Nepal Gorkha Earthquake-2015
INTERNAL REAL TIME EVALUATION ON EMERGENCY
HEALTH RESPONSE SERVICE OF NEPAL

Submitted to:
Health Service Department
Nepal Red Cross Society Headquarters
Kalimati, Kathmandu, Nepal

Prepared by:
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with
Mr. Lalit Khatiwada and Ms. Niru Pradhan Shrestha
Ms. Mona Devkota (Aryal), head of health service department and Mr. Amar Mini Paudel, in charge of WASH section are visiting completely damaged Dhunche district of hospital on 06th May, 2015. Above: damaged delivery room. Below: damaged accident and emergency room.
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Attachment
1. BACKGROUND: WHY AND HOW WE ARRIVED TO NEPAL?

Edward Hullah FdSc, MCPara:
My name is Edward Hullah. I am 24 years old and I reside in Shropshire, England, where I work as an Advanced Paramedic for West Midlands Ambulance Service NHS Foundation Trust. I trained as a Paramedic at Staffordshire University where I studied a Foundation Degree in Paramedic Science. I graduated in September 2012 and I have worked for WMAS since.

When the earthquake of 25th April 2015 struck, I was at work and saw the feature covered by the national news on television. At this time, I was planning a last minute holiday to Turkey. I decided that, due to the ever rising injury and death toll following the disaster, I could use the money in order to travel to Nepal and assist with the relief efforts.

Philip Llewellyn BSc (Hons), PhD
My name is Phil Llewellyn. I am 45 years old and I reside in Worcestershire, England, where I work as an Advanced Paramedic for West Midlands Ambulance Service NHS Foundation Trust. I am married and I have two young children. I have been qualified as a Paramedic for 15 years. Prior to joining the ambulance service, I was a qualified geologist, having studied at Oxford University and Royal Holloway University.

When the earthquake of 25th April struck, I was at work and saw the feature covered by the national news on television. As I have travelled to Nepal five times prior to the earthquake, I have several friends who reside in Nepal. These are people who I have used as guides and porters when I have been trekking and climbing through the Himalayas. Santaman Tamang of Kaule, Nuwakot District, sent me a heartfelt email asking for help for his village and nation. He reported that he had lost several family members and that his village has been destroyed.

Through a mutual work colleague, both Phil and Ed were introduced on social media on Thursday 30th April. Edward had establish contact with Dr. Komal Raj Aryal, having been introduced by a UK disaster planner, Mrs. Gumsley. On Friday 1st May, we decided that we would work together and we arrange for unpaid leave from our employer. Once the leave was granted, we booked our flights and proceeded to plan our relief efforts, which included fundraising and purchasing of medical supplies and equipment.

We departed Birmingham International Airport on the morning of Monday 4th May. We arrived at Kathmandu International Airport on the morning of Tuesday 5th May. On arrival at the immigration department, we found the visa application process quite complicated and unclear. Staff were very helpful, but the process still delayed us by over an hour.

After clearing through customs, we used a taxi to travel to the Nepal Red Cross Society (NRCS) Headquarters. Here, we met Mona Aryal, who introduced us to Dr. Mausam Bohara. After discussing skill set and reviewing our medical supplies, Dr. Bohara decided that we would be useful in a remote setting and asked that we
contact Amelia Hillary, who was involved in a remote medical and aid unit in Timbu, Helambu. The project, called the Helambu, Solu Khumbu Relief Fund, was being managed by Mal Haskins and Sophie Ward, from Australia.

On Wednesday 6th May, we travelled out to the remote camp. On arrival, we relieved a team of Brazilian and Nepali Doctors. Our role was the provision of medical care within the camp medical centre and within remote villages via trekking and 4x4 vehicles. In the remote communities, our goal was to establish health and aid requirements and to provide mobile care and support.

During this deployment, we treated multiple injuries and illnesses across a vast demographic group of patients. A prevalent finding in the remote regions was untreated wounds which had become infected; fractures and muscular/soft tissue injuries.

One patient we managed was an elderly female who had sustained a right side wrist fracture during the earthquake. She stated that her family were very poor and could not afford an x-ray or treatment. This lady had been unaware that following the earthquake, healthcare costs were waivered for earthquake related injuries. We gave this family money to cover the cost of x-rays, management, surgery if required, medications and follow up treatments.

