul style="list-style-type: none"> Is quality and inclusivity of the services (including finance) being maintained under MEDEP? 	<ul style="list-style-type: none"> % users from various vulnerable groups (GESI indicators) Start-up rates Survival rates Sales/profits User satisfaction 	<ul style="list-style-type: none"> Analysis of MIS Data Review of Progress Reports and independent Assessment/study reports (if any) Interviews with project staff, service providers FGDs with target groups 	<ul style="list-style-type: none"> MIS data Progress reports Assessment/St udy reports MTE field notes
		<ul style="list-style-type: none"> Is quality and inclusivity of services (including finance) being maintained under MEDPA? 	<ul style="list-style-type: none"> % users from various vulnerable groups (GESI indicators) Start-up rates Survival rates Sales/profits User satisfaction 	<ul style="list-style-type: none"> Analysis of MIS Data Review of Progress Reports and independent Assessment/study reports (if any) Interviews with project staff, service providers FGDs with target groups 	<ul style="list-style-type: none"> MIS Progress reports Assessment/st udy reports (if any) Notes of MTE team from consultative meetings with MEDPA

					stakeholders
		<ul style="list-style-type: none"> What is the quality and inclusivity of services under NMEFEN, DMEGA 	<ul style="list-style-type: none"> Numbers of users % users from various vulnerable groups (GESI indicators) User satisfaction 	<ul style="list-style-type: none"> Analysis of MIS data Review of Annual Progress Reports, and Study/assessment reports (if any) Interviews with project staff, service providers FDGs with target groups (existing entrepreneurs) 	<ul style="list-style-type: none"> MIS Annual Progress Reports, and Study/assessment reports (if any) Notes from consultative meetings
		<ul style="list-style-type: none"> To what extent have services contributed to impact? 	<ul style="list-style-type: none"> Views of MEs 	<ul style="list-style-type: none"> FGDs with target groups Review of studies/assessment reports (if any) 	<ul style="list-style-type: none"> Field notes Study/assessment reports
	Are legislation and guidelines for MED in place and being used?	<ul style="list-style-type: none"> Are they documented and approved? Are staffs aware of them? Are they being applied? 	<ul style="list-style-type: none"> MED Policy MED Guidelines 	<ul style="list-style-type: none"> Interviews with project staff, MOI management and other staff including MEDPA 	<ul style="list-style-type: none"> MOI Officials MOI documents Project reports Presentations project staff
	Are capable HR, institutional structure, policy, procedures, financial and procurement processes, budget allocations in place?	<ul style="list-style-type: none"> Are required Human Resources put in place? Are there provisions for HR capacity development in place? And implemented? Have MEDEP processes/approaches been built into the MEDPA Operational Guideline to provide surety to quality and inclusive micro-entrepreneurs? Have the guidelines been approved and are they the basis of MEDPA? Is MEDPA successfully managing subcontracting? Has a Cash Transfer 	<ul style="list-style-type: none"> % of staff trained on/ experience in MED Job descriptions in place Performance reviews in place Subcontracting procedures developed and approved % of service providers contracted through these procedures Size and adequacy of budget allocations – comparison of GoN allocation with current MEDEP spend 	<ul style="list-style-type: none"> Analysis of previous Institutional Assessment report/s Institutional assessment workshop to be conducted by Evaluation Team Review of MEDPA Operational Guidelines Interviews with MEDPA officials (DSCI and CSIDB at Central level, regional level and district level) 	<ul style="list-style-type: none"> Project and MOI records, reports MOI documentation Institutional assessment reports Financial records MOI and MEDEP

		assurance mechanism that meets HACT quality standards been developed and implemented?			
	Is the M&E framework providing sufficient and useful information?	<ul style="list-style-type: none"> • Has the project put in place is the MIS in place and functioning? • Does it meet key DCED standard principles in an efficient manner? • Is capacity to maintain and use it in place? • What is the quality of the information? • Is the information being used for programme management and improvement at different levels, accountability and learning? 	<ul style="list-style-type: none"> • Effectiveness of M&E and project MIS • Usefulness of MIS • GESI in M&E and MIS • Views of stakeholders involved 	<ul style="list-style-type: none"> • Review of MIS • Project reports • Presentation by project staff • Interviews with those involved in data collection, processing, analysis at MEDEP, MOI and elsewhere • Interviews with management at MEDEP, MOI and other potential users (including in Districts) • Interviews with UNDP and DFAT 	<ul style="list-style-type: none"> • M&E Guidelines • MIS manual • GESI Guidelines/ strategy and project interventions • Progress Reports • M&E and MIS staff
	What is the effectiveness of partnership arrangements of MEDEP and MEDPA with other institutions such as Local Government, Local Development Fund, Department of Cottage Industries, Chamber of Commerce, etc. in developing a sustainable system for MED.	<ul style="list-style-type: none"> • Are partnership arrangements documented? • What do the different partners contribute? • What are their objectives and results? 	<ul style="list-style-type: none"> • Effectiveness of partnerships • Collaboration with local government bodies • Partnerships with other relevant MED organisations and programmes • Views on effectiveness of those stakeholders involved 	<ul style="list-style-type: none"> • Project staff presentations • Interviews with MEDEP, MEDPA and partners • Consultation meetings with relevant stakeholders 	<ul style="list-style-type: none"> • Project reports • Partnership agreements • Field notes (consultations)
	Is the pooling of funds for MED functioning (progress in establishing a Micro Enterprise Development Fund)	<ul style="list-style-type: none"> • Is MEDF established? And operational? 	<ul style="list-style-type: none"> • Number of DDCs and other players participating in the Fund • Size of the Fund over time compared to requirements • Expenditure over time • Satisfaction of DDCs, 	<ul style="list-style-type: none"> • Presentation project staff • Interviews project staff • Consultation with DEDC members Interviews DDCs, DEDCs 	<ul style="list-style-type: none"> • Project reports • MOI records (or of other holder of the Fund)

			DEDC with procedures and benefits		
Component 1. Government of Nepal delivers MEDPA sustainably					
	Is MOI/MEDPA gradually taking over responsibility for management of MED delivery in the Districts as planned?	<ul style="list-style-type: none"> Is the graduation of MEDEP to MEDPA progressing as planned? What are the reasons for slow progress (if any)? How can the graduation process be speeded up? 	<ul style="list-style-type: none"> Number of Districts that “graduated” from MEDEP to MEDPA compared to plan Number and functionality of DEDCs and VEDCs Compare access to services and impact before and after (as under goal and access level) 	<ul style="list-style-type: none"> Interviews with project staff Interviews MOI/MEDPA 	<ul style="list-style-type: none"> MOI and MEDEP records MIS
		<ul style="list-style-type: none"> To what extent have the above contributed to effective, quality and inclusive MED services being accessed? 	<ul style="list-style-type: none"> Management and other staff causal explanations (i.e. answers linking building the system with access to services) 	<ul style="list-style-type: none"> Interviews with MOI, DSCI, CSIDB officials Interviews with project stakeholders 	<ul style="list-style-type: none"> Project reports Interview notes
		<ul style="list-style-type: none"> Is MOI effectively coordinating other PSD programmes? 	<ul style="list-style-type: none"> Number of coordination meetings Actions taken after meetings Satisfaction of other programmes 	<ul style="list-style-type: none"> Interviews with MOI, DSCI, CSIDB officials Interviews with project stakeholders Interviews with other programmes 	<ul style="list-style-type: none"> Project staff presentation and interviews MOI records Meeting minutes
		<ul style="list-style-type: none"> Is MOI building additional support for MEDPA? 	<ul style="list-style-type: none"> GoN longer-term plans in MED Actions undertaken to build support Donors express interest in supporting MEDPA 	<ul style="list-style-type: none"> Interviews with MOI, DSCI and CSIDB Consultative meetings with DFAT and UNDP 	<ul style="list-style-type: none"> GoN policies, plans
		<ul style="list-style-type: none"> Is a staff incentive scheme in place? Has a plan been developed and approved? 	<ul style="list-style-type: none"> % staff who have received incentives Staff turnover trends Staff satisfaction 	<ul style="list-style-type: none"> Interviews with staff 	<ul style="list-style-type: none"> Project reports MOI documentation MOI records
		<ul style="list-style-type: none"> Are MOI and District level institutions able to deliver MEDPA without MEDEP support? 	<ul style="list-style-type: none"> Number of Districts where MEDPA is being implemented without technical and financial 	<ul style="list-style-type: none"> Project staff interviews Interviews with MOI Interviews with DDCs, DEDCs 	<ul style="list-style-type: none"> Project reports

