RASUWA FLOOD

EMERGENCY RESPONSE & EARLY RECOVERY

OCE PUBLIC CAMPAIGN ✦ INTERNATIONAL DONOR ACTION PLAN

Prepared for Open Collective Europe fundraising and international donor review

Prepared by Naya Nepal Samajik Sanstha (NNSS)

Submission-ready version | 04 September 2026

Campaign ceiling **NPR 150,000,000**	**USD planning equivalent** **USD 986,842.11**	**Exchange rate** **USD 1 = NPR 152**	**Implementation** **6 months**
Shelter target **300 families**	**Food/household target** **500 families**	**Education target** **500 students**	**Medical team** **5 doctors ✦ 5 nurses**

Live financial and programme schedules are hosted on NNSS.org.np and linked throughout this report. Detailed worksheet tables are intentionally not duplicated in the Word report.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -✦ | VIEW BUDGET SUMMARY -✦ | VIEW DETAILED BUDGET -✦

PUBLICATION NOTE & DATA STATUS

This report is designed as the narrative, governance and due-diligence document for the NNSS Rasuwa Flood Emergency Response & Early Recovery campaign. It is intentionally written so that a donor, fiscal host, civil-society partner or technical reviewer can understand the humanitarian context, targeting approach, delivery controls, safeguarding standards, implementation arrangements and financial architecture in one document, while live financial schedules remain accessible through controlled links hosted on the NNSS website.

The document does not reproduce the full Excel-style worksheets. That duplication can create version-control problems when unit rates, beneficiary quantities, cash-flow timing or monitoring results are updated. Instead, each substantive section contains a highlighted live link to the corresponding worksheet. The live sheets are the operational source for detailed tables; this Word report is the narrative and accountability layer. This division mirrors common international NGO practice: a proposal or action plan explains why, who, what, how and under what controls, while detailed cost schedules and monitoring trackers are maintained as structured supporting records.

Situation figures remain preliminary and may change as search, rescue, identification and damage assessment continue. The report therefore states the date and source for external humanitarian figures and distinguishes verified public estimates from NNSS programme targets. Where sex-, age- or household-head-disaggregated affected-population figures are not publicly available, the report identifies the gap rather than inventing a number. NNSS will collect the missing disaggregation through its rapid household verification process before beneficiary selection and will report aggregate, privacy-safe results through the live monitoring and campaign update system.

> **DATA / SOURCE NOTE:** External situation data in this edition draw on Government of Nepal / Ministry of Home Affairs and Health Emergency Operation Centre updates, WHO Nepal, UNICEF Nepal Humanitarian Situation Report No. 1 (31 Aug 2026), UNICEF 3 Sep 2026 WASH update, UNFPA Nepal's 31 Aug flash update, and NDRRMA figures reported by established Nepal media on 3 Sep 2026. All external figures are dated because the emergency is evolving.

How to use the live worksheet links

1. Click the highlighted worksheet name in any section of this report. The link opens the corresponding NNSS-hosted sheet in a browser.
2. The live worksheet should be treated as the current detailed schedule for quantities, rates, evidence records or monitoring data. The narrative in this report is aligned to the current planning model as of 04 September 2026.
3. If a future budget revision changes the total campaign ceiling or any component ceiling, the public narrative should be revised at the same time so that the report and the live financial model remain consistent.
4. Sensitive person-level data, grievance case details, patient information and unredacted beneficiary records must not be placed in public sheets. Public reporting should use aggregate and consent-cleared information only.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW SOURCES & METHODOLOGY -◂ | VIEW DISCLOSURE & PRIVACY -◂

OCE PUBLIC CAMPAIGN BRIEF — READY-TO-PUBLISH COPY

Campaign title

Rasuwa Flood Emergency Response & Early Recovery

Public campaign description

Naya Nepal Samajik Sanstha (NNSS) is mobilizing an emergency response and early-recovery programme for communities affected by the catastrophic 26 August 2026 flash floods along the Bhote Koshi-Trishuli river corridor in Nepal. The programme is designed to help verified flood-affected households move from immediate survival toward safer recovery through shelter support, essential household items, three months of food assistance, safe water and hygiene support, mobile medical care, education recovery for flood-affected students, last-mile logistics, accountable field operations and targeted livelihood/early-recovery support.

The campaign planning ceiling is NPR 150,000,000, equivalent to approximately USD 986,842.11 at the planning exchange rate of NPR 152 per USD. NPR 120,000,000 is allocated to direct programme activities, NPR 12,000,000 to project administration and coordination, and NPR 18,000,000 to contingency. The contingency is a controlled reserve for documented price, access, health or protection shocks and is not treated as automatically spent. Any fiscal-host or platform fee is handled separately through the live fee-scenario sheet until the final OCE arrangement is confirmed.

NNSS will prioritize verified needs and vulnerability rather than first-come-first-served distribution. Assistance lists will be de-duplicated, procurement decisions documented, medical personnel credentialed, grievance channels made available free of charge, and monitoring results summarized through public updates. Individual beneficiary, grievance and patient data will remain protected; only aggregate or consent-cleared information will be published.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN	
VIEW CAMPAIGN OVERVIEW -• | VIEW BUDGET SUMMARY -• | VIEW FUNDING & CONTRIBUTIONS -•	
Public commitment	**What it means in practice**
Needs-based targeting	Household/student support follows documented need, damage and vulnerability criteria; duplicates are screened before approval.
Financial transparency	The live budget, funding and budget-versus-actual schedules provide a traceable donor view of planned and actual use of funds.
Procurement discipline	Quotations or justified procurement methods, approvals, inventory records and delivery evidence are retained for

	review.
Accountability	Feedback and complaints can be raised without charge; sensitive cases are handled confidentially and escalated appropriately.
Evidence-based reporting	Field evidence is dated, captioned, verified and screened for consent before public use.

Table 1. Public transparency commitments

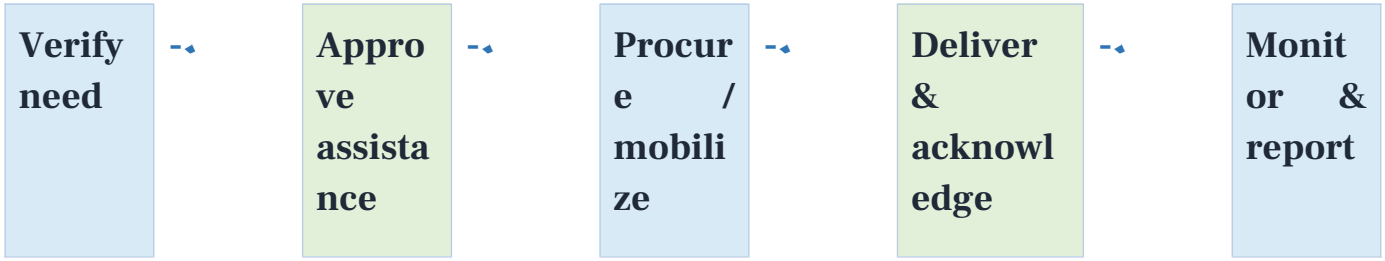

Figure 1. Public accountability chain from need verification to reporting

Table of Contents

PUBLICATION NOTE & DATA STATUS *2*

How to use the live worksheet links **2**

OCE PUBLIC CAMPAIGN BRIEF — READY-TO-PUBLISH COPY *3*

Campaign title **3**

Public campaign description **3**

CONTENTS ..... *Error! Bookmark not defined.*

LIST OF TABLES **8**

LIST OF FIGURES **9**

ACRONYMS & KEY TERMS *10*

Document control and reporting status **10**

EXECUTIVE SUMMARY *12*

1. PROJECT DESCRIPTION & EMERGENCY CONTEXT *13*

1.1 Event overview and humanitarian significance **13**

1.2 Current emergency situation snapshot **13**

1.3 District impact and downstream recovery reporting **14**

1.4 Crisis-affected local units and operational targeting **16**

2. AFFECTED POPULATION, SOCIO-ECONOMIC & VULNERABILITY PROFILE *17*

2.1 Population profile and data limitations **17**

2.2 Sex, age and vulnerability disaggregation status **17**

2.3 Vulnerability and inclusion priorities **18**

3. EMERGENCY IMPACTS AND PRIORITY NEEDS *20*

3.1 Shelter, household assets and displacement **20**

3.2 Food security, nutrition and market disruption **20**

3.3 WASH and public-health risks **20**

3.4 Health, protection and psychosocial impacts **20**

3.5 Education and livelihood disruption **20**

4. POLICY, COMPLIANCE, SAFEGUARDING & DATA-PROTECTION FRAMEWORK *22*

4.1 Operating principle **22**

4.2 Do-no-harm and equitable access **22**

4.3 Safeguarding and PSEA **22**

4.4 Data protection and publication consent **22**

5. ELIGIBILITY, TARGETING & ASSISTANCE FRAMEWORK *24*

5.1 Targeting philosophy **24**

5.2 Verification process **24**

6. INSTITUTIONAL FRAMEWORK & IMPLEMENTATION ARRANGEMENT *26*

6.1 Governance model....26

7. EMERGENCY RESPONSE & HOUSEHOLD RECOVERY DELIVERY PROCESS....28

7.1 Phased delivery....28

7.2 Access and last-mile delivery....29

7.3 Distribution integrity and reconciliation....29

8. SECTOR RESPONSE: SHELTER, HOUSEHOLD, FOOD, WASH, MEDICAL & EDUCATION....30

8.1 Shelter recovery - NPR 35,000,000 (USD 230,263.16)....30

8.2 Household recovery assistance - NPR 14,000,000 (USD 92,105.26)....30

8.3 Three-month food assistance - NPR 22,000,000 (USD 144,736.84)....32

8.4 WASH response - NPR 8,000,000 (USD 52,631.58)....32

8.5 Medical response - NPR 12,000,000 (USD 78,947.37)....33

8.6 Education recovery - NPR 8,000,000 (USD 52,631.58)....34

9. LIVELIHOOD RESTORATION & EARLY RECOVERY....35

10. GRIEVANCE REDRESS, SAFEGUARDING & ACCOUNTABILITY TO AFFECTED PEOPLE..36

10.1 Purpose and access....36

10.2 Accountability to affected populations....37

11. MONITORING, EVALUATION, ACCOUNTABILITY & LEARNING (MEAL)....38

11.1 Monitoring purpose....38

11.2 Baseline, PDM and completion verification....39

11.3 Learning and adaptive management....39

12. PUBLIC INFORMATION, CONSULTATION & PARTICIPATION....40

12.1 Consultation approach....40

12.2 Field evidence and communications....40

13. IMPLEMENTATION SCHEDULE & OPERATIONAL PHASING....41

14. BUDGET REQUIREMENT, PROCUREMENT, CASH FLOW & FINANCIAL CONTROLS....42

14.1 Financial architecture....42

14.2 Procurement and value for money....42

14.3 Cash flow and commitment control....43

14.4 Administration and coordination....43

14.5 Contingency reserve....43

14.6 OCE fiscal-host / platform fee treatment....43

15. RISK MANAGEMENT & SCENARIO PLANNING....45

16. OCE REPORTING, TRANSPARENCY & DONOR ASSURANCE....46

16.1 Public reporting package....46

16.2 Financial assurance....46

16.3 Evidence assurance and privacy....47

17. SUSTAINABILITY, HANDOVER & EXIT STRATEGY *47*
18. CONCLUSION & CALL FOR SUPPORT *49*
ANNEX A. LIVE SUPPORTING WORKSHEET DIRECTORY *50*
ANNEX B. RAPID HOUSEHOLD VERIFICATION FRAMEWORK *51*
ANNEX C. MONITORING INDICATOR DEFINITIONS *52*
ANNEX D. SAFEGUARDING & GRM SERVICE STANDARDS *54*
D.1 Safeguarding minimum operating rules **54**
D.2 GRM escalation matrix **54**
ANNEX E. DATA SOURCES, REFERENCE FRAMEWORK & METHODOLOGY *55*
E.1 Source hierarchy **55**
E.2 External source links **55**
E.3 Reference-framework adaptation statement **56**
ANNEX F. GENDER, AGE, DISABILITY & PROTECTION INCLUSION PLAN *57*
F.1 Why disaggregation matters in this response **57**
F.2 Inclusion actions by programme component **57**
F.3 Safe demographic reporting **58**
ANNEX G. MEDICAL TEAM DEPLOYMENT & HEALTH-RESPONSE FRAMEWORK *59*
G.1 Planned team and deployment readiness **59**
G.2 Mobile medical camp minimum operating package **59**
G.3 Medicine and equipment control **59**
G.4 Health coordination and referral continuity **60**
ANNEX H. DONOR DUE-DILIGENCE & EVIDENCE PACKAGE *60*
H.1 What a donor should be able to verify **60**
H.2 Minimum due-diligence file structure **60**
H.3 Exception management **61**
H.4 Publication readiness check **61**
ANNEX I. 90-DAY MANAGEMENT REVIEW & ADAPTATION CHECKLIST *61*
ANNEX J. DISTRICT & DEMOGRAPHIC OPERATIONAL PROFILE *63*
J.1 Why district and demographic precision matters **63**
J.2 Published demographic and exposure indicators **63**
J.3 District-level operational priorities and verification needs **65**
J.4 Programme demographic outputs to publish after verification **65**
ANNEX K. OCE PUBLIC UPDATE & REPORTING TEMPLATE *67*
K.1 Purpose of the update template **67**
K.2 Minimum content for each OCE public update **67**
K.3 Financial disclosure and reconciliation before publishing **69**

K.4 Suggested short public narrative structure..... 69

FINAL SUBMISSION STATEMENT*.....*71

LIST OF TABLES

Table 1. Public transparency commitments
Table 2. Document control and reporting terminology
Table 3. Document control and reporting status
Table 4. Current emergency situation snapshot
Table 5. District impact and casualty-recovery reporting
Table 6. Government-supported crisis-affected local units
Table 7. Population and vulnerability data status
Table 8. Priority vulnerability and inclusion criteria
Table 9. Emergency needs and programme response logic
Table 10. Compliance and safeguarding control framework
Table 11. Eligibility and assistance framework
Table 12. Institutional roles and responsibilities
Table 13. Response phases and delivery controls
Table 14. Shelter and household recovery quality standards
Table 15. Food assistance and nutrition safeguards
Table 16. WASH and public-health minimum standards
Table 17. Medical response quality and referral standards
Table 18. Education recovery package and verification controls
Table 19. Livelihood and early recovery measures
Table 20. GRM service standards
Table 21. MEAL indicator framework
Table 22. Consultation and information plan
Table 23. Risk register
Table 24. OCE reporting calendar
Table 25. Sustainability and exit milestones
Table 26. Live supporting worksheet directory
Table 27. Rapid household minimum data fields
Table 28. Monitoring indicator definitions
Table 29. Safeguarding and grievance escalation matrix
Table 30. Source hierarchy and data-status rules
Table 31. Gender, age and disability inclusion actions
Table 32. Mobile medical camp minimum operating package
Table 33. Donor due-diligence evidence package
Table 34. 90-day management review checklist
Table 35. Published demographic and exposure indicators
Table 36. District-level operational priorities and verification needs

Table 37. NNSS demographic verification outputs
Table 38. OCE monthly public update minimum content
Table 39. Public financial disclosure and reconciliation checklist

LIST OF FIGURES

Figure 1. Public accountability chain from need verification to reporting
Figure 2. Emergency-to-recovery programme pathway
Figure 3. Geographic impact classification and targeting logic
Figure 4. Institutional coordination tree
Figure 5. Beneficiary verification and delivery workflow
Figure 6. Medical response and referral pathway
Figure 7. Grievance redress and safeguarding pathway
Figure 8. Monitoring and public-reporting cycle
Figure 9. Six-month operational phasing
Figure 10. Procurement-to-payment control chain
Figure 11. OCE fundraising-to-implementation transparency loop

ACRONYMS & KEY TERMS

Acronym	Meaning
AAP	Accountability to Affected Populations
CVA	Cash and Voucher Assistance
EMT	Emergency Medical Team
GBV	Gender-Based Violence
GRM	Grievance Redress Mechanism
HH	Household
MEAL	Monitoring, Evaluation, Accountability and Learning
MHPSS	Mental Health and Psychosocial Support
MoHA	Ministry of Home Affairs
NDRRMA	National Disaster Risk Reduction and Management Authority
NNSS	Naya Nepal Samajik Sanstha
OCE	Open Collective Europe
PDM	Post-Distribution Monitoring
PSEA	Protection from Sexual Exploitation and Abuse
PWD	Person with Disability
SRH	Sexual and Reproductive Health
WASH	Water, Sanitation and Hygiene

Table 2. Document control and reporting terminology

Document control and reporting status

Item	Status in this submission	Control / next update
Situation data	Dated external figures included through 3 September 2026	Update only when a newer government/UN situation report is available; preserve date/source.
Programme targets	300 shelter families; 500 food/household families; 500 students; 10-person core medical team	Targets are planning ceilings and subject to household/student verification.
Budget	NPR 150m / USD 986,842.11 at NPR 152/USD	Detailed schedules remain live; narrative must remain

Item	Status in this submission	Control / next update
		synchronized with approved revisions.
Medical personnel	Roles and capacity defined; public names/credentials controlled in live roster	Publish only after credential verification and consent.
Field photographs	Not embedded in this narrative unless verified and cleared	Use live Field Evidence sheet and consent status before publication.
Sensitive data	Not reproduced in public report	Maintain restricted beneficiary, grievance and patient records.