We identified a shortfall in the access to primary care within this region, with many patients presenting with ongoing medical complaints, which were not related to the earthquake. A common report was that people either could not get to a care centre, and many of those who could reach medical care state they could not afford to.

Our team, comprising two Nepali Doctors, a Norwegian Paramedic, an American Nurse and ourselves. We treated over 350 patients during our deployment. A large proportion of these were pre-existing medical conditions.

Other work undertaken included the distribution of aid to local people and villages. This aid included rice, dahl, garlic, potatoes, onions, tarpaulins, rope, hammers, nails, sanitary pads, cooking pots, soap, toothbrushes and toothpaste. The aid distribution was managed using an audit system, in order to record where the aid was required and provided. This reduced the risk of aid provision being duplicated.

Also at the camp, there was an American building specialist, who worked alongside many Nepali villagers to construct new shelters in a safe manner. The specialist also commenced investigations in to the structural integrity of the local school.

Data from the project has been relayed back by Mal Haskins and Sophie Ward in order to ensure that data analysis is a true reflection.

We returned back to Kathmandu on Sunday 10th May in order to meet Dr. Aryal and Santaman Tamang, in order to discuss a new deployment in to regions where our skill set was most needed. Dr. Aryal informed us that a Red Cross Emergency Response Unit were requesting Paramedic support in the Rasuwa region; however it was deemed too unsafe to deploy there due to the risk of further landslides.
A new plan was formulated and on Tuesday 12\textsuperscript{th} May, we were at the NRCS Headquarters to plan a deployment in to the Nuwakot region to provide medical aid. During our meeting, a large earthquake hit, which measured 7.4 on the Richter scale. We were evacuated in to the Red Cross evacuation shelter, where we remained for several hours.

Dr. Aryal approached us and stated that the deputy Prime Minister has requested that we deploy in to the devastated Charikot region, near to the epicentre of the earthquake. Dr. Aryal arranged for a NRCS vehicle to convey us to collect our medical and personal equipment from our hotel in Thamel, before being taken to the Kathmandu airport.

On arrival at the airport, there was some confusion about how we would be transported to the Charikot district. Dr. Aryal made several telephone calls and soon we were taken to a military helicopter and loaded for departure to the epicentre.

When we landed in Charikot at the Nepal military base helipad, we were briefed by Lieutenant Colonel Shar. We were directed to the local Primary Health Centre (PHC), where we met with Nepali Doctors, including Anaesthesiologists, Surgeons and Trauma Specialist Doctors.

On the first evening after the earthquake, we discussed roster management of teams to avoid fatigue, safety concerns and patient triage with the other volunteers. It was agreed that there would be four teams, each consisting at least one Nepali Doctor and one bilingual member of the team. The shifts would run 2200-0400 hours, 0400-1000 hours, 1000-1600 hours and 1600-2200 hours.

We established our base camp and pitched tents for use during our deployment. We carried our own tents, shelter, clothing, sleeping equipment, food and water filtration kit so that we would be self-sufficient for up to ten days.

In the first evening, many patients with a range of traumatic injuries self-presented to the centre. We managed fractures, wounds, head injuries, crush injuries and muscular injuries.

On Wednesday 13\textsuperscript{th} May, the morning after the earthquake, Phil and I deployed back to the Nepali military base, where we aimed to triage patients arriving on helicopters. The intention was to distinguish the minor injuries and ailments and to direct them to the local PHC and to stabilise and medevac those requiring intensive treatments to Kathmandu.

On Thursday 14\textsuperscript{th} May, we were presented with a seventy year old female who was deeply unconscious. It was reported that she had sustained head and thoracic injuries during a landslide caused by the earthquake of Tuesday 12\textsuperscript{th} May. Together with Anaesthesiologists and a Surgeon, we worked to stabilise the patient ready for helicopter evacuation to Kathmandu.