		<ul style="list-style-type: none"> • Are required structures, capacities and mechanisms in place and functioning? • Have the EDUs been established at MOI, DSCI and CSIDB? 	<ul style="list-style-type: none"> • support from MEDEP • Views of those involved 		
		<ul style="list-style-type: none"> • Considering progress so far, is it likely targets for transfer of responsibility for MEDPA will be met? • Is the progress as planned? • What are the key factors affecting the progress? • What can be done to speed up? 	<ul style="list-style-type: none"> • Achievement versus targets for this period and until project end • Likelihood of changes (speeding up, slowing down) 	<ul style="list-style-type: none"> • Interviews with project staff, and MOI 	<ul style="list-style-type: none"> • Assessment results as above
		<ul style="list-style-type: none"> • Is progress showing signs of being self-sustaining? • Is the current level of GoN support/ engagement sufficient to maintain progress? • Is the political will even at all levels of government? 	<ul style="list-style-type: none"> • Level of institutional support for effective MEDPA implementation • Structure, systems and mechanisms in place and functioning 	<ul style="list-style-type: none"> • Interviews with project staff, MOI (including political leadership), Districts 	<ul style="list-style-type: none"> • Project reports • MOI documents
	How have MEDEP activities and funding contributed to the achievements?	<ul style="list-style-type: none"> • What activities, interventions has MEDEP carried out? • What funding has it provided? • What partnerships have been developed, how, why? • Was this as planned, timely? • Does this constitute a move from implementation to facilitation? 	<ul style="list-style-type: none"> • Planned Targets vs. Achievements • Institutionalisation process and progress 	<ul style="list-style-type: none"> • Interviews with staff and with partners 	<ul style="list-style-type: none"> • Project reports • Presentations made by staff •
	What have been the challenges and causes of over or under achievement?	<ul style="list-style-type: none"> • What are the factors contributing and/or hindering the project achievements? 	<ul style="list-style-type: none"> • Consideration of assumptions, influencing factors, unintended effects in Theory of Change • Views of those concerned 	<ul style="list-style-type: none"> • ToC workshop • All interviews 	<ul style="list-style-type: none"> • Annual Reports • Assessment/evaluation reports

Component 2. Promoting the use of evidence for pro-ME policy making					
	Have more policies, regulations or guidelines been developed that are based on recommendations made in studies and advocacy?	<ul style="list-style-type: none"> How the findings and recommendations from research and policy dialogue are implemented? 	<ul style="list-style-type: none"> Number of research reports, advocacy briefs, advocacy initiatives Number of policies, regulations, guidelines that reflect these 	<ul style="list-style-type: none"> Interviews at MOI Interviews with DDCs, DEDCs 	<ul style="list-style-type: none"> Project staff presentations and interviews Project reports Research reports, briefs Policy etc. documents
		<ul style="list-style-type: none"> Are more dialogue mechanisms in place, of what kind? 	<ul style="list-style-type: none"> Number of workshops, meetings, platforms that constitute public-private dialogue 	<ul style="list-style-type: none"> Interviews at MOI, DDCs and DEDCs, NMEFEN, DMEGA 	<ul style="list-style-type: none"> Project reports, staff presentations MIS
		<ul style="list-style-type: none"> Do more research institutions have the capacity to conduct quality ME related research? 	<ul style="list-style-type: none"> Quality of the studies Satisfaction of commissioners and institutions 	<ul style="list-style-type: none"> Interviews with those who commissioned and used the research, with research institution directors 	<ul style="list-style-type: none"> Project Reports Assessment/Studies
		<ul style="list-style-type: none"> Are budget allocations sufficient to fund research? Will this continue? 	<ul style="list-style-type: none"> Allocations for research at different levels in GoN 	<ul style="list-style-type: none"> Interviews at MOI, other potential commissioners, research institutions 	<ul style="list-style-type: none"> GoN Budget/s
		<ul style="list-style-type: none"> Is demand for ME research increasing? Are more research institutions planning to offer ME research services? 	<ul style="list-style-type: none"> Views of those involved 	<ul style="list-style-type: none"> Interviews at MOI, other potential commissioners, research institutions 	<ul style="list-style-type: none"> Project Reports
		<ul style="list-style-type: none"> Are more government bodies planning to engage in dialogue? 	<ul style="list-style-type: none"> Number of dialogue mechanisms established or planned after those supported by MEDEP 	<ul style="list-style-type: none"> Interviews with project staff Interviews with NMEFEN, DMEGA Interviews with DDCs, DEDCs 	<ul style="list-style-type: none"> Project Reports MoUs/LOIs (if any)
	How have MEDEP activities and funding contributed to the achievements?	<ul style="list-style-type: none"> What activities, interventions has MEDEP carried out? What funding has it provided? 	<ul style="list-style-type: none"> Project targets vs. achievements Component wise achievements 	<ul style="list-style-type: none"> Document reviews Interviews with staff and with partners Consultative meetings with DFAT and UNDP 	<ul style="list-style-type: none"> Project progress reports Presentations made by staff

		<ul style="list-style-type: none"> • What partnerships have been developed, how, why? • Was this as planned, timely? • Does this constitute a move from implementation to facilitation? 			
	What have been the challenges and causes of over or under achievement?	<ul style="list-style-type: none"> • How can the challenges be overcome? 	<ul style="list-style-type: none"> • Consideration of assumptions, influencing factors, unintended effects in Theory of Change • Views of those concerned 	<ul style="list-style-type: none"> • Consultative meetings with project stakeholders at central, regional and district level 	<ul style="list-style-type: none"> • ToC workshop • All interviews
Component 3. Micro Enterprise Association deliver sustainable services to members such as access to markets, finance, technology and advocacy					
	How has the project contributed towards creating and strengthening MEs groups and associations for effective MED services?	<ul style="list-style-type: none"> • Are NMEFEN, DMEGA increasingly offering services? • How effective are the Associations? 	<ul style="list-style-type: none"> • Service portfolio • Number of Districts where services are being offered • Number of staff involved • What is done to promote the services? 	<ul style="list-style-type: none"> • Project presentations staff and interviews • NMEFEN, DMEGA records • Interviews with NMEFEN, DMEGA • FGDs with MEs 	<ul style="list-style-type: none"> • MIS • Project records on training, reports
		<ul style="list-style-type: none"> • Are the services offered of good quality and inclusive 	<ul style="list-style-type: none"> • % of staff experienced in/trained on MED • Inclusiveness of staff involved (GESI indicators) 	<ul style="list-style-type: none"> • Interviews with NMEFEN, DMEGA, individual service providers 	<ul style="list-style-type: none"> • NMEFEN and DMEGA records
		<ul style="list-style-type: none"> • Are NMEFEN, DMEGA increasingly undertaking quality advocacy initiatives? 	<ul style="list-style-type: none"> • Number of advocacy initiatives, total and by District • % that is based on research and/or consultations with members • % that has resulted in improved regulation, procedures, budget allocations 	<ul style="list-style-type: none"> • Interviews with NMEFEN, DMEGA • Interviews at National and District level with participants in dialogue 	<ul style="list-style-type: none"> • MIS • Interviews with project staff • NMEFEN, DMEGA records
		<ul style="list-style-type: none"> • Are services commercially viable and independent of technical support? 	<ul style="list-style-type: none"> • % of cost-recovery • Technical support provided • Increase in demand 	<ul style="list-style-type: none"> • Interviews with NMEFEN, DMEGA 	<ul style="list-style-type: none"> • MIS • Interviews with project staff