Table 3. Document control and reporting status

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -◂ | VIEW SOURCES & METHODOLOGY -◂ | VIEW DISCLOSURE & PRIVACY -◂

EXECUTIVE SUMMARY

On 26 August 2026, a sudden and destructive flood surged through the Bhote Koshi and Trishuli river corridors, producing severe loss of life, displacement and damage to settlements, roads, bridges, health facilities, schools, water systems, markets and hydropower infrastructure. The Government of Nepal's Ministry of Home Affairs identified Rasuwa as the origin point of the emergency and reported severe riverbank impacts in Rasuwa, Nuwakot, Dhading and Gorkha in the immediate aftermath. WHO and Nepal's Health Emergency Operation Centre subsequently described six affected districts: Rasuwa, Nuwakot, Dhading and Chitwan in Bagmati Province, and Gorkha and Tanahun in Gandaki Province, with 15 municipalities declared crisis-affected for three months.

The humanitarian picture has changed rapidly as access has improved and search operations have moved downstream. UNICEF's 31 August situation report estimated 65,000 affected people, including 22,100 children, and approximately 13,000 households requiring immediate WASH support. By 3 September, UNICEF reported that at least 22,000 children urgently needed safe water, sanitation and hygiene assistance. UNFPA's affected-area population analysis highlighted 86,820 women of reproductive age and 4,430 pregnant women living in the affected areas. Public situation reporting did not yet provide a verified count of affected female-headed households, older-person-headed households or affected older persons; NNSS therefore treats these as priority data fields for rapid household verification rather than estimating them without evidence.

The human toll has also continued to rise. A 3 September NDRRMA bulletin reported by Onlinekhabar recorded 1,252 bodies recovered, 4,216 people still missing, 11,993 people rescued and 5,135 injured. The same bulletin reported body recoveries across Rasuwa, Nuwakot, Dhading, Gorkha, Tanahun, East Nawalparasi, West Nawalparasi and Chitwan. These district figures are recovery-location reporting and should not be interpreted as a residence-based demographic breakdown of victims. This report uses such figures only to communicate the evolving scale of the emergency, while NNSS programme eligibility remains based on verified household and student needs in selected operational locations.

Against this context, NNSS proposes a six-month emergency response and early-recovery programme with a planning ceiling of NPR 150 million. The financial model allocates NPR 120 million to direct programme activities, NPR 12 million to administration and coordination, and NPR 18 million to a controlled contingency reserve. The direct programme comprises NPR 35 million for shelter support, NPR 14 million for household recovery assistance, NPR 22 million for three-month food support, NPR 8 million for WASH, NPR 12 million for medical response, NPR 8 million for education recovery, NPR 7 million for logistics, NPR 4 million for field operations/MEAL/GRM, and NPR 10 million for livelihood and early recovery. At NPR 152 per USD, the overall campaign ceiling is approximately USD 986,842.11.

The campaign is deliberately narrower than the overall disaster caseload. It aims to provide meaningful, accountable support to a defined group of verified beneficiaries rather than make an unrealistic claim to cover every affected community. The core programme targets are approximately 300 households for shelter repair/recovery support, 500 households for household essentials and three months of food assistance, 500 flood-affected students for

education recovery assistance, and a mobile medical response built around a planned core team of five doctors and five nurses with referral pathways to functioning health services. WASH, logistics, protection, accountability and early-recovery support complement these core targets.

The delivery model adapts the discipline of a World Bank-linked Resettlement Action Plan structure - baseline profiling, vulnerability analysis, eligibility rules, institutional roles, staged implementation, livelihood restoration, grievance redress, monitoring, consultation, scheduling and explicit administration/contingency budgeting - without importing Philippine laws, compensation entitlements or resettlement rates into the Nepal context. This approach gives donors a familiar control framework while preserving the emergency-response nature of the programme.

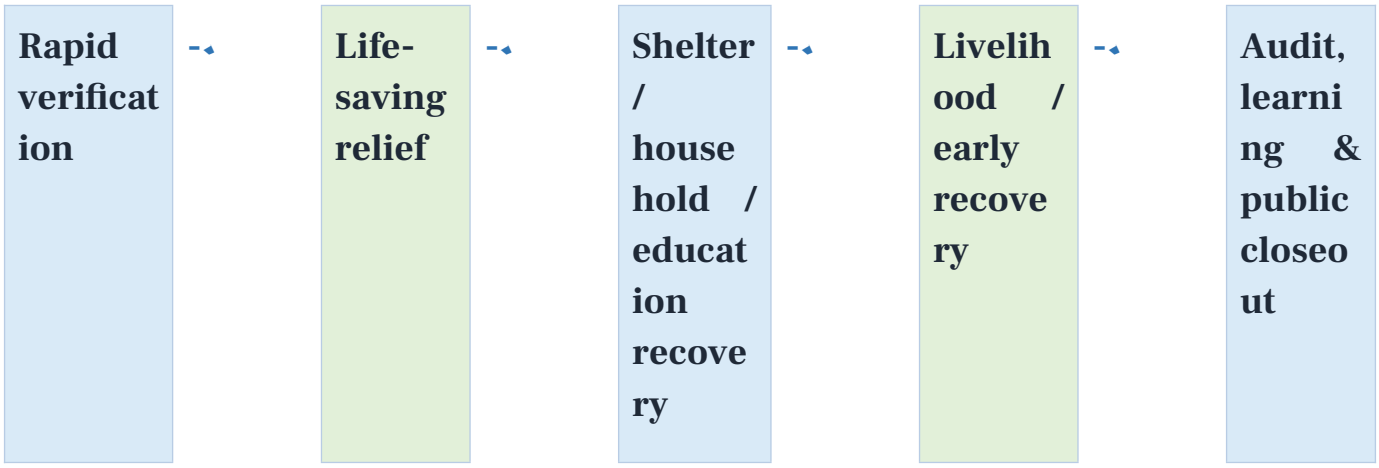

Figure 2. Emergency-to-recovery programme pathway

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -◂ | VIEW PROGRAMME RESULTS -◂ |
VIEW IMPLEMENTATION PLAN -◂ | VIEW BUDGET SUMMARY -◂

1. PROJECT DESCRIPTION & EMERGENCY CONTEXT

1.1 Event overview and humanitarian significance

The emergency began on the morning of 26 August 2026 when an extreme surge of water, mud and debris moved through the Bhote Koshi system in Rasuwa and then downstream into the Trishuli corridor. Government and international health reporting describe the event as a severe flash flood, with preliminary analysis linking the surge to an upstream ice-and-rock avalanche and temporary damming of the Lhende River north of the Nepal-China border. The precise physical trigger remains subject to technical assessment; for the purpose of this humanitarian action plan, the operational fact is that the flood produced a rapid-onset, high-energy impact across river settlements and critical infrastructure, leaving little time for evacuation in the most exposed locations.

The flood's effects were not confined to a single settlement or district. Destruction in the upper corridor affected access routes, customs and border infrastructure, hydropower sites, local markets, homes and health facilities. Downstream movement of floodwaters, debris and bodies broadened the emergency footprint. Damaged roads and bridges disrupted the

movement of relief supplies and emergency referrals, while damaged water and sanitation systems created secondary public-health risks. Families were displaced into host households, religious/community spaces and government-run holding centres, increasing pressure on water, sanitation, privacy and protection arrangements.

1.2 Current emergency situation snapshot

Indicator	Latest figure used in this report	Date / source	Interpretation
People affected	65,000 estimated	31 Aug 2026, UNICEF SitRep No.1	Preliminary inter-agency estimate; subject to change.
Affected households requiring WASH/basic support	Approx. 13,000 households	31 Aug 2026, UNICEF SitRep No.1	Humanitarian caseload estimate, not NNSS beneficiary list.
Affected children	22,100	31 Aug 2026, UNICEF SitRep No.1	UNICEF estimate based on updated affected-population calculation.
Children urgently needing WASH	At least 22,000	3 Sep 2026, UNICEF	Reflects widespread water/sanitation disruption one week after the flood.
Deaths	1,252 bodies recovered	3 Sep 2026, NDRRMA bulletin reported by Onlinekhabar	Evolving national recovery count.
Missing	4,216	3 Sep 2026, same bulletin	Search and identification operations ongoing.
Rescued	11,993	3 Sep 2026, same bulletin	National rescue figure.
Injured	5,135	3 Sep 2026, same bulletin	Reported injured caseload; health needs remain dynamic.
Affected districts	6 identified by WHO/HEOC	31 Aug 2026	Rasuwa, Nuwakot, Dhading, Chitwan, Gorkha, Tanahun.
Crisis-affected	15	31 Aug 2026,	Declared disaster crisis-

Indicator	Latest figure used in this report	Date / source	Interpretation
municipalities		WHO/HEOC	affected for three months.

Table 4. Current emergency situation snapshot

> **DATA / SOURCE NOTE:** The figures above are deliberately dated. Different agencies have used different cut-off times and definitions; therefore, numbers from separate reports should not be combined as if they were a single synchronized dataset.

1.3 District impact and downstream recovery reporting

WHO and HEOC identify six districts as affected by the flood emergency: Rasuwa, Nuwakot, Dhading, Chitwan, Gorkha and Tanahun. The Ministry of Home Affairs' initial public appeal highlighted severe riverbank impacts in Rasuwa, Nuwakot, Dhading and Gorkha. As search and body-recovery operations continued downstream, the 3 September NDRRMA bulletin also recorded recoveries in East and West Nawalparasi. To prevent confusion, the table below distinguishes the six districts identified in the health/humanitarian affected-area reporting from the additional downstream districts appearing in the casualty-recovery distribution.

District	Province / status	Bodies recovered in 3 Sep bulletin	Operational interpretation
Rasuwa	Bagmati - primary affected district	127	Origin/upper corridor; severe settlement, access, health and infrastructure impacts.
Nuwakot	Bagmati - primary affected district	177	Major downstream settlement and infrastructure impacts; relief and holding-centre operations.
Dhading	Bagmati - affected district	60	Downstream impact, access disruption and health-service damage.
Chitwan	Bagmati - affected/downstream district	355	Downstream flood impact and body-recovery reporting.
Gorkha	Gandaki - affected district	69	Affected local units and river corridor impacts.
Tanahun	Gandaki - affected district	38	Affected local units and downstream impacts.
East	Downstream	218	Included in body-recovery

District	Province / status	Bodies recovered in 3 Sep bulletin	Operational interpretation
Nawalparasi	recovery reporting		distribution; not listed among six WHO/HEOC affected districts.
West Nawalparasi	Downstream recovery reporting	208	Included in body-recovery distribution; not listed among six WHO/HEOC affected districts.

Table 5. District impact and casualty-recovery reporting

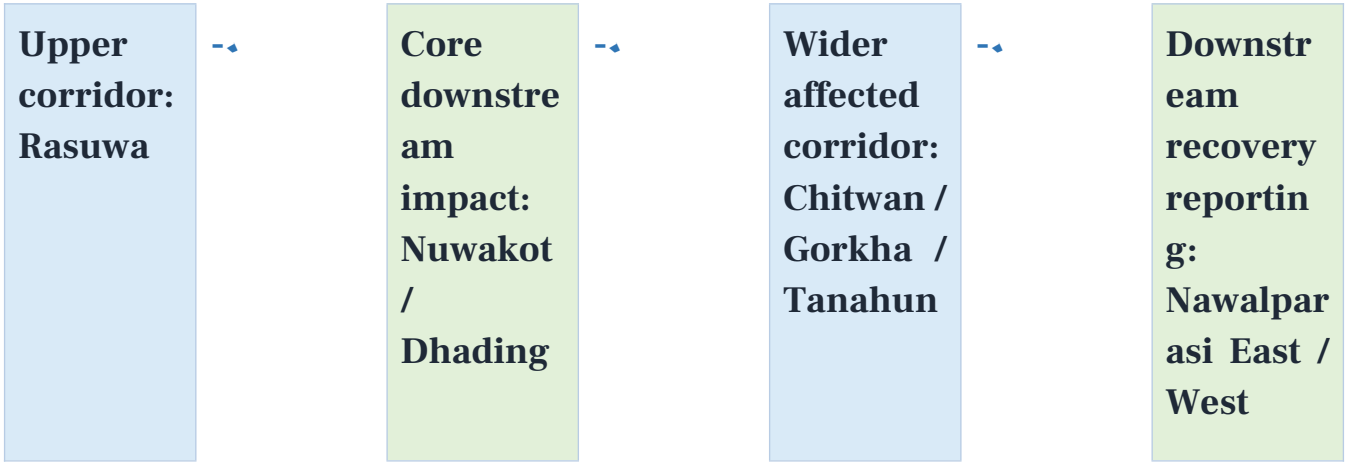

Figure 3. Geographic impact classification and targeting logic

1.4 Crisis-affected local units and operational targeting

Government resource allocations reported on 30 August identify 15 local units in five districts receiving dedicated disaster-management funding for search, rescue and immediate relief. This list provides a practical starting point for coordination and should be cross-checked against current local-government access information before NNSS deploys. It does not automatically determine NNSS beneficiary selection; actual target wards and communities must be based on verified need, access, duplication checks and coordination with local authorities and other responders.