Despite efforts, the patient’s condition deteriorated and so the lady was intubated following a rapid sequence induction (RSI), with manual ventilations and fluid resuscitation. After around twenty minutes, the patient was stable enough to be evacuated by helicopter to Kathmandu.
Unfortunately, despite multiple requests, around one hour after stabilisation, no helicopter had been provided for the medical evacuation. At this point, we were forced to insist that a helicopter is provided immediately in order to avoid the imminent death of that patient. Acting as patient advocates, we asked why a helicopter had not been sent. It was at this point we were informed that the helipad was in use, with Prime Minister Sushil Koirala’s helicopter having landed. We had previously been unaware of the Prime Minister’s visit.

When we asked that the patient be evacuated in the Prime Minister’s helicopter, we were told that this was not possible by military personnel. We requested that a member of the military approach the Prime Minister and ask for permission to use the aircraft, again we were told this is not possible.

Unfortunately, the patient’s condition was so critical that this was not acceptable to us. At this point, Ed approached the pilot of the aircraft and requested that he come to see the patient. Phil then explained how serious the condition was. Soon after, the Prime Minister granted permission and so we were underway to Kathmandu Army Hospital with the patient. Prior to this interaction, we believe that the Prime Minister was completely unaware of the patient or the request for a helicopter medical evacuation.

On returning to Charikot military helipad, we requested a brief meeting with the Prime Minister in order to thank him for lending us his aircraft. Neither of us have any doubt in our mind that without this immediate evacuation, the patient would have died imminently.

When we met with the Prime Minister, we said ‘Namaste’ and he shook us both by the hand. We expressed how grateful we were to him for his help and Ed stated that his generous act helped to save the patient’s life. The Prime Minister returned pleasantries and explained that the Nepali Government are doing all they can to help in the disaster relief efforts.

During our deployment to the epicentre zone of the earthquake of Tuesday 12th May, we felt privileged to work alongside a highly skilled and caring multi-nationality and multi-disciplinary team. As a team, having travelled from another country to Nepal, we feel that there may be some areas that could be discussed in order to make future disaster response more streamlined and efficient.
2. LOCATIONS VISITED

The team visited 12 locations of six districts in central hill and mountain regions of Nepal. The locations are:

I. Timbu, Helambu, Sindupalchok
II. Charikot, Dolakha
III. Kathmandu
IV. Kaule, Nuwakot
V. Singati Bazar, Dolkha
VI. Piskar, Sindupalchok
VII. Dhunche, Rasuwa

(See details for Figure 1: Locations Visited)
3. LESSON LEARNED

3.1 Lessons learned from Timbu, Helambu

3.1.1 Communication & Coordination

- Some villages had already received up to three medical team visits and assessments prior to our arrival, which we were not aware of.
- Many injured people did not know that healthcare fees had been waived and so didn’t seek medical attention.
- Aid provisions of food and shelter were not distributed in a fair manner – some villages had several deliveries, whilst others stated that they had received none.

3.1.2 Geographical

- Those villages close to road networks appear to have received a lot of food, shelter and medical attention, whereas those in more remote villages report lack of aid.
- Many main road routes left blocked by landslides for long periods, preventing mobile teams getting in to many villages.

3.1.3 Medical

- Overwhelmed by non-earthquake related illness and ongoing medical conditions – i.e. hypertension, cellulitis, chest infections, gastro-oesophageal reflux, etc.
- Lack of clinical waste and sharps management, with blooded and dirty waste placed with domestic waste.
- Huge variance in clinical standards due to aid workers from many different healthcare systems throughout the world.

3.2 Lessons learned from Charikot, Dolaka

3.2.1 Health and Safety

- Unicef hospital tents placed within confines of PHC buildings. Four unstable appearing and tall buildings surrounded the two hospital tents. When concerns were raised over this, due to the risk of building collapse on to health workers in subsequent earthquakes, aftershocks or landslides, the Doctors on site found our concerns humorous and repeatedly disregarded our advice on moving the tents to ensure staff and patient safety.
- A team of Italian Red Cross volunteers were mobilised in to the disaster zone, with no survival, personal protective or medical equipment and with no shelter, food, water or spare clothing. At this time, the roads from Charikot to Kathmandu were reported to be blocked and impassable, and flight logistics were uncertain for their return to Kathmandu. This presents a significant risk to these individuals, who could have potentially become casualties.
- There were no briefings provided on local areas of risk, evacuation/muster points, etc.
The only toilets provided were within potentially weakened buildings for several days after the event. There was no long-term plan for provision of sanitation.