					<ul style="list-style-type: none"> NMEFEN, DMEGA records
		<ul style="list-style-type: none"> Is capacity sustainable? 	<ul style="list-style-type: none"> % turnover of staff providing services 	<ul style="list-style-type: none"> Interviews with NMEFEN, DMEGA 	<ul style="list-style-type: none"> NMEFEN, DMEGA records
		<ul style="list-style-type: none"> Is expansion of service delivery to more Districts planned and are resources available? Is MEDEP expected to play a role? 	<ul style="list-style-type: none"> NMEFEN, DMEGA plans Future budget allocations 	<ul style="list-style-type: none"> Project staff interviews 	<ul style="list-style-type: none"> Interviews with NMEFEN, DMEGA Documented plans and budgets
	How have MEDEP activities and funding contributed to the achievements?	<ul style="list-style-type: none"> What activities, interventions has MEDEP carried out? What funding has it provided? What partnerships have been developed, how, why? Was this as planned, timely? Does this constitute a move from implementation to facilitation? 	<ul style="list-style-type: none"> Project targets vs. achievements 	<ul style="list-style-type: none"> Document reviews Interviews with staff and with partners Consultative meetings with DFAT and UNDP 	<ul style="list-style-type: none"> Project progress reports Presentations made by staff
	What have been the challenges and causes of over or under achievement?	<ul style="list-style-type: none"> How can the challenges be overcome? 	<ul style="list-style-type: none"> Consideration of assumptions, influencing factors, unintended effects in Theory of Change Views of those concerned 	<ul style="list-style-type: none"> Consultative meetings with project stakeholders at central, regional and district level 	<ul style="list-style-type: none"> ToC workshop All interviews
Component 4 Micro enterprise development service providers deliver MED sustainably					
	How effective the MEDSPs are in delivering MED services?	<ul style="list-style-type: none"> Has the number of active MEDSPs increased as expected? 	<ul style="list-style-type: none"> Number of MEDSPs accessing funds Number of MEDSPs delivering services Number of Districts in which they are being delivered 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Project records (MIS?) Project reports Project staff presentation, interviews NEDC records

					<ul style="list-style-type: none"> Interviews NEDC
		<ul style="list-style-type: none"> Has training for EDFs been developed and become operational in 5 locations? Has a new curriculum been developed? 	<ul style="list-style-type: none"> Number and level of courses run Number of institutions running them Number of EDFs trained Number ESPs certified 	<ul style="list-style-type: none"> 	<ul style="list-style-type: none"> Project records (MIS?) Project reports Project staff presentation, interviews CTEVT records Interviews CTEVT Interviews training institutions
		<ul style="list-style-type: none"> Has the number of active EDFs increased as planned? 	<ul style="list-style-type: none"> Number of EDFs employed and by whom 	<ul style="list-style-type: none"> Interviews with EDFs (in districts) Interviews with MEDEP/MEDPA officials Interviews with MEDSPs 	<ul style="list-style-type: none"> Project records (MIS?) Project reports Project staff presentation, interviews
		<ul style="list-style-type: none"> Can EDF training be expected to continue? 	<ul style="list-style-type: none"> Number of courses planned Budget allocations, other sources of funding Demand for training Views of those involved 	<ul style="list-style-type: none"> Interviews training institutions, CTEVT Interviews DDCs, DEDCs 	<ul style="list-style-type: none"> CTEVT, training institutions documentation
		<ul style="list-style-type: none"> Can service delivery by MEDSPs be expected to continue? 	<ul style="list-style-type: none"> Staff turnover rates Other demands on staff (staff involved in non-MEDPA activities) Service delivery planned Budget allocations, other sources of funding Views of those involved 	<ul style="list-style-type: none"> Interviews MEDSPs, EDFs, NEDC Interviews DDCs, DEDCs Project staff interviews 	<ul style="list-style-type: none"> Project reports
		<ul style="list-style-type: none"> Are MEDSPs and EDFs increasing in number and 	<ul style="list-style-type: none"> Expected number of MEDSP and EDFs 	<ul style="list-style-type: none"> Interviews NEDC Interviews DDCs, 	<ul style="list-style-type: none"> MIS based forecasts?

		delivering services in an increasing number of Districts, with limited project technical and financial support? (Is crowding in taking place?) Or planning to do so?	delivering services in 3 years ' time • Expected number of Districts • Budget allocations and other sources of funds	DEDCs	• Project staff interviews •
	How have MEDEP activities and funding contributed to the achievements?	<ul style="list-style-type: none"> • What activities, interventions has MEDEP carried out? • What funding has it provided? • What partnerships have been developed, how, why? • Was this as planned, timely? • Does this constitute a move from implementation to facilitation? 	<ul style="list-style-type: none"> • Project targets vs. achievements 	<ul style="list-style-type: none"> • Document reviews • Interviews with staff and with partners • Consultative meetings with DFAT and UNDP 	<ul style="list-style-type: none"> • Project progress reports • Presentations made by staff
	What have been the challenges and causes of over or under achievement?	<ul style="list-style-type: none"> • How can the challenges be overcome? 	<ul style="list-style-type: none"> • Consideration of assumptions, influencing factors, unintended effects in Theory of Change • Views of those concerned 	<ul style="list-style-type: none"> • Consultative meetings with project stakeholders at central, regional and district level 	<ul style="list-style-type: none"> • ToC workshop • All interviews
Component 5 Improving access to finance for micro enterprises					
	Has the project contributed towards developing a functional portfolio of Financial Services for effective MED?	<ul style="list-style-type: none"> • Are more financial service providers (banks, MFIs - FSPs) offering appropriate products to MEs? 	<ul style="list-style-type: none"> • Number of FSPs that target MEs • Number of FSPs with products designed for MEs • Number of Districts in which they are offered 	<ul style="list-style-type: none"> • Interviews FSPs 	<ul style="list-style-type: none"> • Project records (MIS?) • Progress reports • Project staff presentation, interviews •
		<ul style="list-style-type: none"> • Are more Credit and Savings Cooperatives offering appropriate products to MEs? 	<ul style="list-style-type: none"> • Number of cooperatives taking savings and providing loans • Number of Districts in which loans are offered 	<ul style="list-style-type: none"> • Interviews cooperatives 	<ul style="list-style-type: none"> • Project records (MIS?) • Project reports • Project staff presentation, interviews
		<ul style="list-style-type: none"> • Is insurance being offered to 	<ul style="list-style-type: none"> • Number and kind of 	<ul style="list-style-type: none"> • Interviews 	<ul style="list-style-type: none"> • Project records

		MEs and through what mechanism?	insurance products on offer <ul style="list-style-type: none"> • Number of insurers involved • How do MEs learn about insurance and access services? 	DMEGAs, and other players	(MIS?) <ul style="list-style-type: none"> • Project reports • Project staff presentation, interviews
		<ul style="list-style-type: none"> • How are FSPs loans and cooperatives savings and loans performing? 	<ul style="list-style-type: none"> • Portfolio at risk or loans at risk rates • Current recovery rates 	<ul style="list-style-type: none"> • Interviews with cooperatives and other FSPs 	<ul style="list-style-type: none"> • Project records (MIS?) • Project reports • FSPs and cooperatives records and/or interviews
		<ul style="list-style-type: none"> • Are FSPs, cooperatives planning to continue ME operations? • Is more loan capital being raised or allocated? 	<ul style="list-style-type: none"> • FSP and cooperatives plans, views 	<ul style="list-style-type: none"> • Interviews with cooperatives and other FSPs 	<ul style="list-style-type: none"> • Project records (MIS?) • Project reports • FSPs and cooperatives documented plans and/or interviews
		<ul style="list-style-type: none"> • Are FSPs targeting MEs and cooperatives increasing in number and delivering services in an increasing number of Districts, with limited project technical and financial support? (Is crowding in taking place?) Or planning to do so? 	<ul style="list-style-type: none"> • Expected number of FSPs and cooperatives delivering services in 3 years 'time • Expected number of Districts • Budget allocations and other sources of funds 	<ul style="list-style-type: none"> • Interviews FSPs • Interviews DMEGAs • Interviews DDCs, DEDCs 	<ul style="list-style-type: none"> • MIS based forecasts? • Project staff interviews •
		<ul style="list-style-type: none"> • If not, who will be driving this in the system the project is facilitating? 	<ul style="list-style-type: none"> • Project vision of future market system for ME financial services 	<ul style="list-style-type: none"> • Project staff interviews 	<ul style="list-style-type: none"> • Project strategy or vision statement (?) • Project staff presentation •
	How have MEDEP activities and funding contributed to the achievements?	<ul style="list-style-type: none"> • What activities, interventions has MEDEP carried out? • What funding has it provided? • What partnerships have been developed, how, why? 	<ul style="list-style-type: none"> • Project target vs. achievements 	<ul style="list-style-type: none"> • Review of project documents, reports • Interviews with staff and with 	<ul style="list-style-type: none"> • Project progress reports • Presentations made by staff