District	Local unit(s) identified in government relief allocation
Rasuwa	Uttargaya Rural Municipality; Gosainkunda Rural Municipality; Kalika Rural Municipality; Aamachhodingmo Rural Municipality
Nuwakot	Bidur Municipality; Belkotgadhi Municipality; Kispang Rural Municipality; Tarkeshwar Rural Municipality
Dhading	Galchhi Rural Municipality; Siddhalek Rural Municipality; Gajuri Rural Municipality; Benighat Rorang Rural Municipality
Gorkha	Gandaki Rural Municipality
Tanahun	Devghat Rural Municipality; Aanbukhaireni Rural Municipality

Table 6. Government-supported crisis-affected local units

Within Rasuwa and Nuwakot, public reporting has identified severe destruction in multiple settlements and wards along the river corridor. Because the emergency is still evolving, NNSS will not hard-code a final ward-by-ward beneficiary distribution in the narrative report. The operational target list will be maintained in the live implementation and beneficiary-verification systems so that assistance can shift if access, duplication or verified needs change.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -› | VIEW IMPLEMENTATION PLAN -› | VIEW CONSULTATION SUMMARY -›

2. AFFECTED POPULATION, SOCIO-ECONOMIC & VULNERABILITY PROFILE

2.1 Population profile and data limitations

The reference RAP model used a census and socio-economic survey to establish who was affected, what assets or livelihoods were lost, which households were vulnerable, and how recovery should be monitored. The same discipline is necessary in this emergency, but the data environment is different: population movement is ongoing, some communities remain difficult to access, household losses are still being assessed, and public situation reports do not yet provide a complete sex-, age-, disability- and household-head-disaggregated flood caseload. A credible donor proposal should therefore separate confirmed public estimates from planning assumptions and from fields that NNSS still needs to verify.

UNICEF's 31 August estimate of 65,000 affected people, including 22,100 children, provides the most clearly published inter-agency humanitarian denominator used in this report. UNFPA's flash update uses a wider affected-area population base of 310,076 people and identifies approximately 86,820 women of reproductive age and 4,430 pregnant women living in those affected areas. These UNFPA figures are exposure/service-planning estimates for the wider affected geography, not a claim that every person in those demographic groups lost a home or requires NNSS assistance. The distinction is important when communicating with donors.

2.2 Sex, age and vulnerability disaggregation status

Population / vulnerability group	Available estimate	What the figure represents	How NNSS will use it
Children affected	22,100	UNICEF affected-child estimate, 31 Aug	Justifies child-sensitive WASH, protection, education and household assistance.
School-age children needing urgent education/psychosocial support	More than 10,000	UNICEF education-sector estimate	Supports school verification and targeted education recovery.
Women of reproductive age in affected areas	86,820	UNFPA affected-area population analysis	Planning for dignity, SRH, referral and protection capacity; not a direct beneficiary count.

Population / vulnerability group	Available estimate	What the figure represents	How NNSS will use it
Pregnant women in affected areas	4,430	UNFPA affected-area population analysis	Supports maternal referral, dignity and health-service continuity planning.
Pregnant and lactating women requiring nutrition support	Approx. 10,500	UNICEF nutrition-sector estimate	Sectoral planning signal; avoid treating as household-head count.
Adolescents requiring IFA support	28,317	UNICEF/HMIS sector estimate	Nutrition/health service planning signal.
Female-headed flood-affected households	No verified public count located	Data gap as of this report	Mandatory NNSS rapid-assessment field; report aggregate count after verification.
Older persons / older-person-headed affected households	No verified public count located	Data gap as of this report	Priority flag in NNSS verification; support accessible delivery and referral.
Persons with disabilities affected	No verified public count located	Data gap as of this report	Record functional/access needs and avoid exclusion.

Table 7. Population and vulnerability data status

> **DATA / SOURCE NOTE:** The absence of a public sex-of-household-head or older-person affected count is treated as a data-quality gap, not filled with an estimate. This protects the proposal from presenting unsupported demographic claims.

2.3 Vulnerability and inclusion priorities

NNSS will apply vulnerability prioritization across all components rather than operate a single vulnerability category. A household may be prioritized because the dwelling is unsafe, because the family has no safe drinking water, because income and food stocks were lost, because a member requires chronic medical care, or because the household includes people who face additional barriers to accessing relief. The programme will recognize intersecting

vulnerability; for example, an older-person-headed household with a damaged home and a member with mobility limitations may require shelter assistance, home-based delivery, referral support and additional follow-up.

Priority factor	Examples	Programme implication
Immediate life/safety risk	Unsafe shelter, acute injury, no safe water, urgent referral need	Priority 1 response; rapid referral or essential assistance.
Household composition	Female-headed, older-person-headed, pregnant/lactating member, separated child	Priority handling, accessible delivery and protection-sensitive referral.
Disability / chronic health need	Mobility, sensory or psychosocial disability; interrupted medication	Accessibility support, medication/referral planning, do-no-harm delivery.
Economic vulnerability	Severe livelihood loss, food insecurity, no savings or productive assets	Food priority, recovery referral and follow-up.
Child/education vulnerability	Uniform/books lost, school access disrupted, separated/unaccompanied child	School-verified education package and protection referral.
Geographic isolation	Road closure, landslide risk, remote settlement	Alternative last-mile logistics, pre-positioning, adjusted distribution method.

Table 8. Priority vulnerability and inclusion criteria

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW PROGRAMME RESULTS -• | VIEW MONITORING -• | VIEW DISCLOSURE & PRIVACY -•

3. EMERGENCY IMPACTS AND PRIORITY NEEDS

3.1 Shelter, household assets and displacement

The flood has damaged and destroyed housing, swept away household possessions and left many families unable to return safely. Shelter recovery is not simply a construction problem. A household whose dwelling is unsafe may simultaneously lack bedding, cooking utensils, lighting, storage, food stocks, clothing and documentation. Families staying with hosts or in collective settings may also face overcrowding, privacy concerns and limited control over cooking or sanitation. The programme therefore separates shelter assistance from household-recovery assistance so that the response can address structural and non-structural losses without forcing every family into a one-size-fits-all package.

3.2 Food security, nutrition and market disruption

Food assistance is designed around a three-month stabilization period for 500 verified families. The flood disrupted household stocks, income, local trade and physical access, while displacement can increase food expenditure at the same time that livelihoods collapse. The programme will use a context-appropriate mix of in-kind food, locally procured items or approved cash/voucher modalities depending on market functionality, road access, supplier availability and OCE/NNSS financial-control requirements. Nutritionally vulnerable households should not be treated as identical to the average food-assistance household; infants, young children, pregnant and lactating women, older persons and people with diet-related medical conditions require referral and tailored support where feasible.

3.3 WASH and public-health risks

Flooding has damaged water systems and sanitation facilities, and displacement has increased pressure on shared water points and temporary accommodation. UNICEF reported that at least 22,000 children urgently needed safe water, sanitation and hygiene support by 3 September. The immediate risks include unsafe drinking water, diarrhoeal disease, respiratory infection in crowded settings, inadequate menstrual hygiene, poor solid-waste management and reduced ability to maintain hand hygiene. WASH is therefore integrated with household kits, medical response, community messaging and field monitoring rather than treated as a standalone distribution activity.

3.4 Health, protection and psychosocial impacts

Damaged health facilities, disrupted roads and the loss of local service infrastructure can delay trauma care, chronic-disease management, maternal and newborn services, referrals and disease surveillance. WHO has highlighted injuries, diarrhoeal and respiratory illness, unsafe water and food, vector-borne disease and mental-health needs as priority post-flood risks. UNICEF has also reported child separation and protection concerns, while UNFPA has emphasized risks to women and girls, including barriers to sexual and reproductive health care and increased gender-based violence risk in displacement settings. NNSS medical and field teams will therefore operate with referral protocols, confidentiality and safeguarding controls, not simply medicine distribution.

3.5 Education and livelihood disruption

The disaster has disrupted schooling through damaged facilities, loss of uniforms and learning materials, displacement, psychological distress and use of some schools as temporary shelters. UNICEF reported at least 19 schools damaged along the corridor and more than 10,000 school-age children requiring urgent psychosocial support and safe learning opportunities. Livelihood losses are equally important: households may have lost tools, shops, livestock, tourism income, wage employment, transport access or local markets. Early recovery therefore includes a targeted livelihood top-up, skills support and referrals intended to help selected households begin restoring income after immediate relief needs stabilize.

Need / impact	Likely consequence	NNSS response logic
Destroyed or unsafe shelter	Exposure, displacement, unsafe return	Technical assessment, shelter materials/support and completion verification.
Loss of household essentials	Poor sleeping conditions; inability to cook or store items	Household recovery package tailored to verified losses.
Food stocks/income lost	Acute and prolonged food insecurity	Three monthly rounds or equivalent approved modality for 500 families.
Unsafe water / sanitation damage	Waterborne disease and hygiene risk	Household water/hygiene support and selected community water-point repair.
Medical-service disruption	Delayed treatment, maternal/child risk, outbreak potential	Mobile medical response, supplies, referral and public-health coordination.
School disruption	Learning loss, protection and psychosocial risk	Uniform/material support, school verification and education continuity measures.
Livelihood loss	Reduced income and longer dependency	Targeted recovery top-up, skills/starter support and case-based referrals.

Table 9. Emergency needs and programme response logic

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW SHELTER -› | VIEW HOUSEHOLD SUPPORT -› | VIEW FOOD SUPPORT -› | VIEW WASH -› | VIEW MEDICAL -› | VIEW EDUCATION -› VIEW EARLY RECOVERY -›

4. POLICY, COMPLIANCE, SAFEGUARDING & DATA-PROTECTION FRAMEWORK

4.1 Operating principle

The campaign is an emergency humanitarian and early-recovery programme, not a statutory compensation scheme. Assistance is therefore needs-based and programme-defined. The World Bank-linked RAP used by NNSS as a structural reference is useful because it demonstrates disciplined baseline assessment, vulnerability identification, assistance eligibility, institutional responsibility, grievance handling, monitoring and budget control. It is not used as a legal basis for Nepal, and no Philippine compensation entitlement or legal procedure is imported into this programme.

4.2 Do-no-harm and equitable access

NNSS will provide assistance without discrimination on the basis of sex, caste/ethnicity, disability, citizenship documentation, religion, political affiliation or other status. Lack of a document that is not legally required for humanitarian assistance should not be used to exclude a person in urgent need. At the same time, minimum verification is necessary to prevent duplicate assistance and protect funds. Where identity documents have been lost, the programme should use alternative verification through household records, local authorities, schools, health facilities or community verification as appropriate.

4.3 Safeguarding and PSEA

All personnel, volunteers, contractors and partners interacting with affected communities should be bound by a code of conduct that prohibits sexual exploitation and abuse, harassment, discriminatory conduct, coercion and exchange of assistance for money, favours or sexual activity. Safeguarding complaints must be handled separately from ordinary service complaints when confidentiality and survivor-centred referral are required. The programme should minimize collection of sensitive data and never make public the identity of a complainant, patient, separated child or beneficiary whose disclosure could cause harm.

4.4 Data protection and publication consent

Public fundraising requires compelling evidence, but humanitarian dignity must take precedence over publicity. Photographs should be linked to a factual caption, location/date information where safe, the person responsible for collection, verification status and consent status. Images of children, injured people, grieving families, people receiving medical care or survivors of protection incidents require particular care. Donor transparency can be achieved through aggregate data, procurement evidence, financial summaries and consent-cleared photographs without exposing case-level personal data.

Control area	Minimum standard	Public reporting rule
Eligibility	Documented need and de-duplication	Publish criteria and aggregate reach, not household names.
Safeguarding/ PSEA	Code of conduct, confidential channel, trained focal point	Never disclose survivor identity or case narrative.

Control area	Minimum standard	Public reporting rule
Medical confidentiality	Credentialed staff, minimal patient records, referral protocol	Publish aggregate service statistics only.
Child protection	Best-interest principle, referral and family tracing where relevant	No identifying separated-child data.
Photography	Consent/status recorded and factual caption	Publish only cleared evidence.
Financial disclosure	Traceable approvals, procurement and reconciliation	Publish aggregate/component-level financial information.

Table 10. Compliance and safeguarding control framework

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW DISCLOSURE & PRIVACY -• | VIEW FIELD EVIDENCE -• | VIEW MEDICAL TEAM PROFILES -•

5. ELIGIBILITY, TARGETING & ASSISTANCE FRAMEWORK

5.1 Targeting philosophy

NNSS will use a component-based eligibility model. A household may qualify for one component, several components, or referral only. This prevents the common emergency-response problem of treating every registered household as eligible for an identical package regardless of actual loss. It also allows the programme to protect scarce resources and prioritize the highest unmet needs while coordinating with government and other organizations.

5.2 Verification process

5. Register the household or student with a unique programme ID and minimum location/contact data.
6. Record household size and key vulnerability fields, including children, older persons, disability/access needs, pregnancy/lactation and sex of household head.
7. Verify shelter damage, food need, WASH disruption, education loss, medical/referral need and livelihood impact as relevant.
8. Cross-check available local-government, school, health-facility and humanitarian partner information to reduce duplication.
9. Approve eligible components and document any exceptional case decision.
10. Deliver assistance with acknowledgement or other traceable confirmation and record the evidence source.
11. Conduct post-distribution or post-assistance monitoring and close or refer unresolved issues.

Target group / condition	Illustrative eligibility basis	Planned assistance ceiling
Severely flood-affected household with unsafe/destroyed shelter	Verified damage, safety risk and unmet shelter need	Shelter recovery support within the 300-family programme target.
Flood-affected household lacking essential items	Verified loss of bedding/kitchen/basic household items	Household recovery assistance within 500-family target.
Food-insecure flood-affected household	Loss of food stocks/income/access and no duplicate equivalent assistance	Three months of food assistance within 500-family target.
Household with unsafe	Verified WASH disruption or displacement condition	Household WASH package / selected community support.

Target group / condition	Illustrative eligibility basis	Planned assistance ceiling
water/hygiene conditions		
Person requiring emergency/primary care or referral	Clinical assessment by credentialed provider	Medical care/referral within programme capacity; no automatic medicine entitlement.
Flood-affected student	School/guardian verification of loss or access barrier	Education recovery support within 500-student target.
Highly vulnerable household needing early recovery support	Documented livelihood loss and recovery feasibility	Case-based livelihood/recovery support within programme allocation.

Table 11. Eligibility and assistance framework

The assistance values shown in the live worksheets are budget-planning ceilings, not unconditional individual entitlements. Final unit specifications may change after technical assessment, market checks or competitive quotations. Where cash or voucher modalities are used, NNSS should document transfer value methodology, eligibility, approval, distribution, reconciliation and complaints handling.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW PROGRAMME RESULTS -• | VIEW DETAILED BUDGET -• | VIEW MONITORING -•

6. INSTITUTIONAL FRAMEWORK & IMPLEMENTATION ARRANGEMENT

6.1 Governance model

The response requires clear separation between programme authority, technical quality, beneficiary verification, procurement/payment, monitoring and complaints handling. Concentrating all functions in a single person creates fraud, quality and safeguarding risks. NNSS will therefore use a responsibility matrix in which programme leadership approves major decisions, technical leads define sector standards, finance/procurement controls purchasing and payment, MEAL verifies results, and the GRM/safeguarding function can receive concerns independently from frontline distribution staff.