3.2.2 Communication and Coordination

- Reluctance to communicate between the Nepali people – for example, when asking for a vehicle from the military to assist with moving heavy medical supplies, the Nepali medical team stated this is not possible; however, when we asked the army or police directly, they were very accommodating, assisted with carrying equipment and provided vehicles for the duration of our deployment. This was also the situation with provision of clean drinking water. There is uncertainty of whether this is due to cast system or cultural differences.

- On arrival, it was recognised that all medical staff were trying to treat every patient, with no apparent structure of teams or roster system to avoid clinician fatigue. There was a risk that all staff would work through the night, leaving the next day with only overly tired clinical staff or no staff available to treat the high volume of patients.

- On discussion, it was agreed there would be four teams working six hour shifts. Despite this, one team failed to turn up for their shift, with no explanation why. This could be due to poor communication, misunderstanding or lack of desire to start a shift at 0400 hours.

- There were no teams established to equally distribute the different skill sets – for example, two paramedics on one team with two anaesthesiologists, whilst another team had only three nurses and one doctor, none of whom spoke Nepali.

- There was no hierarchy or clinical lead defined in order to oversee operations and to resolve problems as they arose. Due to this, there was very little management of the clinical areas and no decision making. This made the process of formulating plans on patient management and care, evacuation and overall operations very slow.

- There was no standard operation procedures (SOPs) to define what could be treated locally and what needed to be evacuated to a larger hospital.

- There were no team briefings to introduce team members coming in and leaving the facility, nor to define roles.

- There were no clinical patient handovers, meaning that when new staff started their shift, they did not know what was wrong with each patient, nor what treatment they had received and what the ongoing management plan for the patient would be.

- There were multiple members of the public encountered, who reside in remote and isolated villages, who state that the deaths of their friends or relatives have not been correctly recorded and audited. This creates inaccurate data when reviewing death toll.

- There is a very clear inequality between different communities. It appears that sometimes those who live close to main vehicle routes and those with financial assets are receiving multiple aid distributions, whereas those in
isolated villages are not receiving any aid at all. An example of this is Kaule, in Nuwakot district. On our arrival, some twenty-three days after the first earthquake, it appeared that no aid had been received directly to the village whatsoever. This is with the exception of the initial medical helicopter evacuations. Aid had been made available within the lower valley at the roadside, but the aid had all been distributed before representatives of the village were able to reach the distribution points. There was a village encountered in which jewellery shops, food shops and mobile telecommunication shops are still open and there is adequate shelter established. There are aid distributions still being delivered to this village, including food, despite surrounding isolated villages having no shelter or aid.

- Residents of some isolated communities and villages have not received adequate shelter supplies and materials. This means that they are forced to rebuild houses using outdated and dangerous techniques. The village residents were rebuilding houses using recycled stone and wet mud (Kaule, Nuwakot). This poses a significant threat to residents during the impending monsoon period and with any aftershocks

3.2.3 Clinical

- There was no structured approach to patient assessment – usually, it is best practice to have several team members with defined roles. For example, an anaesthesiologist should take control of the assessment of airway and possibly respiratory effort, another team member should perform intravenous cannulation, another should perform a ‘top-to-toe’ survey, etc.

- There was no trauma triage sieve-sort process – this is the process used in multi-casualty major incidents. The structure differentiates patients in to categories, depending on their clinical condition and needs. This delivery system aims to segregate minor injuries and to keep the hospital staff available to treat the major injuries first

- For the duration of our deployment, there were serious patient and clinician safety concerns surrounding the management of clinical waste. Clinicians had mixed used hypodermic needles, bandages, blooded and soiled clothing and domestic waste in to cardboard boxes and waste bags. This meant that sharps and needles were protruding out of boxes and bags, where needle stick injuries could easily be sustained, risking serious blood borne disease and infection to volunteers and patients. We provided clinical waste bags and sharps containers, but nonetheless, staff continued to mix used needles and scalpels with domestic waste. This is not appropriate and requires serious attention!