		<ul style="list-style-type: none"> • Was this as planned, timely? • Does this constitute a move from implementation to facilitation? 		partners	
	What have been the challenges and causes of over or under achievement?	<ul style="list-style-type: none"> • How can the challenges be overcome? 	<ul style="list-style-type: none"> • Consideration of assumptions, influencing factors, unintended effects in Theory of Change • Views of those concerned 	<ul style="list-style-type: none"> • Consultative meetings with project stakeholders at central, regional and district level 	<ul style="list-style-type: none"> • ToC workshop • All interviews
Other key questions and assessment areas					
	Are there any obvious bottlenecks including in access to resource?	<ul style="list-style-type: none"> • The MTE will first establish what the current MEDEP structure is and how it operates, and then consider possible bottlenecks in the adequacy of: <ul style="list-style-type: none"> • The structure itself (e.g. levels of delegation of decision making) • Management systems and tools (e.g. work plans, reporting lines and procedures, information sharing, knowledge management) • Human resources (including GESI indicators) • Resourcing models (DFAT, MEDEP, UNDP, GoN) • Financial systems, tools, procedures <p>Methods to be adopted includes:</p> <ul style="list-style-type: none"> • A participatory workshop (2 hours maximum) with project management and key staff • Staff interviews in Kathmandu and field offices 			
	Does the programme as implemented continue to be relevant to Nepal?	<ul style="list-style-type: none"> • Here the MTE will look at relevance at the national level, in terms of poverty indicators, GoN development plans and policies, as well as at the District and target group level, where questions on (relative) relevance will be included in interviews with market players in the MED system and in FDGs with micro entrepreneurs. 			
	What further progress needs to be made and is it likely that project objectives and targets will be achieved?	<ul style="list-style-type: none"> • Further progress that needs to be made will be assessed by comparison of what has been achieved so far and what is planned to be achieved by the end of the project, as well as consideration of the project's current strategy and its work plan for 2016. • This will enable us to establish if it is plausible that objectives and targets will be achieved under a "business as usual" mode, or whether change is needed. 			
	What changes are needed, over which timeframe, including key technical and operational/management changes (improved ways of working)?	<ul style="list-style-type: none"> • If progress in certain areas is insufficient the MTE will look at the causes and consider whether and how they can be addressed. • Some causes (e.g. lack of political will or national budget allocations, effects of the earthquake) may be among the external factors that affect the Theory of Change and may be less amenable to change. Other causes may lie in incorrect assumptions in the Theory of Change (e.g. the assumption that success with selected MEDSPs would result in "crowding in" of others), or project strategy and implementation 			

		<p>issues (e.g. project activities were of inadequate quality or not delivered in a timely manner). The feasibility of addressing these is likely to be higher. Our analysis will indicate this and make suggestions for addressing those causes that can be affected, or where negative effects can be mitigated. This will consider changes in:</p> <ul style="list-style-type: none"> • Design and strategy • Tactics (actions, methods to implement the strategy) • Project operational and management set-up and resources • Recommendations will be specific and actionable. The MTE will provide an indicative timing for each.
	What are the possible options for sustaining the Government's efforts (systems, structures, human resources, political will) for consolidating the foundation made in MED after MEDEP IV?	<ul style="list-style-type: none"> • Sustainability will be considered in our assessment of each component. Here the MTE will look at possible weaknesses and threats with regard to sustainability and consider ways to address these. This will in part be based on suggestions made by market players in the planned interviews. If our findings justify it, the MTE may decide on a FGD with key market players after our return from the Districts. • The MTE will not only consider the Government's part of the system (e.g. MOI) but other types of market players (e.g. FSPs, MEDSPs) too, since these all have a crucial role to play.
	What are the development options in the sector post-MEDEP IV? What should this look like – nature and duration of assistance?	<ul style="list-style-type: none"> • The project still has nearly 2.5 years to go, and it would seem early to address post-MEDEP development assistance options. The MTE team suggests to delete this question from the TOR. If it remains, the MTE is likely to be able to make some technical suggestions only.

Annex 3 – Documents reviewed

SN	Document
1.	Key Performance Indicators – 2013
2.	MEDEP Annual Report 2013
3.	Edited Risk and Issues Log Matrix
4.	MEDEP Annual Report 2013
5.	Progress Against Annual Target
6.	Final Annual Progress Report 2014
7.	List of Indicators to measure results
8.	Final RBMP- MEDEP Version 2
9.	Final Report_MEDEP RBME System & Guidelines
10.	Form 1-8 English
11.	Form Translated Revised_13 May 10
12.	G1 Form Final
13.	G2 Form Final
14.	Rajan_Gantt Chart of Component Revised
15.	Rajan_Gantt Chart of Component Revised
16.	M & E Strengthening Plan 2014
17.	Gantt Chart _MEDPA_Megharaj
18.	Gantt Chart _CDS
19.	Gantt Chart component Five_Gokul
20.	Gantt Chart _C3_RV_Rajesh
21.	Delivery Plan of IMC 4 II
22.	MEDPA Implementation Component 1
23.	MEDS Ps_CM4_Rajan KC
24.	ME Plan of 2014 in Gantt Chart
25.	Draft of Gantt Chart of Major Actions
26.	Component Five_Gokul
27.	Component 3 Rajesh
28.	Communication and Documentation activities
29.	Rajan Gantt Chart of Component Revised
30.	Rajan KC Gantt Chart of Component Revised
31.	M&E Strengthening Plan 2014
32.	Gantt Chart MEDPA_Megharaj
33.	Gantt Chart CDS
34.	Gantt Chart Component Five_Gokul
35.	Gantt Chart C3-RV_Rajesh
36.	Delivery Plan of IMC 4 II
37.	Overall and by components wise indicators
38.	Final Results level summary report
39.	Basic Information for Monitoring Purpose
40.	Process Indicators Access to Finance
41.	CFC Monitoring Indicators
42.	Monitoring Indicators in Formats Scale up of Existing MEs
43.	Monitoring Indicators for MEDPA MEDEP
44.	Some other Indicators
45.	Project Board Minutes Phase IV First

46.	Project Board Meeting Minutes second
47.	LPAC
48.	32th PB minutes
49.	32 PB Annex
50.	31 st PB minutes
51.	30 th PB minutes
52.	3 rd PB meeting minutes
53.	Annex 1 Progress against targets 2014
54.	Annex 1 Progress against targets 2014
55.	Annex 1 Progress on Output Indicators
56.	Annex 1 Progress on Output Indicators
57.	Must Indicators – ME Framework
58.	Draft of Result Measurement Tools ME
59.	1998-2014 Year and Phase wise target vs. Achievements
60.	1998-2014 Year and Phase wise target vs. Achievements
61.	1 st QWP 2015
62.	2 nd QWP 2015
63.	3 rd QWP 2015
64.	4 th QWP 2015
65.	CSIDB and DCSI support from MEDEP
66.	DEDC and DDC Expenses support from MEDEP
67.	Draft StrategyME Activities_2016
68.	Expenses Detail- MEs Association
69.	Final AWP for Prodoc Phase IV_ July 2013
70.	GESI data of target Vs Achievement phase IV
71.	III Phase Project Document
72.	III Phase Project Document.doc
73.	Impact Level IndicatorsLL, NPM
74.	Key Performance Indicators
75.	M & E Framework, MEDEP IV
76.	M & E related information for MTE Team
77.	MEDEP APR_D1_120122015
78.	MEDEP data sheet
79.	MEDEP DATABASE CHECKLIST
80.	MEDEP Draft DTCO format
81.	MEDEP IV Phase Target Vs. Achievement
82.	MEDEP IV Project Document 1
83.	MEDEP Phase IV Agreement with UNDP
84.	MEDEP QAI_2014 02 27_for public share-1
85.	MEDEP-Final Scale up Manual
86.	MEDPA OG English Final
87.	MEDPA OG_English_Notarized
88.	MEDPA Phase wise districts, graduate districts
89.	MEDPA Strategic Plan_English_Final
90.	Monitoring & Evaluation System of ME
91.	MTE team Monitoring& Evaluation System
92.	Nepal EA UNDP 7 feb
93.	Per ME Cost compilation
94.	Phase wise MEDEP MEDPA District