Entity / function	Core responsibility
NNSS Response Lead	Overall programme authority, OCE coordination, risk escalation, major approvals and public accountability.
Field Coordination	Local-government/community liaison, access planning, registration, verification and distribution coordination.
Shelter / Technical Lead	Damage classification, shelter safety, technical specification, quality and completion verification.
Medical Lead	Clinical protocols, credential verification, medical procurement specification, referral quality and confidentiality.
Procurement & Finance	Quotations, purchase approvals, contracts/orders, payments, inventory, reconciliation and donor financial records.
MEAL	Baseline data, indicator tracking, PDM, evidence verification, learning and donor reporting.
GRM / Safeguarding Focal	Complaint intake, confidential case management, safeguarding/PSEA referral and escalation.
Communications	Consent-cleared evidence, factual captions, campaign updates and donor/public communication.
Local authorities / community representatives	Local verification, access coordination, duplication checking and referrals.
Health facilities / schools	Clinical referral/public-health coordination and student verification/education continuity.
Independent auditor/reviewer	Independent financial and implementation assurance, as commissioned.

Table 12. Institutional roles and responsibilities

OCE / DONORS / PUBLIC ACCOUNTABILITY				
v				
NNSS RESPONSE LEAD				
v	v	v	v	v
Field Coordination	**Shelter / Technical**	**Medical**	**Finance / Procurement**	**MEAL / Accountability**
v	v	v	v	v
Local authorities / communities	Engineers / suppliers	Health facilities / EMTs	Bank / vendors / auditor	GRM / safeguarding / reporting

Figure 4. Institutional coordination tree

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN
VIEW IMPLEMENTATION PLAN -› | VIEW PROCUREMENT PLAN -› | VIEW MONITORING -› | VIEW CONSULTATION SUMMARY -›

7. EMERGENCY RESPONSE & HOUSEHOLD RECOVERY DELIVERY PROCESS

7.1 Phased delivery

The programme is organized in phases so that life-saving support is not delayed by recovery activities, while recovery planning begins early enough to reduce prolonged dependency. Timing is indicative and may shift with access, funding availability, weather, market conditions and local-government coordination. The live implementation plan is the operational source for monthly scheduling.

Phase	Indicative timing	Core activities	Required controls
1. Rapid verification and life-saving response	Days 1-14	Registration/de-duplication; urgent food/WASH/household support; medical deployment; logistics setup	Verified lists, access checks, medical roster, initial procurement evidence.
2. Stabilization	Weeks 3-6	Second food round; shelter material support; water-point action; school verification	Technical shelter checks, distribution reconciliation, referral records.
3. Recovery acceleration	Months 2-3	Third food round; education support; shelter follow-up; selected recovery referrals	Output verification, PDM, expenditure reconciliation.
4. Early recovery and closeout	Months 4-6	Livelihood/recovery support; completion monitoring; audit/review and public closeout	Case closure, final reconciliation, lessons learned and donor reporting.

Table 13. Response phases and delivery controls

Register & assign unique ID

v

Verify need, location and vulnerability

v

Check duplication and approve component(s)

v

Procure / authorize assistance

v

Deliver and record acknowledgement

v

Post-distribution / completion verification

v

Resolve complaints and report aggregate results

Figure 5. Beneficiary verification and delivery workflow

7.2 Access and last-mile delivery

Mountain and river-corridor emergencies require flexible logistics. Road access may be cut by landslides, bridge damage or debris; weather may suspend helicopter movement; and some communities may require porter, tractor, ropeway, local boat or other locally appropriate alternatives. The programme therefore includes a logistics allocation and a contingency reserve but requires documented justification when a higher-cost transport option is used. Delivery planning should prioritize safety of communities and staff, avoid crowding at distribution points and use staggered schedules or household delivery where necessary for older people, people with disabilities or medically vulnerable households.

7.3 Distribution integrity and reconciliation

Every distribution or transfer should connect three records: the approved beneficiary list, the inventory/payment record, and the acknowledgement or verification record. This 'three-point match' is essential for donor confidence. Any variance - damaged items, failed transfer, duplicate name, changed household location, inaccessible settlement or rejected delivery - should be documented and resolved rather than silently overwritten. The same principle applies to shelter materials, medical supplies, school kits and livelihood support.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW IMPLEMENTATION PLAN -› | VIEW LOGISTICS -› | VIEW FIELD OPERATIONS -› | VIEW MONITORING -›

8. SECTOR RESPONSE: SHELTER, HOUSEHOLD, FOOD, WASH, MEDICAL & EDUCATION

The six core sector components are designed as one integrated package. A household may move through several components, but each component has its own technical and financial ceiling. This avoids hidden cross-subsidization and makes it possible for OCE/donors to see which activities are funded, delivered or still facing a gap. The amounts below are controlled by the live workbook and are repeated only as narrative ceilings; the detailed line-item tables remain online.

8.1 Shelter recovery - NPR 35,000,000 (USD 230,263.16)

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW SHELTER -

Shelter is the largest direct programme component because the physical safety of a household affects every other recovery outcome. NNSS plans shelter repair/recovery support for approximately 300 severely affected families. Assistance may include construction materials, technical safety assessment, basic repair tools, site clearing/debris support, targeted top-ups for the most severely damaged cases and additional delivery costs for remote sites. The exact package will depend on damage classification, site safety, local construction practices, market availability and any government reconstruction standards in force.

NNSS will not equate a cash amount with a technical solution. Before significant shelter support is released, the programme should verify whether the house is safe to repair, whether relocation or temporary accommodation is required, whether the household has already received equivalent material, and whether the proposed support is adequate to achieve a defined minimum outcome. Completion evidence should focus on safety and habitability rather than cosmetic appearance.

Quality area	Minimum control	Evidence
Damage classification	Destroyed/unsafe/severe/ moderate/minor categories applied consistently	Assessment form and dated site evidence.
Technical safety	Qualified technical review for structural/safety concerns	Technical checklist / recommendation.
Material specification	Clear material quantities/specifications and acceptable substitutions	Approved bill/list and procurement record.
Delivery	Traceable household allocation and last-mile receipt	Delivery note / acknowledgement.
Completion	Verify intended repair/recovery outcome and	Completion record / photo where consent permits.

Quality area	Minimum control	Evidence
	unresolved safety risks	

Table 14. Shelter and household recovery quality standards

8.2 Household recovery assistance - NPR 14,000,000 (USD 92,105.26)

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW HOUSEHOLD SUPPORT -

Household recovery assistance is planned for approximately 500 families who have lost basic items or are displaced. The package can cover bedding, kitchen items, seasonal clothing/winterization, lighting, storage and other essential household items, along with packaging and distribution requirements. Standard kits improve procurement efficiency, but the programme should retain limited flexibility for household composition and disability/accessibility needs. A family with an infant, an older person or a member with limited mobility may need a different mix than a smaller household of working-age adults.

Distribution teams should communicate clearly that receiving household essentials does not automatically make a family ineligible for food, WASH or shelter support; eligibility is component-specific. Equally, a household that already received a complete equivalent kit from another responder should not receive a duplicate package merely because it is registered with NNSS.

8.3 Three-month food assistance - NPR 22,000,000 (USD 144,736.84)

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW FOOD SUPPORT -•

The food component is designed for 500 verified households for three months, equivalent to 1,500 family-months of assistance. The live food worksheet models a staple basket and flexible local-market components. Final delivery may use in-kind procurement, vouchers, cash or a blended modality, but the chosen method must be justified by market functionality, price monitoring, supplier access, beneficiary preference, transport constraints and OCE/NNSS financial controls.

The objective is not only to deliver calories but to prevent crisis coping while households restore access to income and services. The programme therefore includes staple food, pulses/protein, oil, flour or alternative cereal, salt, sugar, fresh-food support, cooking fuel and targeted nutrition top-ups within the approved budget envelope. Procurement should consider culturally appropriate foods, safe storage, shelf life and household cooking conditions. If market prices change materially, the budget should be updated transparently rather than reducing quantities without explanation.

Food-assistance safeguard	Required practice
Market check	Confirm availability, price stability, vendor capacity and access before selecting cash/voucher or local procurement.
Nutrition sensitivity	Identify infants, young children, pregnant/lactating women, older persons and medically restricted diets for referral/top-up.
Monthly re-verification	Confirm household remains eligible and record equivalent assistance received elsewhere.
Food safety	Procure from acceptable suppliers; check packaging, expiry and storage conditions.
Cooking feasibility	Ensure households have fuel, utensils and safe water to prepare distributed food.
Post-distribution monitoring	Check adequacy, use, protection concerns, access barriers and complaints.

Table 15. Food assistance and nutrition safeguards

8.4 WASH response - NPR 8,000,000 (USD 52,631.58)

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW WASH -•

The WASH component responds to damaged water systems, unsafe household storage, sanitation disruption and hygiene needs in displacement or damaged settlements. Assistance

can include safe drinking-water storage/treatment kits, family hygiene kits, dignity/menstrual hygiene support, temporary or repaired community water points, and sanitation cleanup/disinfection. The programme will coordinate with health teams because WASH failures can quickly translate into diarrhoeal and other disease outbreaks.

Household water treatment products require clear user instruction and should be matched to the product and local water conditions. Hygiene promotion should not be reduced to message distribution; teams should observe whether people can actually access water, soap, toilets and safe waste disposal. Women and girls should be consulted on menstrual hygiene and privacy needs, while accessible water and sanitation arrangements should be considered for older persons and people with disabilities.

WASH domain	Minimum standard for NNSS response
Safe water	Provide safe storage/treatment and link with restoration of community systems where feasible.
Hygiene	Provide practical household supplies with context-appropriate hygiene information.
Menstrual hygiene	Include dignity materials and safe/private access considerations.
Sanitation	Support cleanup, temporary arrangements or minor repairs where assessed and coordinated.
Water quality / disease risk	Coordinate testing/monitoring and outbreak messages with health authorities/partners where available.

Table 16. WASH and public-health minimum standards

8.5 Medical response - NPR 12,000,000 (USD 78,947.37)

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW MEDICAL -• | VIEW MEDICAL TEAM PROFILES -•

The medical component is designed around a planned core team of five doctors and five nurses, supported by medicines, clinical consumables, basic diagnostic equipment, mobile medical camp setup, field allowances, emergency referral/ambulance support, PPE and outbreak/public-health contingency. The programme is not intended to create a parallel hospital. Its purpose is to provide mobile first-contact care, continuity support, public-health screening and referral in coordination with government health services and established health-cluster mechanisms.

Before deployment, each clinician should have identity, qualification, professional registration, role, specialty/focus, availability and publication-consent status verified. Public donor materials may show a professional profile only after the individual has consented. Patient data must remain confidential and should not be placed in public campaign worksheets. Medical procurement specifications should be approved by the Medical Lead, and medicines should be used only within legal and clinical scope.

Maternal and newborn care, chronic disease, injury follow-up, mental health and psychosocial needs require referral pathways. A mobile team should know which facilities are functioning, which roads are accessible, where ambulance or alternative transport can be obtained, and how to escalate a patient whose condition is beyond the team's capacity. The medical budget includes referral transport because a consultation without a feasible referral option may not be enough for seriously ill or injured people.

Medical quality area	Standard
Credentialing	100% of public-facing clinical team verified before deployment.
Scope of practice	Providers work within professional scope and agreed clinical protocols.
Medicines / equipment	Medical Lead approves specification; inventory, storage and use are recorded.
Referral	Document functioning referral destinations and transport options.
Confidentiality	Collect only necessary clinical information; no patient-identifying public reporting.
Infection prevention	PPE, hand hygiene, waste management and disinfection integrated into camp setup.
MHPSS / protection	Provide psychological first aid and appropriate referral; avoid unsupported clinical claims.

Table 17. Medical response quality and referral standards

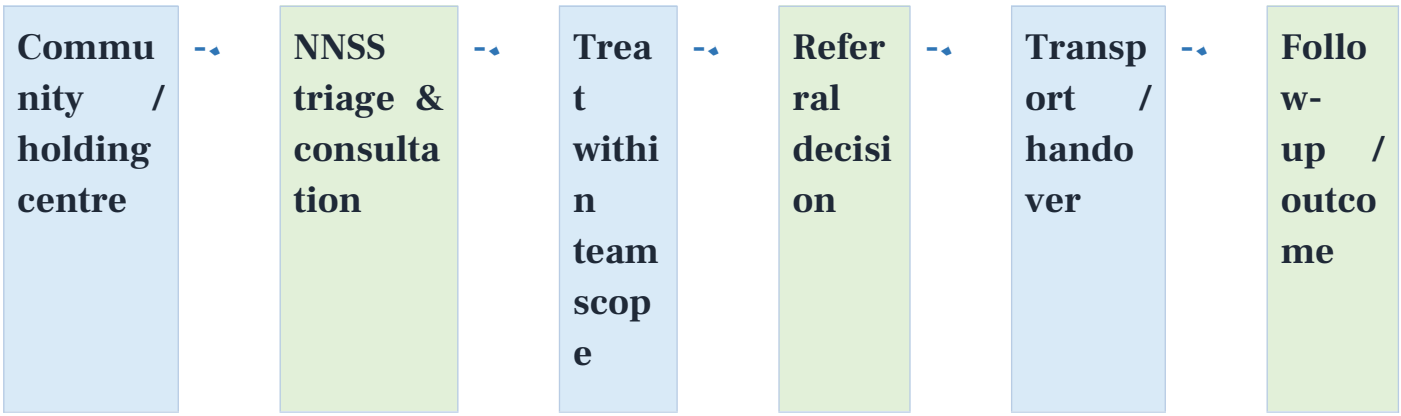

Figure 6. Medical response and referral pathway

8.6 Education recovery - NPR 8,000,000 (USD 52,631.58)

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW EDUCATION -◂

Education support is planned for 500 flood-affected students. The live budget includes school uniforms, bags and stationery, shoes/socks/rain protection, textbooks/learning materials,

temporary learning or catch-up support, and selected school-access/enrolment/document assistance. Eligibility should be verified through schools and guardians to reduce duplication and ensure that package specifications match actual school requirements.

Education recovery is also a protection intervention. Restoring routine, safe learning spaces and peer contact can reduce distress and exposure to harmful coping. The programme should coordinate distribution timing with school reopening and identify students with disability, displacement, lost documents or transport barriers who may need additional support rather than only a standard kit.

Education element	Verification / delivery control
Uniform	Confirm school, class/grade and size before procurement.
Learning materials	Coordinate with school to avoid duplication with government/partner replacements.
Footwear / rain protection	Use needs-based distribution and appropriate sizing.
Temporary learning / catch-up	Coordinate with school/local education authority and include safe WASH conditions.
Access / document support	Case-based assistance with traceable, legitimate costs only.

Table 18. Education recovery package and verification controls

9. LIVELIHOOD RESTORATION & EARLY RECOVERY

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW EARLY RECOVERY -•

Relief alone cannot restore a household whose income source, tools, shop, livestock, transport link or local market has been destroyed. The early-recovery component therefore provides NPR 10,000,000 (USD 65,789.47) for targeted livelihood/recovery assistance. The current model includes household recovery top-ups, skills training with starter support, psychosocial and child-protection support, disability/older-person accessibility support, legitimate document-replacement/referral costs and community cleanup/shared recovery works.

Early recovery will be case-based rather than automatically distributed to every relief recipient. Selection should consider the severity of livelihood loss, household vulnerability, feasibility of the proposed recovery activity, duplication with government or other programmes, and the household's own recovery priorities. For training, NNSS should avoid training for training's sake; the course should be linked to realistic local demand, participant capacity, starter tools or linkages, and follow-up.

Community cleanup and shared recovery works can support access and public spaces while creating short-term income, but they must be designed safely. Tasks that involve unstable debris, contaminated material, electricity hazards or heavy machinery require technical supervision and appropriate protective equipment. Children should never be involved in hazardous work, and people with disabilities or older persons should not be excluded from benefits simply because they cannot participate in physical labour.