- At the end of each day, the Nepali staff were burning clinical waste and sharps on a fire pile which was placed within 10 metres of the hospital. This meant that toxic fumes and smoke was filling the hospital tents, causing patients respiratory difficulties. Increased coughing increases the risk of airborne spread of infection and disease. Needles that had not properly combusted due to the lack of temperature control in the fire were left on the ground, again creating significant risk for potentially years to come
We met many patients who had previously been treated in Kathmandu hospitals, having been evacuated by helicopter from their villages. The concern is that many people still have injuries requiring follow up treatments, but do not have the financial or logistical means to access appropriate healthcare facilities. For example, we met a male who had staples in his right forearm following a surgical repair to a fracture. The arm was left in plaster cast and the patient had no means to remove this cast or the staples. Furthermore, we met numerous patients who had previously had their wounds assessed by clinicians, but who had developed serious infections due to lack of clinical review and poor wound cleansing following treatment.

3.3 Observation from Nepal Police & Nepal Army Hospitals:
During our visit to the two above stated locations, we were afforded the opportunity to explore the facilities available. It was immediately clear that both organisations placed serious focus on and commitment to the safety of their staff, volunteers and patients. Buildings with damage were listed as condemned and patients are managed in large tents away from potential building collapse regions. This is in contrast to the experience in Charikot, where our safety concerns were flippantly disregarded.

The two hospitals are providing very efficient and focused healthcare and definitive surgical procedures. It is difficult to find any areas to criticise the work of either establishment, nor to provide any constructive feedback or recommendations for improvement.

4. SUMMARY
The experience was primarily a positive one and we feel that most patients ultimately received appropriate care during the emergency facilitated by Nepal Red Cross Society in partnership with the Government of Nepal and local communities. This care does need to be more streamlined and the concerns we have highlighted, if considered for future disaster response, would inevitably help to create a more efficient, safe and streamlined response.

Primary health care facilitation should be integrated to all relief and recovery programmes.

Localised wild animal attacks incidents (snakes bites, jackal and wild cats) have been reported in post-earthquake environment in remote locations. The NRCS health service department should consider these emerging health risks.
INITIAL SUMMARY FIELD VISIT REPORT FROM SINGATI BAZAR OF DOLKHA DISTRICT
(17th - 19th May 2015)

Submitted to:
Health Service Department
Nepal Red Cross Society

Prepared by:
Dr. Komal Raj Aryal, Volunteer (Vulnerability Assessment & Humanitarian Response), UK
Dr. Ikcha Shrestha Ladyr, Volunteer (Emergency Medical Response), Czech Republic
Dr. Saugat Shrestha, Volunteer (Emergency Medical Response), Nepal
BACKGROUND
Singati bazar used to be a main local business hub for 22 remote mountain and hill villages of Dolkha district. The geo code of the location is E00417575, N 03069518, N 27°44' 29.3'' and E 81° 09' 49''.
Over 95 percent houses, livestock and infrastructures have been destroyed by Nepal Gorkha Earthquakes on 25th April and frequent powerful aftershocks particularly the one occurred on 12th May 2015.

OBJECTIVE
The main objective of the field visit is to provide real time situation up date of Sangati Bazar of Dolkha district.

METHODOLOGY
• Face to Face Interviews with first responders (Nepal Army, Armed Police and Nepal Police, Nepal Red Cross Sub Chapters, key local people, elderly, children and women)
• Focused Group Discussions
• Observation

RESULTS
1. Immediately after Nepal Gorkha Earthquake (25th April, 2015), Government of Nepal deployed a Nepal Army special response team to coordinate local emergency relief and response. The team stationed in Singati Lamosagu Electricity Substation Office (SLESO) compound with a command of two Majors rank. One Major is leading relief operation while other one is coordinating local emergency response and relief service. In addition, Armed Police Force and Nepal Police are also stationed in Lamidada 6 Singati (Parliamentary Election Area- Dolkha -2)
2. On 12th May, 2015, the first relief distribution for people of Chi-ling kha Village Development was facilitated by a local Nepalese Youth Group from Kathmandu. It was coordinated by Nepal Army Special Response Team (between 10:00 -13:00 hours). According to first responders, over 540 people received the relief materials on that day. However, as of 19th May 2015 (6 days after the earthquakes) people who came to receive the relief packages from ward no. 6, 8 and 9 are out of contact. Due to heavy landslides in complex mountain terrain and limited resources (rescue equipment) the first responders are finding it difficult to reach landsides hot spots.
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(Source: Mr. Jagat Kadhaka, Age 60 years. One of the Key informants and resident of Chilingkha Village ward No.9. Interview was taken on 19th May, 2015 in his village)