95.	Responses to Comments from DFAT_APR
96.	Results Measurement Framework, 2014
97.	Revised Final Copy of MEDEP_Result Target and progress
98.	Staff requirement and organogram in ME
99.	Tracking 2
100.	Two tracking System, MEDEP IV
101.	UNDP Monitoring Tools
102.	Annex 1.1 Component 1
103.	Annex 1.5 component 5
104.	Annex 3.1 Component 1
105.	Component Report on Institutional Capacity Development
106.	Progress of Component 1 for MTR 1
107.	Cover MEDEP Policies
108.	MEDEP Policies
109.	Agri Business Report Dec 21
110.	Bagar Kheti_Guidelines_2070_Draft 1
111.	Bagarkheti Niti_UPDATED_08.08.2013
112.	Bee Policy 2072 edit
113.	Component 2 (Policy Dialogue) in MEDEP
114.	Detail of Com 2
115.	MEDEP_Mapping final Report_5
116.	Summary of Com 2
117.	Monetary policy
118.	Financial Literacy for Micro entrepreneurs
119.	Financial Mapping Study Report
120.	Monetary_Policy Clause 102 and 103
121.	MoU with FSPs (July 17, 2014)
122.	Final Report GESI Impact Study MEDEP 2
123.	GoN Capacity Needs Assessment Final
124.	MEDEP IV Capacity Development Strategy
125.	A2F Report for Mid-Term Review Gokul
126.	Component 1 Final 20 Jan 2
127.	Component 1 Jan 21
128.	Component 2 Policy Dialogue in MEDEP
129.	DEDSP Guidelines
130.	GESI Presentation for MTE 1
131.	Institutional Capacity Building MTR 2016
132.	MEDPA Guidelines Amended
133.	MTR C3 Major output table
134.	MTR presentation A2F 1
135.	MTR Presentation for A2F 2
136.	MTR Report C3
137.	Presentation for MTE Team leader and team
138.	Status of M & E
139.	Table of MTR for A2F 1
140.	VEDP Guidelines approved by GoN
141.	Advocacy Dialogue edited indicators
142.	Aggregate Summary of Components
143.	Annex 3.1 component 1

144.	Annex 3.3 Component 3
145.	Annex 3.4 Component 4
146.	Annex 3.5 Component 5
147.	Annex 3.6 Communication and documentation
148.	Annex 4 overall and by components
149.	Edited by Laxmi_annex 4 overal and by components
150.	Final draft of indicators of results at all level
151.	MEDEP_Report_Phase 2 _ Structure 1
152.	Policy Component 1
153.	MEDEP Report Phase 2 Final Report 5 Sept
154.	Nepal EA UNDP 7 Feb, Phase 1
155.	Aid Quality Check for MEDEP 2015
156.	14 12 31 NMEFEN Communication Strategy
157.	20 Dec Final Report Capacity Assessment
158.	Allo_Final_Cover Page
159.	CP_NEP_2013-2017 final
160.	Darchula RA Annex D
161.	Darchula RA_FGD with DMEGA Annex C
162.	Darchula RA Final Report
163.	Detail of Com 2
164.	Direct Tracking System
165.	DMEGA Membership service Guideline final
166.	Economic Empowerment of Women
167.	Exim Study Final Report
168.	Final CO_Gender Equality and Social Inclusion
169.	Final Doc_Sign_UNDAF_Nepal_2013_17
170.	Final Inception report 9 Feb 2
171.	Final Report GESI Impact Study MEDEP
172.	Final Report on Consolidation and Standardization
173.	Final Report allo study NFA 5 March
174.	Impact Assessment NARMA 5dec10
175.	ING833_AQC_AID_Quality_Check_2015
176.	Letter from MoI
177.	MEA Capacity Assessment_ACIn_Final
178.	MED Model Externalization final
179.	MED System Definition Indicators costing
180.	MEDEP APR 22 jan 2016
181.	Final_Gender Equality Strategy 2014-17
182.	MEDEP IV Capacity Development Strategy
183.	MEDEP MEDPA evaluation final draft
184.	MEDEP report phase 2 final report 5 sept
185.	MEDEP report phase 2 final
186.	MEDEP Mass Impact Study (MIS) report
187.	RA Score Card Annex A
188.	Rapid assessment checklist Annex B
189.	RBM&E Nepali Handbook MEDPA 5 th
190.	Reference Document List for MEDEP MT
191.	Report Allo Demand report final
192.	Report Technology CKA final 7.7.2015

193.	Resiliency Assessment Report final
194.	Study report on capacity assessment of Institutional Dev Guidelines for MED
195.	UNDP guidance on outcome level evaluation
196.	Updated draft MEDPA Progress report NPC
197.	Final gender equality strategy 2014 -2018

Annex 4 – People interviewed

List of People Interviewed

S.N	Name of the Person	Position	Organization
1.	Renaud Meyer	Country Director	UNDP Nepal
2.	Sophie Kemkhadze	Deputy Country Director UNDP	UNDP Nepal
3.	Heema Devi Khadka	Assistant Country Director	UNDP Nepal
4.	Nabina Shrestha	Program Analysts	UNDP Nepal
5.	Dr. Laxman Pun	Chief Technical Advisor	MEDEP
6.	Dr. Ramji Nepaune	National Project Manager	MEDEP
7.	Rohini Prasad Regmi	Admin & Finance Manager	MEDEP
8.	Laxmi Limbu	Senior Monitoring and Evaluation Specialist	MEDEP
9.	Megharaj Acharya	Intervention Manager	MEDEP
10.	Rajesh Verma	Intervention Manager	MEDEP
11.	Bhupendra Rana Magar	Intervention Manager	MEDEP
12.	Ranjan KC	Intervention Manager	MEDEP
13.	Gokul Pyakuryal	Intervention Manager	MEDEP
14.	Sabita Dhakhwa	Senior Institutional Development and Strategy Specialist	MEDEP
15.	Indra Dhoj Kshetri	Communication and Documentation Specialist	MEDEP
16.	Tara Gurung	Director, Development Programme	Australian Embassy/DFAT
17.	Padam Bhusal	Program Manager, Livelihood	DFAT
18.	Sarah Boddington	First Secretary, Development Co-operation	DFAT
19.	Ainsley Hemming	Second Secretary, Development Co-operation	DFAT
20.	Poshan B. KC	National Program Advisor	Samartha/DFID
21.	Yam Kumari Khatiwada	Joint Secretary/NPD	MOI
22.	Ananda Pokharel	Under Secretary/Planning Division	MOI
23.	Deepak Ghimire	National Programme Coordinator	MOI
24.	Narayan Prasad Bidari	Director General	MOI
25.	Pramila Rijal	Section Officer	MOI
26.	Reshmi Raj Pandey	Joint Secretary	MoFALD
27.	Ramesh K. KC	Under Secretary	MoFALD
28.	Nagendra Bhattarai	Chartered Accountant	Kathmandu
29.	Arun Dhoj Adhikari	Consultant	Kathmandu
30.	Deepak Poudel	Director, Curriculum Development Division	CTEVT
31.	Dr. Raj Bahadur Shrestha	Deputy Programme Manager	CCP
32.	Jose Assalino	Country Director	ILO
33.	Shailendra Jha	Senior National Programme Officer	ILO
34.	Nabin Karna	National Programme Officer	ILO
35.	Eva Majurina	EDP Specialist	ILO
36.	Dilip Thapa	Master Trainer	SIYB, Secretariat, KTM
37.	Amir Lama	Senior Business Promotion Officer	IEDI
38.	Rachana Pandit	Chairperson	NEDC
39.	Laxmi Acharya	Programme Coordinator	NEDC
40.	Yasoda Subedi	AFA	NEDC
41.	Bimal Gaire	Programme Coordinator	MEDSP, Udayapur
42.	Kima Lama	Planning Officer	NPC
43.	Gopi Mainali	Joint Secretary	NPC