Recovery measure	Targeting logic	Expected result
Household recovery top-up	Highly vulnerable households with documented uncovered recovery need	Replace essential livelihood assets or bridge a critical recovery gap.
Skills training ✦ starter support	Selected participants with feasible livelihood pathway	Improved capacity to resume or diversify income.
Psychosocial / child-protection support	Affected families/children requiring basic support or referral	Reduced distress, improved referral and protective support.
Accessibility / older-person support	Cases with mobility, disability or age-related barriers	Safer access to assistance and essential services.
Document / referral support	Legitimate replacement/access costs after flood loss	Restore access to education, services or livelihood documentation.

Recovery measure	Targeting logic	Expected result
Community cleanup / shared works	Community-selected, safe and documented activities	Restore access/function and support collective recovery.

Table 19. Livelihood and early recovery measures

10. GRIEVANCE REDRESS, SAFEGUARDING & ACCOUNTABILITY TO AFFECTED PEOPLE

10.1 Purpose and access

A grievance mechanism is not only a complaints box; it is an operational control that helps identify exclusion, duplicate assistance, staff misconduct, procurement problems, unsafe distributions, misinformation and emerging needs. The mechanism should be free of charge, understandable, available through multiple channels and accessible to people who cannot read or use digital tools. Anonymous feedback should be accepted where feasible.

Ordinary programme complaints and safeguarding/PSEA cases must be triaged differently. A complaint about a missing food item can be investigated through normal programme records. A sexual-exploitation allegation, child-protection concern or sensitive medical/privacy complaint requires restricted handling, minimum information sharing and specialized referral. Public reporting should show aggregate trends and resolution performance, not case details.

Stage	Service standard	Control
Intake	In-person help desk; phone/SMS/WhatsApp; email; referral	Assign case ID; do not collect unnecessary sensitive information.
Triage	Classify normal / high-risk / safeguarding-PSEA	Sensitive cases routed only to authorized focal persons.
Acknowledge	Target within 2 working days where contact is available	Confirm receipt, explain next step and expected timeline.
Review / action	Target normally within 10 working days for routine cases	Investigate fairly; document evidence and action.
Escalate	Management, technical or specialist referral as needed	Escalate unresolved, conflict-of-interest or high-risk cases.
Close	Communicate outcome and record follow-up	Close only when action is documented or case is formally referred.
Report	Monthly aggregate trend review	Publish categories/timeliness without names or confidential details.

Table 20. GRM service standards

Receive feedback / complaint

v

Assign case ID and triage

v

Routine case OR confidential safeguarding route

v

Investigate / respond / refer

v

Communicate outcome

v

Close with evidence and aggregate reporting

Figure 7. Grievance redress and safeguarding pathway

10.2 Accountability to affected populations

Accountability also requires proactive information. Communities should know what NNSS is providing, who may qualify, whether assistance is free, what documents are actually required, how selections are made, when distributions occur, and how to raise a concern. When plans change because a road is blocked, a supplier fails or a distribution date moves, affected people should be informed quickly to reduce rumours and unnecessary travel.

Feedback data should be reviewed as management information. Repeated complaints about inaccessible distribution points may indicate an inclusion problem. Reports of incorrect beneficiary lists may reveal weak verification. Questions about unit value may show that public communication is unclear. NNSS should therefore include feedback trends in monthly management and OCE updates, while protecting confidentiality.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW FIELD OPERATIONS -› | VIEW MONITORING -› | VIEW CONSULTATION SUMMARY -› | VIEW DISCLOSURE & PRIVACY -›

11. MONITORING, EVALUATION, ACCOUNTABILITY & LEARNING (MEAL)

11.1 Monitoring purpose

Monitoring will answer five questions: Did assistance reach the intended people? Was it delivered in the planned quantity and quality? Was it timely and accessible? Did it reduce the priority problem it was designed to address? Were funds and evidence handled in a way that can withstand donor or audit review? These questions combine output monitoring with quality, outcome, accountability and financial monitoring.

The reference RAP emphasizes internal and external monitoring. NNSS adopts the same control logic in an emergency format. Internal monitoring should be continuous and linked to operational decisions. Independent audit or review provides a separate assurance layer. External review is particularly useful for verifying whether selection and assistance were implemented as designed and whether grievances and financial controls were handled appropriately.

Indicator	Target / standard	Evidence	Frequency
Households receiving verified shelter support	Up to 300 families	Damage assessment, delivery/completion record	Monthly
Households receiving household recovery assistance	Up to 500 families	Distribution record + PDM	Monthly
Households completing 3 food rounds/equivalent	Up to 500 families	Round-by-round reconciliation	Monthly
Students receiving education recovery support	Up to 500 students	School-verified list and distribution evidence	Monthly
Medical personnel credential-verified	10 planned team members before public deployment	Medical Team Profiles / credential review	Before deployment
Medical camp deployments	Up to 10 planned deployments/rotations	Camp register + aggregate service data	Per camp
WASH household support	Up to 500 family packages / verified sites	Distribution and site check	Monthly

Indicator	Target / standard	Evidence	Frequency
Recovery households supported	Up to 300 selected households / cases	Approved case file / recovery record	Monthly
Grievance handling	Target response times and aggregate resolution rate	GRM aggregate dashboard	Monthly
Public updates	At least launch + periodic + closeout updates	OCE/public links	Monthly / milestone

Table 21. MEAL indicator framework

11.2 Baseline, PDM and completion verification

A minimal baseline is created during household verification. PDM should then test whether the assistance was received, useful, complete, safe and accessible. For shelter, completion monitoring should verify safety and intended use. For food and household items, PDM should look at adequacy, use, quality and protection concerns. For education, follow-up can check whether the student returned to learning and whether the package matched the school's requirements. For early recovery, follow-up should focus on whether the support contributed to resuming income or addressing the documented recovery gap.

11.3 Learning and adaptive management

The programme should not wait until closeout to learn. Monthly reviews should compare planned versus actual reach, unit rates, access conditions, complaint trends, supplier performance and cash flow. If food prices rise, the team should consider approved substitution or transfer-value adjustment. If shelter work is delayed by road access, the programme may need to rephase cash flow. If repeated complaints show an inaccessible distribution point, the delivery model should change. Learning is therefore connected directly to management decisions and donor transparency.

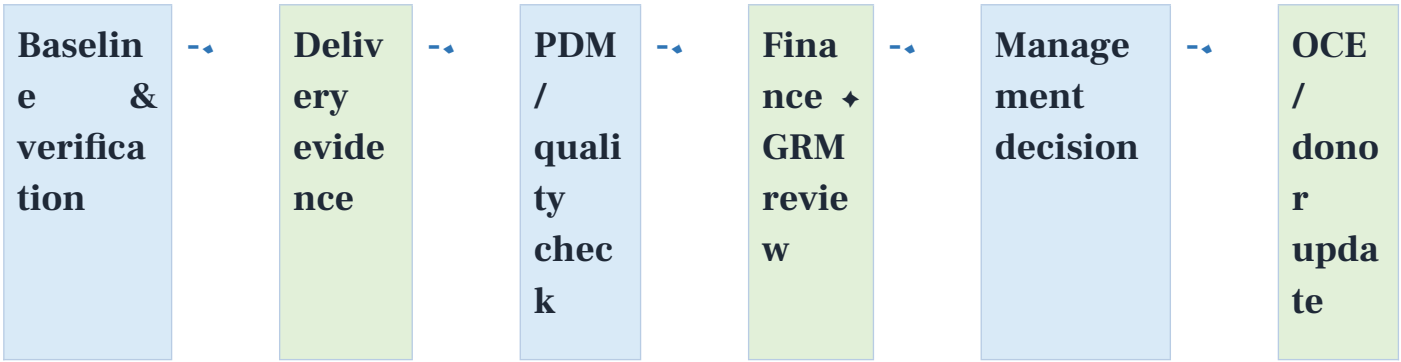

Figure 8. Monitoring and public-reporting cycle

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW MONITORING -◂ | VIEW PROGRAMME RESULTS -◂ | VIEW BUDGET VS ACTUAL -◂ | VIEW FUNDING & CONTRIBUTIONS -◂

12. PUBLIC INFORMATION, CONSULTATION & PARTICIPATION

12.1 Consultation approach

Consultation should begin before final beneficiary selection and continue through delivery and monitoring. In an emergency, long formal meetings are not always possible or appropriate; short structured consultations, help-desk interactions, school/health-facility coordination, targeted discussions with women, older people and people with disabilities, and post-distribution conversations can provide actionable information. The programme should document who was consulted, the main issue raised, the decision or commitment, responsibility and follow-up status.

Participation must not become a condition for aid. People who are ill, grieving, working, caring for children, displaced elsewhere or unable to attend a meeting should still be able to access information and assistance. The programme should use multiple communication channels and ensure that decisions are not dominated only by the most visible or powerful community representatives.

Stage	Consultation / information activity	Purpose
Assessment	Local authority/community briefing; targeted household checks; sector consultation	Validate locations, needs, duplication and access barriers.
Selection	Publish criteria and complaint channel; school/health verification	Reduce confusion and provide a route to correct errors.
Pre-distribution	Confirm date, location, package/modality, required evidence and accessibility arrangements	Support orderly, safe and inclusive delivery.
Post-distribution	PDM, help desk, community feedback and supplier/service review	Identify quality gaps and unintended effects.
Recovery / closeout	Community review, lessons learned and public result summary	Confirm outstanding needs, referrals and sustainability actions.

Table 22. Consultation and information plan

12.2 Field evidence and communications

The public campaign should show credible evidence of both need and delivery, but evidence must be ethically collected. Each public photograph should have a factual caption, date, location at an appropriate level, photographer/collector, verification status and consent/publication status. Images should not exaggerate, stage or sensationalize suffering. Where a photograph could identify a child, patient, grieving family or protection-risk survivor, the communications team should apply a higher consent and do-no-harm threshold.

The live Field Evidence sheet is intended to become the controlled index for publication-cleared material. The Word report does not embed unverified or placeholder photographs. This means the document can be shared safely even while field evidence continues to be updated online.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CONSULTATION SUMMARY -◂ | VIEW FIELD EVIDENCE -◂ | VIEW DISCLOSURE & PRIVACY -◂

13. IMPLEMENTATION SCHEDULE & OPERATIONAL PHASING

The programme is designed for six months, with the heaviest emergency-relief expenditure in the first three months and progressively greater emphasis on shelter completion, education continuity, early recovery, monitoring and closeout in later months. The schedule remains adaptive because road access, weather, search-and-rescue operations and government recovery decisions can affect sequencing. Rather than reproduce the live month-by-month worksheet in this report, the narrative defines the management logic that should govern rephasing.

Month 1 concentrates on rapid verification, immediate food/WASH/household support, medical mobilization, logistics setup and commencement of shelter assistance. Month 2 continues emergency delivery while scaling technical shelter work, school verification and early-recovery case identification. Month 3 is expected to complete the third planned food round or approved equivalent, continue shelter and education delivery and review unresolved protection, WASH and medical needs. Months 4-5 shift the centre of gravity toward shelter completion, education follow-up, selected livelihood recovery, monitoring and audit preparation. Month 6 focuses on closeout, final verification, referrals, financial reconciliation, independent review and public reporting.

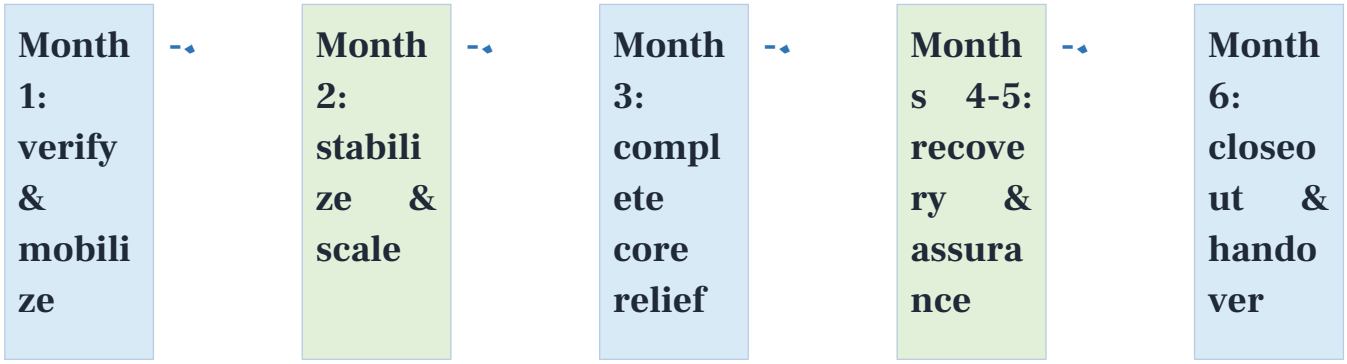

Figure 9. Six-month operational phasing

The live Implementation Plan is the authoritative operational schedule and should be updated whenever a milestone is rephased. The Cash Flow sheet provides the corresponding financial phasing. Programme managers should review schedule, procurement and cash flow together so that commitments do not exceed realistic delivery capacity or available funding. Any material rephasing that changes donor expectations should be explained in the next OCE public update.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW IMPLEMENTATION PLAN -• | VIEW CASH FLOW -• | VIEW PROCUREMENT PLAN -•

14. BUDGET REQUIREMENT, PROCUREMENT, CASH FLOW & FINANCIAL CONTROLS

14.1 Financial architecture

The campaign planning ceiling is NPR 150,000,000. At the planning exchange rate of NPR 152 per USD, this is approximately USD 986,842.11. The model follows a deliberately transparent structure: NPR 120,000,000 in direct programme costs, a 10% administration and coordination allocation of NPR 12,000,000, and a 15% contingency allocation of NPR 18,000,000. The administration and contingency percentages are calculated on the direct programme subtotal. This structure is aligned with the control logic used in the reference RAP, while the actual programme components and unit costs are specific NNSS planning assumptions for the Rasuwa response.

The direct programme subtotal is allocated across nine components: NPR 35 million shelter; NPR 14 million household support; NPR 22 million food; NPR 8 million WASH; NPR 12 million medical; NPR 8 million education; NPR 7 million logistics; NPR 4 million field operations/MEAL/GRM; and NPR 10 million livelihood/early recovery. These amounts total exactly NPR 120 million. Adding NPR 12 million administration and NPR 18 million contingency produces the NPR 150 million overall ceiling. The Word report should not contain a second line-item schedule because that would create duplicate sources of truth; detailed unit rates and quantities are available in the live Detailed Budget sheet.

- Direct programme: NPR 120,000,000 (USD 789,473.68) - 80% of the overall campaign ceiling.
- Project administration and coordination: NPR 12,000,000 (USD 78,947.37) - 8% of the overall campaign ceiling and 10% of direct programme cost.
- Controlled contingency reserve: NPR 18,000,000 (USD 118,421.05) - 12% of the overall campaign ceiling and 15% of direct programme cost.
- Overall campaign ceiling: NPR 150,000,000 (USD 986,842.11) at the planning rate of NPR 152 per USD.

