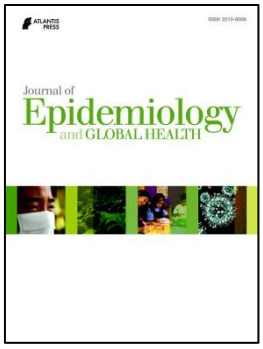

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LETTER TO THE EDITOR

Central coordination of humanitarian aid in Nepal

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We arrived in Nepal within 4 days of the earthquake on April 25. The journey from the airport alone was striking with the destruction of ancient temples and a strong smell hung in the air from the disposal of dead bodies. Parks and open spaces were filled with bright orange tents–makeshift camps for people to seek refuge away from their unstable or now derelict homes. Kathmandu was the second worst affected district in Nepal, with over 1039 fatalities. At this stage, the total death toll as reported by the United Nations (UN) was 5582, and this figure rose to more than 8000 during our stay with the constant aftershocks and finally a second earthquake, comparable in size to the first.

With over 100 foreign medical teams (FMTs) and 2300 overseas health workers present in Nepal from the early onset, a new direction was chosen for disaster management and a clear attempt was made to coordinate teams and activity. This was different to the earthquakes in Haiti and the Philippines. Nepal is a low income country [1] and prior to the earthquake, there was concern about unmet healthcare needs and preventable death in Nepal [2]; this was only compounded further by the disaster.

FMTs on arrival were asked to register with the Ministry of Health and UN to ensure accountability and teams were allocated to regions as per the need. The impetus was on supporting existing health systems with safe infrastructure, thereby promoting sustainable health development, rather than the rush to save lives and the ''fix and go'' approach. The success of such an approach, however, lies in there being both cooperation and engagement of all agencies, so that they work as a cohesive networking unit, rather than in isolation.

As an FMT, we were tasked with covering Lapu, a small village near the epicentre in the mountainous district of Gorka. After an arduous 9 h bus drive, we could better appreciate the challenges of the hostile terrain. Indeed, landslides and impassable roads hampered our ability to reach our destination in the foothills of the Himalayas and helicopters were not readily available for several days.

The coordination of relief efforts may not have been perfect in Nepal, but the foundations and intentions were commendable. Information gathering was hampered in the early stages due to the disparate nature of the population and difficulty

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contacting and accessing remote areas. The use of drones helped in part to facilitate this. District centres for the coordination of national and international aid were set up by the World Health Organisation, who held initially daily health ''cluster'' meetings guiding delivery of manpower and resources [3]. The trade-off for the individualism of non-governmentalorganisation is the cross-disciplinary fertilisation that occurs through the round table approach garnered in Nepal. The latter allows for better rationalisation and targeting of resources, information gathering, data monitoring, and clinical governance.

Conflict of interest

None declared.

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