S.N	Name of the Person	Position	Organization
44.	CK Pokhrel	Member	NPC
	Sunil Singh	Chief	DADO, Kalikot
45.	Surya Bdr. Sahi	Chairperson	FNCCI, Kalikot
46.	Bhanu Bhakta Acharya	Treasure	FNCCI, Kalikot
47.	Hasta Bahadur Bam	Member	FNCCI, Kalikot
48.	Tirtha Bahadur Sahi	Member	FNCCI, Kalikot
49.	Binod Dev Panta	Chief	CSIDBO, Surkhet
50.	Madhav Neupane	Account Officer	CSIDBO, Surkhet
51.	Yogendra B. Chand	Internal Auditor	DDC Surkhet
52.	Yagam Katlel	SDO	DDC Surkhet
53.	Shiva Raj Bhatta	Information Officer	DDC Surkhet
54.	Yagya Gautam	Program Officer	LWF
55.	Khem Prasad Oli	Program officer	IDE Anukulan
56.	Bhagirath Bhatta	SD	LGCDP, Kailali
57.	Narendra Bista	RC	LGCDP, Kailali
58.	Tej Bahadur BC	ASPM	MEDEP-ASPO Dhangadi
59.	Moti Giri	GSS Dadeldhura	MEDEP-ASPO Dhangadi
60.	Balaram Sharma	MDS	MEDEP-ASPO Dhangadi
61.	Kedar Dahal	GSS	MEDEP-ASPO Dhangadi
62.	Nabindra Shrestha	MISSA	MEDEP-ASPO Dhangadi
63.	Amit KC	AFO	MEDEP-ASPO Dhangadi
64.	Tarak Thapa	MDS	MEDEP-ASPO Dhangadi
65.	Lekhnath Ojha	Internal Auditor	Dhangadi Sub-Metropolitan Municipality
66.	Dilliraj Ojha	Senior Accountant	Dhangadi Sub-Metropolitan Municipality
67.	Dirgha Ram Bhatta	DE	Dhangadi Sub-Metropolitan Municipality
68.	Surendra Singh Karki	Admin Officer	Dhangadi Sub-Metropolitan Municipality
69.	Krishna Raj Panta	Member	FNCCI/NFSCI, Dhangadi
70.	Mahesh Dahal	Sec Officer	FNCCI/NFSCI, Dhangadi
71.	Surya Man Shrestha	Member	FNCCI/NFSCI, Dhangadi
72.	Jyoti Bhatta	Office Manager	FNCCI/NFSCI, Dhangadi
73.	Tritha Raj Pathak	Member	FNCCI/NFSCI, Dhangadi
74.	Sujit Sharma	EDF Trainer	FNCCI/NFSCI, Dhangadi
75.	Sanjay Kumar Dahal	Chairperson	Shree Sindhuli
76.	Sabita Koirala	APSM	MEDEP-APSO-Hetauda
77.	Rama Timilsina	Member	MEDEP-APSO-Hetauda
78.	Bedraj Dahal	Program Co-ordinator	Shree Sindhuli
79.	Rameshwor Dahal	Vice-Secretary	Shree Sindhuli
80.	Renu Pokhrel	AFA	Shree Sindhuli
81.	Shrinkhala Karki	DBA	Shree Sindhuli
82.	Pitambar Phuyal	EDF	Shree Sindhuli
83.	Kabita Pariyar	EDF	Shree Sindhuli
84.	Pabitra Ghising	EDF	Shree Sindhuli
85.	Lila Kumari Yadav	EDF	Shree Sindhuli
86.	Pawan Bhandari	Chairperson	SEWAK Nepal (MED-SP)

S.N	Name of the Person	Position	Organization
			Kailali
87.	Gagan Singh Thagunna	Treasure	SEWAK Nepal (MED-SP) Kailali
88.	Naresh Prasad Bhatta	Member	SEWAK Nepal (MED-SP) Kailali
89.	Yagya Raj Awasthi	Member	SEWAK Nepal (MED-SP) Kailali
90.	Chandani Shahi	Program Coordinator	SEWAK Nepal (MED-SP) Kailali
91.	Kalpana Bhandari	EDF	SEWAK Nepal (MED-SP) Kailali
92.	Sirmala Chaudhary	EDF	SEWAK Nepal (MED-SP) Kailali
93.	Nisha Joshi	AFA	SEWAK Nepal (MED-SP) Kailali
94.	Gyani Shahi	EDF	SEWAK Nepal (MED-SP) Kailali
95.	Ramsingh Chaudhary	EDF	SEWAK Nepal (MED-SP) Kailali
96.	Puran Shahi	EDF	SEWAK Nepal (MED-SP) Kailali
97.	Keshav Prasad Bimali	LDO	DDC, Kalilali
98.	Kedar Dahal	GSS	ASPO Kailali (Dhangadi)
99.	Krishan Prasad Khanal	Chieft Accountant	DDC, Kalilali
100.	Hari Priya Bam	Chief	Women and Children Development Office, Kailali
101.	Govinda Raj Joshi	Chief	District Agriculture Office
102.	Ganesh Bahadur Bista	Chair	DMEGA-Kailali
103.	Jagadish Prasad Gupta	Chief	District Forest Office, Kailali
104.	Purukal Karmacharya	President	Federation of Nepal Cottage and Small Scale Industry, Kailali
105.	Goma Adhikari	DEDC Member	FNCCI, Kailali
106.	Dipesh Thakur	Public Officer	DDC, Kailali
107.	Harka Bahadur Kathayat	PMAO	DDC, Kailali
108.	Shiva Raj Bhat	Communication Officer	DDC, Kailali
109.	Dilip Bahadur Chanda	Industry Officer	Small and Cottage Scale Industry-Kailali
110.	Surendra Prasad Panta	Focal Person	CSIO Kailali
111.	Basudev Khadka	DTCO Staff	DTCO, Kailali
112.	Prem Bahadur Bogati	DTCO Staff	DTCO, Kailali
113.	Bhola Prasad Chapagain	LDO	DDC Kalikot
114.	Sunil Singh	Senior Agriculture Officer	District Agriculture Office Kalikot
115.	Bhanubhakta Baral	Treasure	FNCCI, Kalikot
116.	Krishna Lal Chaulagain	Chairperson	Federation of Small and Cottage Scale Industry
117.	Madhav Prasad Neupane	Chairperson	DMEGA, Kalikot

S.N	Name of the Person	Position	Organization
118.	Jaman Singh Bam	Staff	District livestock service office, Kalikot
119.	Sita Thapa	Officer	District Women and Children office, Kalikot
120.	Pyarelal Tharu	Chief	District Treasury Comptroller Office, Kalikot
121.	Gorakh Sahi	Branch Manager	Rastriya Banijya Bank, Kalikot
122.	Indra Bahadur Thapa	Evaluation Officer	CSIDB
123.	Rajendra Bahadur Sahi	Accountant	DDC
124.	Purnalal Khatri	Member	Dalit Upliftment Coordination committee
125.	Pashuram Kafle	Section Officer	District Agriculture Office Kalikot
126.	Ashok Nath Yogi	Chairperson	Social Awareness & Development Academy (SADA-Nepal)
127.	Lilaraj Bam	Vice Chairperson	SADA-Nepal
128.	Basanta Yogi	Accountant	SADA-Nepal
129.	Durga Bahadur Bista	Field Coordinator	SADA-Nepal
130.	Dalsingh Kumal	Field Coordinator	SADA-Nepal
131.	Dalsingh Giri	Computer Operator	SADA-Nepal
132.	Mr. Keshav Dutta Dawadi	APSM	ASPO Pokhara
133.	Rajani Thapa Magar	MDS	ASPO Pokhara
134.	Mr. Moti Bdr. Giri	GSS	ASPO Kailali (Dhangadi)
135.	Prem Raj Neupane	APSM	ASPO Biratnagar
136.	Madhu Kumar Bishwakarma	APSM	Kalikot District Under ASPO Surkhet
137.	Khem Raj Ojha	LDO	DDC, Jhapa
138.	Him Raj Sedhai	MEDPA, Focal Person	DDC, Jhapa
139.	Bhimsen Gacchedar	Manager	Forward, Jhapa
140.	Ashok Chaudhari	Field Staff	Forward, Jhapa
141.	Netra Mani Thapa	Field Staff	Forward, Jhapa
142.	Pandre Chaudhari	Field Monitor	Forward, Jhapa
143.	Nava Raj Paneru	Chairperson	FNCCI, Jhapa
144.	Gopi Ghimire	Office Chief	CSIO, Jhapa
145.	Gopal Limbu	Planning Officer	CSIO, Jhapa
146.	Chandra Mishra	Planning Officer	CSIO, Jhapa
147.	Sudarshan Baral	VDC, Secretary	Shantinagr VDC, Jhapa
148.	Rajan Regmi	Staff	Sagarmatha Samudayik Bikas Kendra (MEDSP)
149.	Kuber Dhakal	Staff	Sagarmatha Samudayik Bikas Kendra (MEDSP)
150.	Hira Khandar	Senior Manager	Forward, Biratnagar
151.	Krishna Bhattra	Chief Manager	Forward, Biratnagar