> **DATA / SOURCE NOTE:** No Excel-style budget table is duplicated here. The live Budget Summary and Detailed Budget worksheets are the current financial schedules. Every financial figure stated in this narrative must remain synchronized to those sheets.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW BUDGET SUMMARY -• | VIEW DETAILED BUDGET -• | VIEW ADMINISTRATION -• | VIEW CONTINGENCY -•

14.2 Procurement and value for money

Procurement must balance speed with competition, quality and documentation. Emergency conditions may make a standard three-quotation process impractical in every case, but any exception should be justified in writing. Procurement files should show the requirement/specification, supplier outreach or market check, quotation/evaluation, approval, purchase order or contract, delivery/GRN, invoice and payment evidence. For

medical procurement, supplier licensing and clinical specification require additional attention. For food, quality, expiry, storage and delivery capacity are key. For shelter, technical specifications and acceptable substitutions should be clear before ordering.

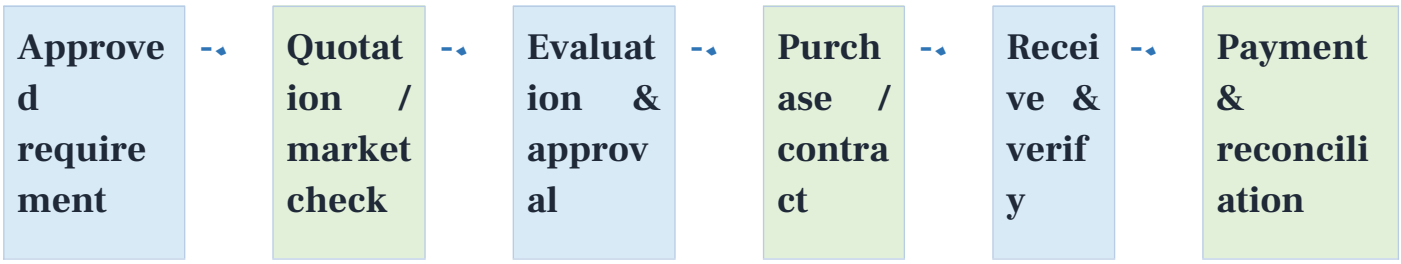

Figure 10. Procurement-to-payment control chain

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW PROCUREMENT PLAN -•

14.3 Cash flow and commitment control

The Cash Flow sheet phases the NPR 150 million envelope across six months. Early months are expected to carry higher expenditure because food, WASH, household items, medical mobilization and initial shelter procurement are front-loaded. Later months carry shelter completion, early recovery, monitoring, audit and closeout. Cash-flow planning is not the same as spending authorization; commitments should be made only against confirmed funding and approved procurement. Funding gaps should be visible so that programme managers can prioritize life-saving components rather than commit to activities without resources.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CASH FLOW -• | VIEW FUNDING & CONTRIBUTIONS -• | VIEW BUDGET VS ACTUAL -•

14.4 Administration and coordination

The NPR 12 million administration and coordination envelope covers functions needed to deliver and account for the programme: project leadership and inter-agency coordination; finance/accounting/procurement controls; internal monitoring/field supervision; independent audit/external review; compliance/safeguarding/legal support; communications/translation/public reporting; secure data systems; and essential programme support/office operations. These costs are not hidden overhead; they are the control infrastructure that allows a large emergency campaign to operate safely and transparently.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW ADMINISTRATION -•

14.5 Contingency reserve

The NPR 18 million contingency is a reserve, not an automatic spending line. The live model divides the reserve across likely emergency triggers such as price escalation/supplier

shortage, access/transport disruption, health/outbreak surge and unforeseen protection or critical needs. Release should require documented evidence of the trigger, management approval and a budget note showing how the contingency use affects the remaining reserve. This protects the programme from both under-budgeting and uncontrolled discretionary spending.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CONTINGENCY -◂

14.6 OCE fiscal-host / platform fee treatment

The core NPR 150 million model does not assume an unconfirmed OCE fiscal-host or platform fee. A separate live scenario sheet illustrates the effect of different fee rates if the fee is added on top of the programme target or deducted from the NPR 150 million ceiling. The public campaign should use only the final fee arrangement confirmed with OCE. Until that point, the fee scenario is a planning tool rather than a commitment or public cost claim.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW FISCAL HOST FEE -◂

15. RISK MANAGEMENT & SCENARIO PLANNING

The response operates in a high-risk environment where access, weather, price, health and information conditions can change quickly. Risk management therefore combines prevention, contingency planning and escalation. Risks are reviewed not only for their probability but also for their potential effect on life safety, programme integrity, protection and donor trust.

Risk	Likelihood	Impact	Mitigation / control
Road/landslide access disruption	High	High	Stage supplies, use alternative transport, maintain access checks and controlled contingency.
Supplier shortage / price volatility	High	High	Competitive checks, staged procurement, approved substitutions and contingency release.
Duplicate or inequitable assistance	Medium	High	Unique IDs, de-duplication, vulnerability criteria, partner coordination and GRM.
Unsafe shelter intervention	Medium	High	Technical assessment, safety scope, quality/completion checks.
Medical credential / quality risk	Low-Medium	High	License verification, Medical Lead protocols, referral pathway and confidentiality.
Safeguarding / PSEA incident	Low-Medium	Critical	Code of conduct, confidential reporting, trained focal point and survivor-centred referral.
Fraud/diversion / weak evidence	Medium	High	Segregated duties, procurement files, inventory, reconciliation, audit and evidence checks.
Privacy / harmful publicity	Medium	High	Data minimization, consent, restricted records and publication review.
Funding shortfall	Medium	High	Prioritize life-saving components, phase commitments and disclose funding gaps.
Renewed flood / secondary hazard	Medium	Critical	Monitor official warnings, suspend unsafe operations and pre-identify evacuation/access contingencies.

Table 23. Risk register

Scenario planning should consider at least three operating conditions. In a normal-access scenario, the programme follows the planned six-month sequence. In a constrained-access scenario, high-volume shelter and household deliveries may be delayed while medical, protection, information and cash/voucher options are prioritized where feasible. In a renewed-hazard scenario, staff and beneficiary safety takes precedence; field activities may be suspended and resources redirected to evacuation, emergency communication or medically urgent needs under approved contingency procedures.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CONTINGENCY -› | VIEW IMPLEMENTATION PLAN -› | VIEW SOURCES & METHODOLOGY -›

16. OCE REPORTING, TRANSPARENCY & DONOR ASSURANCE

16.1 Public reporting package

OCE contributors should be able to understand what the campaign is trying to achieve, how much it seeks to raise, how funds are allocated, what has been delivered and what remains outstanding. The public reporting package should therefore combine concise narrative updates with live financial/monitoring schedules and consent-cleared field evidence. The campaign should not overwhelm donors with operational spreadsheets, but it should make those records accessible for anyone who wants to review the detail.

A practical reporting rhythm is: launch/update 0 explaining the plan and baseline; monthly or milestone updates summarizing reach, key expenditure and operational challenges; a 90-day stabilization update after the three food rounds and major emergency deliveries; and a final/closeout report covering outputs, expenditure, remaining gaps, audit/review and lessons. If the campaign continues beyond six months, an updated recovery plan should replace repeated extension of the emergency narrative.

Reporting moment	Minimum public content	Supporting live sheets
Campaign launch	Context, targets, budget ceiling, safeguards, current funding status	Campaign Overview; Budget Summary; Funding & Contributions
Monthly / milestone update	Reach, key activities, expenditure trend, risks, complaints summary, cleared evidence	Monitoring; Budget vs Actual; Field Evidence
90-day stabilization update	Three-month food progress, household/WASH reach, shelter/education status, medical response	Food Support; Shelter; Education; Medical; Monitoring
Closeout	Final reach, financial reconciliation, audit/review, unresolved referrals and lessons	Budget vs Actual; Programme Results; Sources & Methodology

Table 24. OCE reporting calendar

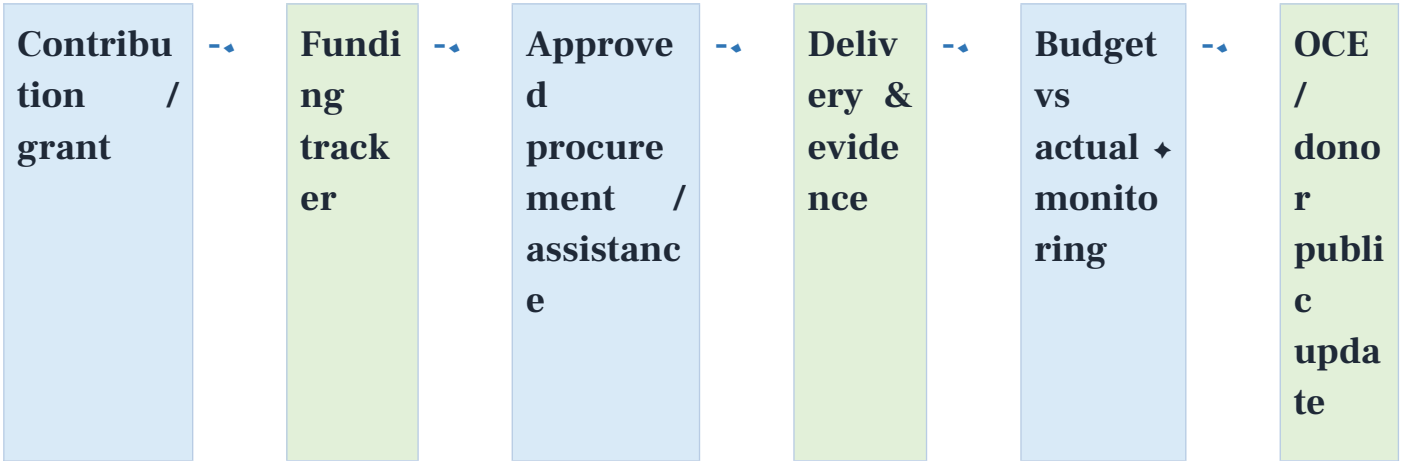

Figure 11. OCE fundraising-to-implementation transparency loop

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -↗ | VIEW FUNDING & CONTRIBUTIONS -↗ | VIEW BUDGET VS ACTUAL -↗ | VIEW MONITORING -↗ | VIEW FIELD EVIDENCE -↗

16.2 Financial assurance

Donor assurance depends on consistency across narrative, budget, procurement, bank/payment records, inventory and reported outputs. The live workbook is designed so that the component budgets total the direct programme subtotal and the administration/contingency structure reconciles to the NPR 150 million ceiling. Actual expenditure should be recorded against the same component categories so that budget-versus-actual reporting remains intelligible. Any material budget revision should be approved, documented and explained in the next public update.

16.3 Evidence assurance and privacy

Public transparency does not mean publishing every record. Beneficiary names, grievance narratives, patient data, staff personal contact information and unredacted credential documents are not appropriate for unrestricted public access. Donor due diligence can be supported through controlled sharing where necessary. The public report should instead rely on aggregate results, anonymized samples, consent-cleared photographs, procurement summaries and audit/review outputs. The public-versus-restricted disclosure rules are maintained in the live Disclosure & Privacy worksheet linked in the reporting callout above.

17. SUSTAINABILITY, HANDOVER & EXIT STRATEGY

Emergency assistance should be designed with an exit from the first month. Food assistance is time-bound to three months unless a new verified humanitarian rationale and funding decision justify continuation. Shelter support should lead to a defined safety/habitability outcome or referral, not indefinite material distributions. WASH interventions should link household treatment and hygiene support to restoration of community systems. Medical activities should strengthen referral and continuity with existing health services rather than substitute for them permanently.

Early-recovery support is the bridge between emergency relief and longer-term recovery. Selected households should leave the programme with restored essential assets, improved access to income, an appropriate referral or a clear pathway into government/partner recovery schemes. NNSS should identify unresolved cases during month five so that referrals and handover can be completed before financial closeout.

Programme systems can also create longer-term value. A de-duplicated beneficiary database, documented GRM, supplier performance records, field evidence standards and monitoring routines can strengthen NNSS readiness for future emergencies. Lessons from access constraints, inclusion barriers and community feedback should be documented and incorporated into preparedness procedures rather than archived only for donor compliance.

Exit area	Closeout condition	Handover / sustainability action
Food	Third round/equivalent completed and PDM conducted	Refer households with continued severe food insecurity to government/partner/social protection options.
Shelter	Assistance delivered and safety/completion status verified	Refer unresolved structural/relocation cases to responsible technical/government recovery mechanism.
WASH	Household support completed; community-site action stabilized	Coordinate longer-term system rehabilitation with local authority/WASH actors.
Medical	Mobile response reduced as services stabilize	Ensure referral records are closed appropriately and health facilities/authorities have continuity information.
Education	Student package delivered and school verification complete	Refer longer-term learning/protection needs to school/education/protection actors.
Early recovery	Case support completed and outcome checked	Link viable cases to longer-term livelihood/social protection support where available.
GRM / data	Open cases reviewed and records archived securely	Maintain channel for post-closeout financial or safeguarding issues for a defined period.

Table 25. Sustainability and exit milestones

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW PROGRAMME RESULTS -• | VIEW MONITORING -• | VIEW CONSULTATION SUMMARY -•

18. CONCLUSION & CALL FOR SUPPORT

The Rasuwa flood emergency is larger than any single civil-society campaign. Government agencies, security forces, health services, UN agencies, local authorities, community groups and multiple humanitarian organizations are responding across a wide and difficult river corridor. NNSS's role is therefore not to claim comprehensive coverage, but to deliver a defined, transparent and technically controlled package to verified households and students while coordinating with the wider response.

The proposed NPR 150 million campaign combines immediate relief with practical early recovery. The design protects 80% of the envelope for direct programme activities and makes administration and contingency explicit rather than hidden. It places high-value components - shelter, food, medical care and household support - alongside WASH, education, logistics, accountability and livelihood recovery so that assistance addresses the interconnected realities of displacement and loss.

Donor support will be translated into documented assistance through a chain of verification, approval, procurement, delivery, monitoring and public reporting. Live NNSS worksheets allow detailed financial and programme schedules to remain current without duplicating them inside this narrative report. This reduces version-control risk and gives donors a direct route to the evidence behind the campaign.

NNSS invites OCE, institutional donors, partner organizations and individual contributors to support the campaign in a manner that is timely, flexible and accountable. Early funding allows the programme to secure essential supplies, mobilize technical and medical capacity, reach remote communities before needs deepen, and move vulnerable households from survival toward safer recovery.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -◂ | VIEW FUNDING & CONTRIBUTIONS -◂ | VIEW BUDGET SUMMARY -◂

ANNEX A. LIVE SUPPORTING WORKSHEET DIRECTORY

The following live worksheets are hosted on the NNSS website. They are the current structured supporting records for the campaign. The Word report intentionally does not duplicate the detailed worksheet tables. Each sheet can be opened directly using the link below.

Sheet	Worksheet	Live link	Sheet	Worksheet	Live link
0	**Campaign Overview**	OPEN -›	14	**Programme Results**	OPEN -›
1	**Shelter**	OPEN -›	15	**Implementation Plan**	OPEN -›
2	**Household Support**	OPEN -›	16	**Procurement Plan**	OPEN -›
3	**Food Support**	OPEN -›	17	**Cash Flow**	OPEN -›
4	**WASH**	OPEN -›	18	**Monitoring**	OPEN -›
5	**Medical**	OPEN -›	19	**Medical Team Profiles**	OPEN -›
6	**Education**	OPEN -›	20	**Field Evidence**	OPEN -›
7	**Logistics**	OPEN -›	21	**Consultation Summary**	OPEN -›
8	**Field Operations**	OPEN -›	22	**Funding & Contributions**	OPEN -›
9	**Early Recovery**	OPEN -›	23	**Budget vs Actual**	OPEN -›
10	**Administration**	OPEN -›	24	**Fiscal Host Fee**	OPEN -›
11	**Contingency**	OPEN -›	25	**Sources & Methodology**	OPEN -›

Sheet	Worksheet	Live link	Sheet	Worksheet	Live link
12	**Budget Summary**	OPEN -↗	26	**Disclosure & Privacy**	OPEN -↗
13	**Detailed Budget**	OPEN -↗			

Table 26. Live supporting worksheet directory

> **DATA / SOURCE NOTE:** Sheet numbering in this annex follows the NNSS public worksheet viewer: Campaign Overview starts at sheet=0 and Disclosure & Privacy ends at sheet=26.