3. Big black birds were seen over many landsides spots. According to Mr. Badri Kadhaka, local businessman who lost over USD 15000.00 by the earthquake, it was unusual see such birds in that location (Singati Bazar Area). When we visited to few completely damaged houses we felt a strong unpleasant smell.

4. People from Suri, Laduk and Chilankha have not been received any relief materials. It takes around 4 to 5 hours to reach there by walk from Singati bazar.

5. Relief materials are dumped in Singati Lamosagu Electricity Substation Office (SLESO) compound various by various agencies. Nepal Army is providing security to relief materials. However without presence of village secretaries and representatives from international agencies, Nepal Army is not allowed to
distribute despite of constant request from locals. We observed that Nepal Army were providing their own food to villagers who came to seek for relief materials.

6. On 18th May 180 households received steel materials and few packets of noodles from Thailand based a Nepalese Disaster Relief Support Group.

7. Three schools and a college have been completely destroyed and 1400 students are affected.

8. Over 600 children particularly girls are exposed to high risk of exploitation.

9. Thefts cases have been increased in Singati bazar area.

10. In Singati bazar area only over 2000 chicken have been killed by the earthquake. We saw in every small tarpaulin over 20 people are staying. People are using open area are for toilet near to water sources and temporary tarpaulin roofed accommodation. There are lots of big flies. Local people are highly exposed to localised landslides.

11. As of 19th May, 2015 Nepal Army has:
   - Rescued 10 alive
   - Recovered 49 dead bodies.

**WHAT WE NEED THERE?**

1. Dead body bags
2. WASH
3. Temporary toilets.
4. Disinfectant (to avoid disease outbreaks)
5. Safety equipment for the first responders to recover dead bodies.
6. Helicopters to deliver immediate relief items.
7. Strong tents not tarpaulin (plastic sheet).
8. Urgent presence of Government representatives, INGOs or NGOs in remote areas to facilitate relief distribution as earliest as possible.
9. Psychosocial team.
10. Mobile nurses facilities to provide basic health care. Not only stationed in health posts.

**LOGISTICS**

1. Only SMART Mobile phone service have network and NTC CDMA.
2. Safe location to stay: Singati Lamosagu Electricity Substation Office (SLESO) compound right now.
   
   **Helicopter landing areas:**
   - For Small Helicopter: Singati Lamosagu Electricity Substation Office (SLESO) compound.
   - For Bigger Helicopter: Maize field near to old police post.

**OTHER**

1. First responders believe that over 300 bodies are stills under the debris in road towards Jhorung Shorung Biju and Tamakoshi from Singati Bazar.
2. Do not recommend to allow international agencies without local security advice and consultation with local emergency response command centre (Nepal Army). Terrain is very difficult and in some locations even GPS cannot receive signal. Let's learn the lesson on how American Army helicopter crashed recently?.
Dr. Komal Raj Aryal, NRCS International Volunteer from the United Kingdom is assessing damage of Singati Bazar of Dolkha district on 19th May, 2015 with a humanitarian responder from Chez Republic. NRCS International volunteers were the first to assess damage in the village.

Dr. Ikcha Shrestha Ladyr, NRCS International Volunteer from Chez Republic and Dr. Saugat Shrestha NRCS Volunteer for Health Service Department are providing emergency medical care in Singati Bazar of Dolkha district on 20th May, 2015. Later one of the elderly women was airlifted to Kathmandu by NRCS for medical treatment.
Dr. Ikcha Shrestha Ladyr, NRCS International Volunteer from Czech Republic is providing emergency medical care for an elderly in Singati Bazar of Dolkha district on 19th May, 2015.