S.N	Name of the Person	Position	Organization
152.	Rajesh Chaudhari	Accountant	Forward, Biratnagar
153.	Chirinjivi Poudyal	LDO	LDO, Myagdi
154.	Hari Krishna Acharya	SDO	DDC Myagdi
155.	Bishnu Poudyal,	PM & EO	DDC Myagdi
156.	Binod Regmi	Account Officer	DDC Myagdi
157.	Chandra Kanta Kafle	Department Head	Swabalamban Laghubitta Bank, Myagdi
158.	Amit Shrestha	Head, SME/Micro	Megha Bank, Myagdi Branch
159.	Janardan Dev Panta	Branch Manager	Nirdhan Utthan Bank, Myagdi
160.	Yuba Raj Guragain	Branch Manager	Civil Bank, Myagdi Branch
161.	Roop Bahadur Khadka	Manager	Rural Microfinance Development Centre Ltd.
162.	Mira Adhikari	Office Chief	CSIDB, Myagdi
163.	Indra Poudyal	Admin Officer	CSIDB, Myagdi
164.	Sanjay Paudel	Accountant	CSIDB- Myagdi
165.	Kabita Gurung	EDF	CSIDB- Myagdi
166.	Jiwan Bishwakarma	President	CCI- Myagdi
167.	Dhan Bahadur Khati	Chairperson	DMEGA-Myagdi
168.	Dayaram Chapagain	Chief	DLSO-Myagdi
169.	Lilaram Gautam,	President	FNCSI-Myagdi
170.	Mira Adhikari	Office Chief	CSIDB-Myagdi
171.	Yubraj Paudel	Chief	DTCO
172.	Bina Khadka	Vice President	District Women Coordination Committee
173.	Shyam Prasad Risal	Chief	DADO-Myagdi
174.	Shankar Subedi	Chairmann	BDSPO SANGAM
175.	Ramchandra Subedi	Member	BDSPO SANGAM
176.	Phayamaya Pun	Member	BDSPO SANGAM
177.	Khar Maya Bitaula	Member	BDSPO SANGAM
178.	Yubraj Paudel	Chief	DTCO
179.	Dhan Bahadur Khati	President	DMEGA-Myagdi
180.	Bishnu Gurung	Treasurer	DMEGA-Myagdi
181.	Lila Pun	Member	DMEGA-Myagdi
182.	Neksari Pun	Member	Allo MEG
183.	Bhagawati Sharma	Co secretary	DMEGA-Myagdi
184.	Hira Subedi	Member	DMEGA-Myagdi
185.	Dilo Gurung	Member	Dhaka MEG
186.	Anita Thapa	District Program Coordinator	DMEGA-Myagdi
187.	Hari Paudel	Chairman	NGO Federation Myagdi
188.	Nagendra Regmi	MSFP	DMEGA-Myagdi
189.	Basanta Pachabhaigo	Manager	Clean Village
190.	Salikram Sharma	Manager	DCRDC
191.	Santosh Parti	Member	LGCDP
192.	Tilu Rana	Member	Milan NGO
193.	Uttam Kumar Karmacharya	Senior Vice President	Chamber of Commerce and Industries, Myagdi
194.	Sunil Shrestha	Vice President	Chamber of Commerce and

S.N	Name of the Person	Position	Organization
			Industries, Myagdi
195.	Rachana Pandit	Chairperson	National Entrepreneurship Development Center (NEDC)
196.	Laxmi Acharya	Program Coordinator	NEDC
197.	Bamal Baire	Staff	NEDC
198.	Yasoda Subedi	AFA	NEDC

Participation Lists in Focus Group Discussion (FGD)

Name of CFC: Soda Gandhi Bangur Palan Samuha

Year of Establishment: 2070/09/16

District: Jhapa

VDC: Jalthal Ward No 8, Jhapa

S.N	Name of the Participation	Position	Organization	Remarks
199.	Yet Maya Shankar	Member	Soda Gandhi Bangur Palan Samuha	
200.	Hem Kumari Kandangwa	Member	Soda Gandhi Bangur Palan Samuha	
201.	Ramina Aastha	Chairperson	Soda Gandhi Bangur Palan Samuha	
202.	Pramila Aastha	Member	Soda Gandhi Bangur Palan Samuha	
203.	Sangeeta Aastha	Member	Soda Gandhi Bangur Palan Samuha	
204.	Manju Aastha	Member	Soda Gandhi Bangur Palan Samuha	
205.	Sarita Mishra	Member	Soda Gandhi Bangur Palan Samuha	
206.	Renu Aastha	Member	Soda Gandhi Bangur Palan Samuha	
207.	Anjali Muramu	Member	Soda Gandhi Bangur Palan Samuha	
208.	Sirati Sharan	Member	Soda Gandhi Bangur Palan Samuha	
209.	Lalita Tundul	Member	Soda Gandhi Bangur Palan Samuha	

Name of CFC: Nawajiwan Laghu Uddham samuha, Members supported with CFC

Year of Establishment: 2070

District: Jhapa

VDC: Damak, Jhapa

S.N	Name of the Participation	Position	Organization	Remarks
210.	Nirmala Rai	Chairperson	Nawajiwan Laghu Uddham samuha	
211.	Dambar Kumari Limbu	Member	Nawajiwan Laghu Uddham samuha	
212.	Pramila Ale Magar	Member	Nawajiwan Laghu Uddham samuha	
213.	Tanka Shrestha	Member	Nawajiwan Laghu Uddham samuha	
214.	Bhim Maya Rai	Treasurer	Nawajiwan Laghu Uddham samuha	

Name of Non CFC Micro Entrepreneurs: Jun Tara Laghu Uddham Samuha

Year of Establishment: 2070

District: Jhapa

VDC: Damak, Jhapa

S.N	Name of the Participation	Position	Enterprise	Remarks
215.	Dhanu Subba	Member	Pig farming	
216.	Bhumika Jogi	Treasurer	Pig farming	
217.	Nanda Kumar Shrestha	Secretary	Vegetable farming	
218.	Vishnu BK	Member	Pig farming	
219.	Mangal BK	Member	Pig farming	
220.	Vishnu Maya Tamang	Member	Pig farming	
221.	Sabitra BK	Member	Pig farming	
222.	Manamaya Fyaka	Non participant	-	

Name of the CFC: Kanya Chyau Utpadan Laganshil Samuha

Year of Establishment: 2072

District: Myagdi

VDC: Kuhun

Tole: Varjula Gahiri Tole

S.N	Name of the Member	Sex	Age	ME	Remarks
223.	Bir Bahadur Sherpurja	M	47	Mushroom Production Group	
224.	Nita Pun	F	21	Mushroom Production Group	
225.	Bishnumaya Jugjali	F	46	Mushroom Production Group	
226.	Chandra Kumari Pun	F	33	Mushroom Production Group	
227.	Goma Pun	F	24	Mushroom Production Group	
228.	Yogendra Jugjali	M	39	Mushroom Production Group	
229.	Yam Bahadur Rokka	M	62	Mushroom Production Group	
230.	Bal Bahadur Sherpurja	M	53	Mushroom Production Group	
231.	Gyan Bahadur Tilija	M	48	Mushroom Production Group	
232.	Bhim Bahadur Jugjali	M	36	Mushroom Production Group	
233.	Dalmaya Sherpurja	F	54	Vegetable Production Group	
234.	Kamti Sherpurja	F	56	Vegetable Production Group	
235.	Parbati Kisan	F	41	Vegetable Production Group	
236.	Taradevi Pun	F	60	Vegetable Production Group	
237.	Dilmati Kishan	F	40	Vegetable Production Group	
238.	Chandra Kumari Kisan	F	39	Vegetable Production Group	
239.	Yomati Pun	F	61	Vegetable Production Group	
240.	Gunmaya Jugjali	F	49	Vegetable Production Group	
241.	Yamkumari Pun	F	73	Vegetable Production Group	
242.	Uma Jugjali	F	29	Vegetable Production Group	
243.	Krishna Kumari Sherpurja	F	51	Vegetable Production Group	
244.	Yamkumari Kisan	F	36	Vegetable Production Group	
245.	Tuli Kisan	F	65	Vegetable Production Group	
246.	Subash Kisan	M	21	Vegetable Production Group	

Name of the CFC: Ratnechaur Dhaka Laghu Udyami Samuha

Year of Establishment: 2071

District: Myagdi

Municipality: Beni Municipality Ward No 1.