ANNEX B. RAPID HOUSEHOLD VERIFICATION FRAMEWORK

The rapid household verification framework is the mechanism for converting broad humanitarian estimates into a defensible NNSS beneficiary list. It should be short enough to use under emergency conditions but complete enough to support de-duplication, vulnerability analysis, component eligibility and later monitoring. Personal data should be limited to what is operationally necessary and stored securely.

Domain	Minimum fields	Use in programme
Identification & location	Unique HH ID; date; municipality/ward; community; reference contact/alternative verifier	De-duplication, routing and follow-up.
Household composition	HH size; sex of household head; children; older persons; pregnancy/lactation; disability/access needs	Vulnerability prioritization and accessible delivery.
Shelter damage	Destroyed/unsafe/severe/moderate/ minor; site safety; evidence reference	Shelter eligibility and technical prioritization.
Household-item loss	Bedding, kitchen, clothing, lighting/storage and other essential losses	Household recovery package selection.
Food security	Food-stock loss; income/access disruption; current assistance; cooking capacity	Food eligibility and monthly re-verification.
WASH	Water source; contamination; storage; sanitation damage; hygiene-item loss	WASH package/site intervention.
Health	Urgent injury/illness; chronic medication interruption; maternal/newborn need; referral requirement	Medical/referral priority; collect minimal sensitive detail.
Education	School-age children; school; uniform/material loss; access disruption; other assistance	Education package verification and duplication check.
Livelihood	Primary livelihood; disruption/loss; tools/assets; recovery priority	Early-recovery case selection.
Existing assistance	Government/NGO/other support received or promised	Avoid duplication and identify gaps.
Consent / publication	Programme data notice; photo consent kept separate from assistance eligibility	Data protection and ethical evidence use.

Table 27. Rapid household minimum data fields

Female-headed households, older-person-headed households and older persons are explicitly included because current public flood situation reports do not provide a verified count for these groups. NNSS can therefore generate a programme-specific, evidence-based disaggregation after registration. Aggregate results can be published in the Monitoring sheet without disclosing household identities.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW MONITORING -› | VIEW DISCLOSURE & PRIVACY -›

ANNEX C. MONITORING INDICATOR DEFINITIONS

Indicator	Numerator / definition	Denominator / target	Verification note
Shelter households supported	Unique households with approved shelter assistance delivered and recorded	Up to 300 families	Do not count partial material dispatch unless household allocation is documented.
Household recovery assistance	Unique households receiving approved household-essential package/support	Up to 500 families	De-duplicate repeated deliveries to same household.
Food assistance completion	Unique households completing three monthly rounds or approved equivalent	Up to 500 families	Track each round separately; report completed households and cumulative household-rounds.
Education support	Unique school-verified students receiving approved education recovery package	Up to 500 students	Prevent duplicate counting across multiple items.
Medical team credentialing	Planned clinical staff with verified qualification/registration and deployment approval	10 planned staff	Publication consent is separate from operational

Indicator	Numerator / definition	Denominator / target	Verification note
			credential verification.
Medical camps/deployments	Completed organized mobile medical service events/rotations with service record	Up to 10 planned	Use aggregate service data; protect patient identity.
WASH households	Unique households receiving approved water/hygiene package	Up to 500 family packages	Community-site interventions reported separately.
Early recovery households	Unique approved household/case receiving recovery support	Up to 300 selected cases/households	Report type of support and follow-up outcome.
Grievance response	Cases addressed within target timeline / eligible routine cases	Target to be finalized in protocol	Exclude safeguarding cases from inappropriate public detail.
Budget execution	Actual eligible expenditure recorded / approved component budget	Per component	Reconcile to finance records; explain material variance.

Table 28. Monitoring indicator definitions

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW MONITORING -↗ | VIEW BUDGET VS ACTUAL -↗ | VIEW PROGRAMME RESULTS -↗

ANNEX D. SAFEGUARDING & GRM SERVICE STANDARDS

D.1 Safeguarding minimum operating rules

- Assistance is free; staff, volunteers and contractors may not request money, favours or sexual activity in exchange for aid.
- Children should not be interviewed or photographed unnecessarily, and child-sensitive consent/assent procedures should be followed.
- Sensitive complaints are disclosed only to personnel who need the information to manage risk or referral.
- Survivor safety, dignity and informed choice take priority over programme reputation or publicity.
- Medical and psychosocial information is confidential and excluded from public evidence logs.
- Distribution and consultation arrangements should be accessible to women, older persons, people with disabilities and people with limited literacy or connectivity.
- Retaliation against complainants or whistleblowers is prohibited.

D.2 GRM escalation matrix

Case type	Examples	Route	Public reporting
Routine service	Missing item, timing, eligibility query, distribution quality	Field/GRM focal -> relevant programme lead	Aggregate category and response time.
Financial / fraud concern	Diversion, supplier collusion, unauthorized payment	GRM/management -> finance/compliance -> independent review as needed	Aggregate only; preserve investigation confidentiality.
Safeguarding / PSEA	Sexual exploitation/abuse, harassment, serious misconduct	Authorized safeguarding focal -> survivor-centred referral / management protocol	No identifying detail; only safe aggregate reporting.
Child protection	Separated child, abuse/exploitation concern	Protection focal -> competent child-protection authority/service	No identifying detail.
Medical safety / privacy	Clinical complaint, unsafe care, confidentiality breach	Medical Lead / safeguarding route depending severity	Aggregate quality reporting only.
Conflict of	Complaint against person assigned to	Escalate to alternate senior/independent	Document recusal and

Case type	Examples	Route	Public reporting
interest	handle the case	reviewer	outcome.

Table 29. Safeguarding and grievance escalation matrix

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW FIELD OPERATIONS -↓ | VIEW DISCLOSURE & PRIVACY -↓

ANNEX E. DATA SOURCES, REFERENCE FRAMEWORK & METHODOLOGY

E.1 Source hierarchy

Situation data are prioritized in the following order: Government of Nepal official emergency/health/disaster sources; United Nations agency situation reports and official humanitarian updates; established international or Nepal media reporting that explicitly attributes figures to government authorities; and NNSS field verification for programme-specific targeting. When figures conflict because of different dates or definitions, the report retains the date/source rather than blending them.

Source	Document / date	Use in this report
Government of Nepal, Ministry of Home Affairs	Official Disaster Relief Appeal, published after 26 Aug 2026	Event onset and initial severe district impacts.
Government of Nepal, Health Emergency Operation Centre / WHO Nepal	Rasuwa Flash Floods 2026 event page / health response	Six affected districts, 15 crisis-affected municipalities and health-system impacts.
UNICEF Nepal	Humanitarian Situation Report No.1 - Rasuwa Flood, 31 Aug 2026	65,000 affected people, 22,100 children, WASH/health/nutrition/education/protection needs.
UNICEF	3 Sep 2026 WASH update	At least 22,000 children urgently needing safe water, sanitation and hygiene.
UNFPA Nepal	Flash Update on the Nepal Floods, 31 Aug 2026	Affected-area women-of-reproductive-age and pregnancy estimates; SRH/GBV risk.
NDRRMA bulletin reported by Onlinekhabar	3 Sep 2026	Deaths, missing, rescued, injured and district body-recovery distribution.
Kathmandu Post	30 Aug 2026 government allocation report	List of 15 local units receiving disaster-management funds.
World Bank-linked reference document	Metro Manila Flood Management Project RAP, Batch 3 Pumping Stations	Structural/control reference only: baseline, vulnerability, assistance matrix, institutions, GRM, monitoring, consultation, schedule, budget.

Table 30. Source hierarchy and data-status rules

E.2 External source links

- Government of Nepal Ministry of Home Affairs - Official Disaster Relief Appeal
- WHO Nepal - 2026 Rasuwa flash floods
- Nepal Health Emergency Operation Centre - Rasuwa Flash Floods 2026
- UNICEF Nepal Humanitarian Situation Report No.1 (31 Aug 2026)
- UNICEF 3 Sep 2026 WASH update
- UNFPA Nepal - Nepal flash floods / flash update
- Onlinekhabar - 3 Sep 2026 NDRRMA casualty update
- Kathmandu Post - government support to 15 local units

E.3 Reference-framework adaptation statement

The uploaded 2023 Metro Manila Flood Management Project Resettlement Action Plan (Batch 3 Pumping Stations) is used as a structural and control reference because it provides a detailed example of socio-economic baseline work, vulnerability treatment, impact/assistance matrices, institutional responsibility, livelihood restoration, grievance redress, internal/external monitoring, consultation, implementation scheduling, and budget presentation with explicit project administration and contingency. This Rasuwa report does not treat Philippine laws, agencies, compensation rates, household statistics or resettlement entitlements as applicable to Nepal. The adaptation is methodological, not legal or factual.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW SOURCES & METHODOLOGY -◂

ANNEX F. GENDER, AGE, DISABILITY & PROTECTION INCLUSION PLAN

F.1 Why disaggregation matters in this response

Flood impacts are not experienced uniformly. A household may appear equally affected in a damage list while facing very different recovery barriers depending on age, gender, disability, care responsibilities, health conditions, displacement status and access to information. The purpose of disaggregation is therefore not simply to populate donor tables; it is to change operational decisions. If verification identifies a high number of older-person-headed households in a target settlement, distribution timing, porter support, home delivery and medical referral capacity may need to change. If women and girls report privacy or menstrual-hygiene concerns in a holding centre, WASH and protection arrangements must respond accordingly.

The public humanitarian sources available for this edition do not provide a verified count of affected female-headed households or affected older persons. NNSS will therefore generate programme-level disaggregation from verified records. The aggregate monitoring dataset should, at minimum, be able to show the number of supported households by sex of household head, households containing older persons, households with disability/accessibility needs, households with pregnant or lactating members, and households with children. These categories can overlap and should not be summed as if they were mutually exclusive.

F.2 Inclusion actions by programme component

Component	Gender / age / disability consideration	Operational action
Shelter	Older people and people with disabilities may be unable to clear debris or supervise repair; women-headed households may have weaker access to labour/technical networks.	Provide technical support, accessible delivery, debris/labour referral and priority follow-up based on verified barriers.
Food	Household size, infant/child needs, older-person diets and pregnancy/lactation can affect adequacy and use.	Use household-size information, nutrition referral and safe/culturally appropriate food selection.
WASH	Women/girls need privacy and menstrual-hygiene support; mobility limitations affect access to water/toilets.	Consult users, ensure dignity items, consider accessible water points and home delivery where needed.
Medical	Older people/chronic-disease patients may face medication interruption; pregnant women need timely referral; persons	Triage chronic/maternal needs, maintain referral list, use accessible communication and protect confidentiality.

Component	Gender / age / disability consideration	Operational action
	with disabilities may face communication barriers.	
Education	Girls, children with disabilities, displaced children and separated children can face higher return-to-school barriers.	School verification, accessibility check, protection referral and case-based transport/document support.
GRM	Women, adolescents, older people and people with disabilities may not use the same complaint channel.	Offer multiple channels, private options, assisted reporting and anonymous feedback where feasible.

Table 31. Gender, age and disability inclusion actions

F.3 Safe demographic reporting

Aggregate demographic reporting should be purposeful and privacy-safe. NNSS should avoid publishing very small cell counts at settlement level when they could identify an individual, particularly for pregnancy, disability or protection-related categories. Public reporting can show programme-level totals and percentages, while detailed household-level information remains restricted. Sex-of-household-head should not be used as a proxy for vulnerability on its own; the programme should combine it with damage, income, care burden, disability, age and other verified factors.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW MONITORING -• | VIEW DISCLOSURE & PRIVACY -• | VIEW CONSULTATION SUMMARY -•

ANNEX G. MEDICAL TEAM DEPLOYMENT & HEALTH-RESPONSE FRAMEWORK

G.1 Planned team and deployment readiness

The current financial model provides for a core medical team of five doctors and five nurses. The exact professional mix should be finalized against field needs and available personnel. A useful deployment may include clinicians comfortable with emergency/primary care, maternal and child health, chronic disease continuity, public-health screening and referral. The roster should identify who is deployed on each date, which location the team covers, the responsible Medical Lead, transport arrangements, referral facilities and the stock issued to the team.

Credential verification is a pre-deployment requirement, not merely a public-relations exercise. NNSS should verify professional registration/license status, identity, qualification and role before the clinician is allowed to provide care under the programme. Public profile publication is a separate decision requiring consent. The live Medical Team Profiles sheet is designed to separate these two issues: operational readiness and public disclosure.

G.2 Mobile medical camp minimum operating package

Area	Minimum operating requirement
Site selection	Safe, accessible location with privacy for consultation and a clear referral/evacuation route.
Registration / triage	Minimal patient information; urgent cases identified immediately; no unnecessary personal data.
Clinical supplies	Approved medicines/consumables and basic diagnostics matched to team scope and public-health risk.
Infection prevention	Hand hygiene, PPE, waste segregation, sharps safety, cleaning and safe water.
Maternal/ newborn care	Identify pregnancy/newborn risk, emergency referral need and continuity of essential services.
Chronic disease	Screen for medication interruption and refer/replenish within legal/clinical scope.
MHPSS	Psychological first aid/basic support and referral; no unsupported diagnosis or treatment claims.
Referral	Current list of functioning facilities, contact points and transport alternatives.
Reporting	Aggregate consultations, referrals, priority conditions and supply use; no public patient identifiers.

Table 32. Mobile medical camp minimum operating package

G.3 Medicine and equipment control

Medical inventory requires tighter control than general relief items because expiry, storage, clinical authorization and traceability affect patient safety. Stock should be received against an approved specification, recorded into inventory, issued to a named team or camp, reconciled after use and disposed of according to applicable rules where necessary. Controlled or high-risk medicines should not be included unless legal, storage and prescribing requirements can be met. Donations of medicines should be screened against actual need and expiry rather than accepted automatically.

G.4 Health coordination and referral continuity

WHO and HEOC reporting show that government-led health coordination is active. NNSS should align medical deployments with local health authorities and functioning health facilities so that the team fills gaps rather than duplicates services. Referral records should be operationally useful but privacy-protected. At closeout, unresolved patients or chronic-care needs should be handed over to appropriate services with consent rather than disappearing when the mobile team leaves.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN
VIEW MEDICAL -• | VIEW MEDICAL TEAM PROFILES -• | VIEW FIELD EVIDENCE -•

ANNEX H. DONOR DUE-DILIGENCE & EVIDENCE PACKAGE

H.1 What a donor should be able to verify

A strong humanitarian campaign should allow an independent reviewer to trace a reasonable sample from public promise to field result. For example, a reviewer should be able to start with the shelter budget, see the approved procurement or delivery method, identify a sample of verified household allocations, confirm receipt/completion evidence, compare actual expenditure with the approved component ceiling and review whether complaints or exceptions were recorded. The same logic should apply to food, household items, education, medical supplies and early-recovery support.