Tole: Ratnechaur

S.N	Name of the Member	Sex	Age	ME	Remarks
247.	Khum Kumari Thapa	F	36	Dhaka Laghu Udyami Samuha	
248.	Syani Thapa	F	28	Dhaka Laghu Udyami Samuha	
249.	Samjhana Pun	F	23	Dhaka Laghu Udyami Samuha	
250.	Bharati Kisan	F	22	Dhaka Laghu Udyami Samuha	
251.	Dhana Khatri	F	32	Dhaka Laghu Udyami Samuha	
252.	Sunita Thapa	F	32	Dhaka Laghu Udyami Samuha	
253.	Sahanshila Pun	F	39	Dhaka Laghu Udyami Samuha	
254.	Kalpana Thapa	F	22	Dhaka Laghu Udyami Samuha	
255.	Chameli Thapa	F	26	Dhaka Laghu Udyami Samuha	
256.	Jamuna Kisan	F	23	Dhaka Laghu Udyami Samuha	

Participants Lists on Nigalkot CFC Center, Kalikot

S.N	Name of the Participation	Position	Organization	Remarks
257.	Juthe Kathayat	Chairperson	Nigalkot CFC Center	
258.	Puse Bohara	Vice-Chairperson	Nigalkot CFC Center	
259.	Jase Bohora	Treasurer	Nigalkot CFC Center	
260.	Laxmi Bohora	Secretary	Nigalkot CFC Center	
261.	Log Bohora	Member	Nigalkot CFC Center	
262.	Lalsari Basnet	Member	Nigalkot CFC Center	
263.	Gorikali Bohora	Member	Nigalkot CFC Center	
264.	Gorikala Bohora	Member	Nigalkot CFC Center	
265.	Krishna Bohora	Member	Nigalkot CFC Center	
266.	Jalu Bohora	Member	Nigalkot CFC Center	
267.	Kali Bohora	Member	Nigalkot CFC Center	
268.	Nanda Bohora	Member	Nigalkot CFC Center	
269.	Devisara Bohora	Member	Nigalkot CFC Center	
270.	Muga B.K	Member	Nigalkot CFC Center	
271.	Kabita B.K	Member	Nigalkot CFC Center	
272.	Kaikosha B.K	Member	Nigalkot CFC Center	
273.	Krishna B.K	Member	Nigalkot CFC Center	
274.	Dhansari B.K	Member	Nigalkot CFC Center	

Name of CFC: **Kotkhal Malika Allo Prasodhan Tatha Kapada Bunai Laghu Udhhami Samuha**

Year of Establishment: 2065

District: Kalikot

VDC: Bharta Ward no 2, Thuni.

S.N	Name of the Participation	Position	Organization	Remarks
275.	Pansara Rokka Magar	Chairperson	Kotkhal Malika Allo Prasodhan Samuha	
276.	Khagisara Rokka Magar	Vice Chairperson	Kotkhal Malika Allo Prasodhan Samuha	
277.	Aaiti Rokka Magar	Treasure	Kotkhal Malika Allo Prasodhan Samuha	
278.	Kaushi Budha Magar	Secretary	Kotkhal Malika Allo Prasodhan Samuha	
279.	Bimala Budha Magar	Member	Kotkhal Malika Allo Prasodhan Samuha	
280.	Mangli rokka Magar	Member	Kotkhal Malika Allo Prasodhan Samuha	
281.	Binsara Rokka Magar	Member	Kotkhal Malika Allo Prasodhan Samuha	
282.	Bira Budha Magar	Member	Kotkhal Malika Allo Prasodhan Samuha	
283.	Debisara Budha Magar	Member	Kotkhal Malika Allo Prasodhan Samuha	
284.	Dutta Bahadur Shahi	VDC Staff	Bharta VDC, Kalikot	
285.	Ambar Sarki	Social Mobiliser		
286.	Bindu Devi Shahi	Senior EDF	DMEGA	
287.	Mamata Bista	OJT-EDF	DMEGA	
288.	Jharana Bista	OJT EDF	DMEGA	

Participants Lists on Fulbari CFC, Riverbed Farming in Kailali District

S.N	Name of the Participation	Position	Organization	Remarks
289.	Bhojraj Chaudhary	Member	Fulbari CFC	
290.	Binitram Chaudhary	Member	Fulbari CFC	
291.	Janaki Devi Chaudhary	Member	Fulbari CFC	
292.	Phulmaya Chaudhary	Member	Fulbari CFC	
293.	Binita Chaudhary	Member	Fulbari CFC	
294.	Balaram Chaudhary	VDC Secretary	Fulbari VDC	
295.	Omprakash Chaudhart	Member	VEDC	
296.	Aushiyaram Chaudhary	Member	VEDC	
297.	Rajendra Chaudhary	Member	VEDC	
298.	Bhojraj Chaudhary	Member	VEDC	
299.	Anita Chaudhary	Member	VEDC	
300.	Jaganlal Chaudhary	Member	VEDC	
301.	Dipak Khadka	Member	VEDC	

Participants Lists on Naya Sijana CFC, Dhangadhi-04, Uttarbehadi

S.N	Name of the Participation	Position	Organization	Remarks
302.	Rasmi Chaudhary	Member	Naya Sijana CFC	
303.	Sunita Chaudhary	Member	Naya Sijana CFC	
304.	Rama Chaudhary	Member	Naya Sijana CFC	
305.	Lalmati Rana	Member	Naya Sijana CFC	

Annex 5 –The MEDEP/MEDPA service model and the delivery system

MEDEP service model:

Resource and market research to identify micro enterprise opportunities is followed by:

- Social mobilisation – including participatory rural appraisal to identify target candidates, creation of groups, socialisation of idea.
- Entrepreneurship training – Start and Improve Your Business, Micro Enterprise Creation and Development
- Technical skills development – basic skills training related to the enterprises expected to start
- Financial services access – Establishment of linkages between financial services providers (MFIs, cooperatives) and start-ups
- Market linkages and business counselling – scale up, advanced training, business advice and linkages with wholesale buyers and markets

Start-ups take up to 2 years to graduate, and another 2 years to become resilient.

Delivery system (simplified):

- Micro Enterprise Development Fund (MEDF): MEDPA activities in the Districts will be funded from a District-level MEDF, to which the Ministry of Finance, District Development Committees, Village Development Committees and donors contribute.
- Village Enterprise Development Committees (VEDCs) under VDCs submit village enterprise development plans and requests for MED to DCC, monitor, also ensure access to markets and finance
- District Enterprise Development Committee, under the DCC, draws up district enterprise development plan, manages the MEDF, selects MED Service Providers (based on competitive tenders), monitors implementation and evaluates (Monitoring Sub-committee), but also ensures access to markets, finance
- DDC: approves the plan
- District Offices of the Department of Cottage and Small Industries (DCSI) and Cottage and Small Scale Industries Development Board (CSIDB) prepare implementation plans, contract MED Service providers to carry out new ME creation on the basis of competitive tenders, monitor implementation, and maintain and manage the MIS. Ensure access to markets and finance. Selects MEs for advanced scale-up training.
- MED Service Providers implement the programme, including preparatory activities and service provision. Provide data on MEs created to the above.
- National Entrepreneurship Development Centre: supports MEDSPs through capacity building and in the bidding process.
- National level Selection Committee: pre-selects MEDSPs that are qualified to bid.
- Financial services providers including cooperatives provide credit.
- MEDPA Steering Committee at policy and strategic level (Inter-ministerial)
- MEDPA Executive Committee.
- CSIDB and DCSI at the national level: overall management and supervision, staff training, maintaining Management Information System, reporting,
- DMEGAs: Advocacy for pro-ME policies, district and national, and provide services to members as well as support to linkages to finance, skills training and markets (not in the start-up phase).
- National Micro-Entrepreneurs' Federation of Nepal (MNEFN): national level advocacy, support to DMEGAs.