The evidence package should be organized by component and month rather than stored only in individual staff phones or email accounts. File naming should include date, component, location/ID and evidence type where appropriate. Sensitive files should sit in a restricted location with role-based access, while public evidence is indexed in the Field Evidence sheet. This separation helps NNSS respond quickly to donor questions without risking accidental public disclosure of personal data.

H.2 Minimum due-diligence file structure

File area	Examples of evidence	Access level
Governance	Approved action plan, roles, conflict-of-interest declarations, major decisions	Donor / controlled

File area	Examples of evidence	Access level
Beneficiary verification	Assessment forms, de-duplication checks, approval lists	Restricted / sampled for DD
Procurement	Specifications, quotations, evaluations, approvals, PO/contracts, GRN	Donor / controlled
Finance	Invoices, payment evidence, bank reconciliation, budget-vs-actual	Donor / finance controlled
Distribution / completion	Delivery notes, acknowledgements, PDM, shelter completion evidence	Donor / privacy reviewed
Medical	Credential files, stock records, aggregate camp reports, referral protocols	Controlled; patient data restricted
GRM / safeguarding	Aggregate dashboard, protocol, evidence of handling standards	Case-level restricted
Communications	Consent-cleared photos/captions, public updates, publication approvals	Public / donor as cleared
Audit / review	Independent audit/review TOR, findings, management response	Donor / public summary as appropriate

Table 33. Donor due-diligence evidence package

H.3 Exception management

Emergency operations inevitably produce exceptions: a supplier may be the only accessible option; a beneficiary may relocate; a planned road may close; a household may lose its identification documents; a medical referral facility may become inaccessible. Good control does not mean pretending exceptions do not happen. It means documenting why the normal rule could not be followed, who approved the alternative, how risk was mitigated and how the exception was reconciled. A clear exception log protects both affected people and programme staff.

H.4 Publication readiness check

- Latest situation figures are dated and attributed; no unsupported demographic estimates are presented as facts.
- Narrative budget figures reconcile exactly to the live Budget Summary.
- OCE/platform fee language reflects the confirmed arrangement or is clearly identified as illustrative.
- Medical personnel shown publicly have verified credentials and publication consent.
- Photographs have factual captions, verification and appropriate consent status.
- No beneficiary names, grievance narratives or patient data are exposed in public links.

- Funding received and actual expenditure are updated before claiming implementation results.
- Any material budget or scope revision is explained in the next public update.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW PROCUREMENT PLAN -› | VIEW BUDGET VS ACTUAL -› | VIEW FIELD EVIDENCE -› | VIEW SOURCES & METHODOLOGY -›

ANNEX I. 90-DAY MANAGEMENT REVIEW & ADAPTATION CHECKLIST

At approximately 90 days, NNSS should conduct a formal management review because the programme will have completed or substantially completed the three planned food rounds and many early emergency distributions. The review is an opportunity to decide whether the original assumptions remain valid before the programme moves further into shelter completion and early recovery. It should not wait until the final audit.

Review area	Questions for management decision
Targeting	Are the planned 300 shelter / 500 food-household / 500 student targets still appropriate? Which verified needs remain uncovered?
Budget	Are unit rates and component ceilings still realistic? Has contingency been used and properly approved?
Funding	How much has been received, committed and spent? Which activities should be prioritized if a funding gap remains?
Access	Which communities remain difficult to reach? Are alternative delivery methods still needed?
Quality	What do PDM, shelter checks, medical referrals and school verification show about assistance quality?
Protection / GRM	What complaint trends or inclusion barriers require a design change?
Medical / WASH	Are public-health risks increasing or decreasing? Are mobile services still filling a real gap?
Recovery	Which households are ready for early-recovery support and which need referral to longer-term programmes?
Reporting	Does the OCE/public narrative match actual reach and expenditure? What should be disclosed in the 90-day update?

Table 34. 90-day management review checklist

The management review should produce a short decision note: confirmed/updated targets, approved budget reallocations if any, remaining risks, priority activities for months four to

six, and reporting commitments. Where a change affects public expectations or financial allocations, the OCE campaign should be updated promptly.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW FUNDING & CONTRIBUTIONS -› | VIEW BUDGET VS ACTUAL -› | VIEW MONITORING -› | VIEW IMPLEMENTATION PLAN -›

ANNEX J. DISTRICT & DEMOGRAPHIC OPERATIONAL PROFILE

J.1 Why district and demographic precision matters

The flood emergency spans a river corridor rather than a single administrative unit. For programme management, it is therefore important to separate three different types of geographic information: districts formally described as affected in government/health reporting; local units receiving disaster-management resources; and downstream locations where bodies or debris have been recovered. These categories overlap, but they are not interchangeable. NNSS should use verified household need and access to select operational locations instead of assuming that casualty-recovery counts represent the residential distribution of affected households.

The same distinction applies to demographic information. Humanitarian agencies have published useful sectoral and exposure estimates for children, women of reproductive age, pregnant women and other groups, but the available public sources do not provide a verified count of flood-affected female-headed households, older-person-headed households, older persons or persons with disabilities. This report therefore presents what is known, identifies what is not known, and defines the programme data that NNSS must collect before final beneficiary selection.

J.2 Published demographic and exposure indicators

Indicator / group	Published figure used	Status of figure	Programme implication
Estimated people affected	65,000	UNICEF SitRep estimate, 31 Aug 2026	Use as broad humanitarian context, not NNSS beneficiary denominator.
Children affected	22,100	UNICEF estimate, 31 Aug 2026	Child-sensitive WASH, education, protection and household delivery.
Children urgently needing WASH	At least 22,000	UNICEF update, 3 Sep 2026	Prioritize safe water, sanitation and hygiene continuity.
Women of reproductive age in affected areas	Approx. 86,820	UNFPA affected-area exposure estimate	Plan dignity, SRH, referral and protection capacity; not a direct affected-beneficiary count.
Pregnant women in affected areas	Approx. 4,430	UNFPA affected-area exposure estimate	Ensure maternal/newborn referral continuity and

Indicator / group	Published figure used	Status of figure	Programme implication
			accessible services.
Pregnant/ lactating women requiring nutrition support	Approx. 10,500	UNICEF sector planning estimate	Nutrition/referral signal; do not convert into household-head statistics.
Female-headed affected households	Not publicly verified	Data gap	Collect sex of household head in NNSS rapid verification and report only aggregate results.
Older persons / older-person-headed affected households	Not publicly verified	Data gap	Collect age and older-person-headed status; plan accessible delivery, home/porter support and referral.
Persons with disabilities affected	Not publicly verified	Data gap	Record functional/access barriers, not only diagnosis; adapt distribution and communication.

Table 35. Published demographic and exposure indicators

> **DATA / SOURCE NOTE:** UNFPA's 310,076 affected-area population base is an exposure/service-planning denominator for people living in affected areas, not a verified count of people who personally lost homes or require NNSS assistance. The report does not convert this population base into unsupported beneficiary estimates.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -• | VIEW MONITORING -• | VIEW DISCLOSURE & PRIVACY -•

J.3 District-level operational priorities and verification needs

District / corridor	Published status	Likely operational focus for NNSS verification	Data to verify before deployment
Rasuwa	Primary affected district; upper Bhote Koshi corridor	Severe shelter loss, isolated communities, household essentials, WASH, medical access, logistics	Target wards/settlements; access; damage category; current assistance; health/referral routes.
Nuwakot	Primary downstream affected district	Displacement/holding-centre needs, shelter/household loss, food/WASH, student verification	Affected settlements; duplication; school/health access; market and transport status.
Dhading	Affected district with health/access impacts	WASH, medical referral, shelter/food gaps and access constraints	Road access; health-facility function; water systems; underserved settlements.
Chitwan	WHO/HEOC affected downstream district	Downstream humanitarian needs and referral/coordination	Community-level need versus recovery-location reporting; avoid inferring residence from body-recovery counts.
Gorkha	Affected district; crisis-affected local unit reported	Targeted relief/recovery where verified needs remain	Affected communities, access and partner coverage.
Tanahun	Affected district; crisis-affected local units reported	Targeted downstream relief and recovery gaps	Local-unit priorities, access, duplication and service continuity.
Nawalparasi East / West	Appears in downstream body-recovery	Coordination and evidence review rather than automatic	Confirm whether household humanitarian

District / corridor	Published status	Likely operational focus for NNSS verification	Data to verify before deployment
	reporting	programme targeting	needs fall within NNSS campaign scope before any allocation.

Table 36. District-level operational priorities and verification needs

J.4 Programme demographic outputs to publish after verification

Once household verification begins, NNSS should replace the current data gaps with privacy-safe programme statistics. The purpose is not to create a census of the disaster, but to demonstrate that the campaign reached people equitably and adapted delivery to barriers. Aggregate reporting should preserve overlap between categories; for example, a household can be female-headed, include an older person and include a person with disability at the same time.

Programme output	Minimum disaggregation / metric	Why it matters
Households verified	District/local unit; household size; sex of household head	Shows geographic reach and whether female-headed households are being included.
Older-person inclusion	Households with person aged 60+; older-person-headed households	Supports accessible delivery, home/porter support and health referral planning.
Disability/ access inclusion	Households reporting mobility, sensory, communication or other access barriers	Tests whether standard distributions unintentionally exclude people.
Maternal/infant vulnerability	Pregnant/lactating member; infant/young child where operationally relevant	Supports nutrition, dignity, WASH and medical referral decisions.
Assistance overlap	Components received by unique household	Allows transparent multi-sector support without double-counting households.
Complaints / barriers	Aggregate complaint category and access issue, without names	Shows whether targeting and distribution arrangements need correction.

Table 37. NNSS demographic verification outputs

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW MONITORING -↓ | VIEW PROGRAMME RESULTS -↓ | VIEW CONSULTATION SUMMARY -↓ | VIEW DISCLOSURE & PRIVACY -↓

ANNEX K. OCE PUBLIC UPDATE & REPORTING TEMPLATE

K.1 Purpose of the update template

The campaign page should become more credible as implementation progresses, not less. Each public update should connect three layers of evidence: what changed in the humanitarian situation, what NNSS delivered, and what the financial records show. The live worksheets make this possible without pasting large operational tables into the public narrative. The update itself should remain readable for a donor who has only a few minutes, while clear links allow a reviewer to inspect the underlying schedules.

A monthly or milestone update should never report expenditure without programme output, or output without the corresponding funding context. If only part of the campaign target has been funded, NNSS should say so and explain which components are being prioritized. If planned quantities, unit rates or implementation dates change, the update should identify the reason and direct the reader to the current live sheet rather than leaving an outdated number in the public narrative.

K.2 Minimum content for each OCE public update

Update block	Minimum information	Primary live worksheet link
Situation change	Date/cut-off; meaningful change in access, needs, government/UN situation or hazards	Campaign Overview / Sources & Methodology
Funding status	Campaign target, amount received/committed, funding gap, material restrictions	Funding & Contributions
Programme reach	Unique households/students reached by component and key output progress	Monitoring / Programme Results
Financial progress	Approved component budget, actual eligible expenditure, material variance	Budget vs Actual / Budget Summary
Procurement / logistics	Major procurement completed, delivery bottlenecks or justified exceptions	Procurement Plan / Cash Flow
Quality & accountability	PDM/verification findings, aggregate complaints, safeguarding/access changes	Monitoring / Consultation Summary / Disclosure & Privacy
Medical response	Credentialed team status, aggregate camps/referrals and public-health priorities	Medical / Medical Team Profiles
Evidence	Only dated, factual, consent-cleared photos or other public evidence	Field Evidence

Update block	Minimum information	Primary live worksheet link
Next period	What will happen next, key decisions, risks and funding priorities	Implementation Plan / Contingency

Table 38. OCE monthly public update minimum content

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -◂ | VIEW FUNDING & CONTRIBUTIONS -◂ | VIEW MONITORING -◂ | VIEW BUDGET VS ACTUAL -◂ | VIEW FIELD EVIDENCE -◂

K.3 Financial disclosure and reconciliation before publishing

Before an update is published, the finance and programme teams should reconcile the numbers together. The public funding amount should agree with the Funding & Contributions sheet. Actual expenditure should agree with the Budget vs Actual record and supporting finance records. Programme outputs should agree with the Monitoring sheet and evidence register. Any material difference between committed, paid and delivered value should be explained rather than collapsed into one number.

Check before publication	Required confirmation	If not reconciled
Campaign ceiling	Narrative still states NPR 150,000,000 / USD 986,842.11 unless an approved revision has been made	Do not publish a new ceiling until approved and updated in all public records.
Component ceilings	Narrative references remain consistent with the live Budget Summary	Correct narrative or approved model before release.
Funding received	Received amount is supported by OCE/bank/payment records	Report as pledged/committed rather than received until confirmed.
Actual expenditure	Reported spend is eligible, posted and reconciled to supporting records	Use the last reconciled cut-off and state the date.
Outputs	Reach numbers are unique/verified and do not double-count repeat distributions	Use provisional language or delay the figure until de-duplication is complete.
Evidence	Photographs/captions have verification and appropriate consent/publication status	Keep evidence internal until cleared.
Sensitive information	No beneficiary, grievance, patient or private staff data is exposed	Remove/redact before publication.
OCE fee	Fee language matches the confirmed fiscal-host arrangement	Keep illustrative scenario separate until confirmed.

Table 39. Public financial disclosure and reconciliation checklist

K.4 Suggested short public narrative structure

Opening: state the reporting period and one or two significant changes in the situation. Progress: summarize the verified people/households/students reached and the main components delivered. Finance: state funding received, eligible expenditure to date and the remaining funding gap using the same cut-off date. Accountability: summarize important quality findings, aggregate feedback and any material operational change. Evidence: include only cleared photographs or field records. Next steps: identify the next delivery priorities, key risks and the specific funding gap that would unlock them.

This structure keeps the OCE page human-readable while preserving a direct path to technical detail. A donor who wants the headline can read the update in a few minutes; a technical or finance reviewer can open the linked sheets and trace the underlying programme and financial schedules.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW FUNDING & CONTRIBUTIONS -◂ | VIEW BUDGET VS ACTUAL -◂ | VIEW MONITORING -◂ | VIEW IMPLEMENTATION PLAN -◂ | VIEW DISCLOSURE & PRIVACY -◂

FINAL SUBMISSION STATEMENT

This version is prepared for OCE and international donor review as a clean narrative action plan linked to live NNSS financial and programme worksheets. Detailed spreadsheet tables are not duplicated in the Word document. The financial figures stated in the narrative are synchronized to the current NPR 150,000,000 planning model at NPR 152 per USD. Situation statistics are dated and attributed, and data gaps in sex-of-household-head and older-person affected counts are explicitly acknowledged rather than estimated without evidence.

NNSS will maintain a transparent implementation record through the live worksheet system, public OCE updates, financial reconciliation, monitoring, consultation, grievance handling and consent-cleared field evidence. Any material change in programme scope, campaign ceiling, exchange-rate assumption or OCE fee treatment should be reflected in both the live model and the narrative reporting before the revised version is circulated.

LIVE SUPPORTING WORKSHEETS - CLICK TO OPEN

VIEW CAMPAIGN OVERVIEW -◂ | VIEW BUDGET SUMMARY -◂ | VIEW DETAILED BUDGET -◂ | VIEW MONITORING -◂ | VIEW FIELD EVIDENCE -◂ | VIEW FUNDING & CONTRIBUTIONS -◂

NAYA NEPAL SAMAJIK SANSTHA (NNSS)

Rasuwa Flood Emergency Response & Early Recovery

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