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Himalayan Trauma: Administrative Thrombosis and Citizens' Response

Robert E. Beazley
Cornell University, reb265@cornell.edu

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Himalayan Trauma: Administrative Thrombosis and Citizens' Response

Robert E. Beazley

In this paper, the author uses excerpts from social media postings and traditional media to highlight how various citizen and volunteer responses to the 2015 earthquake helped fill in the gaps created by institutional dysfunction. Further, he shows how these two types of media played a critical role in facilitating communication between grassroots aid initiatives and earthquake affected people and their families and friends, not only in Kathmandu but also in neglected mountainous areas as well. The author uses a personal, reflexive approach to help situate the distinct experiences of earthquake affected people including trauma patients, people with disabilities, and volunteer aid workers.

Keywords: Nepal, earthquake, trauma, citizens' response, health care, disaster aid and relief.

Introduction

Sudan Gurung arrived by scooter at the Bir National Trauma Center on April 25, 2015, carrying a man with an injured leg. The entrance to the Trauma Center was littered with injured people waiting for help. In the wake of the 7.8 earthquake that occurred earlier that day, the already overloaded healthcare system was itself in critical condition (HPS 2015; Pandey 2016; Sifferlin 2015; Thomas 2015). While Sudan was at the Trauma Center, he witnessed a young woman die, clutched in her mother's arms. His description of this moment on social media is a moment of personal transformation. He recognizes the vital role he can play to help his fellow citizens.

> That was the moment everything changed for me. I knew this was where I was needed. Everyone was dehydrated. Doctors don't have time to eat or drink; they are saviors but they needed saving. I went to find water and eventually found one shop open. I did 22 journeys on my scooter taking water to the hospital. In the evening I brought noodles. There was one boy, about five years old, in a really bad state. His mother had already lost one child and I could feel her pain. I said, 'Don't worry, I am here for you.' It was the best I could do. I called the doctor and said, 'You've got to save this child.' Thankfully he survived. I posted on Facebook, 'I am here distributing water and food... but I can't do it alone.' The post was shared by 985 people and got 1,080 likes. The next day I had 30 to 40 volunteers, and

> the day after that 300 volunteers. In two weeks, we had 1,200. I assigned two volunteers to one patient, so they received 24-hour service; they'd fan them, wash them, feed them. One team looked after the medical staff, and another was assigned to clean the hospital twice a day, inside out. I didn't rest for the first two days and nights and on the third night I collapsed. The doctors told me I had to rest. My feet were swollen from excessive walking, but I couldn't stop. (Gurung quoted in Carpenter 2015)

Sudan decided to call the rescue and relief effort he started I 2 We. I would come to know it well.

I had arrived in Nepal in April 2014 as a Cornell University Natural Resources Department PhD candidate on a Fulbright Hays Doctoral Dissertation Research Abroad Fellowship. I set up my Kathmandu residence at Ram's Rooms, near the Boudhanath Stupa, which I used as a base when not conducting social science research at my site in northern Rasuwa District near the Tibetan border.

Within the first 45 days of the initial earthquake, Nepal experienced 553 aftershocks of local magnitude greater than 4.0 on the Richter scale (Adhikari et al. 2015), not to mention the major aftershocks greater than magnitude 4.0 and the main aftershock of May 12, 2015 (magnitude 7.3) which created a whole new round of destruction and chaos, especially in rural areas northeast of Kathmandu. The aftershocks continued and are still occurring presently in Nepal.[1]

Like Sudan, I was caught off-guard by the earthquakes, despite all of the ways that the possibility of natural disaster always looms large in Nepal. And, like Sudan, after these events, I found myself swept up in relief efforts, much of which was facilitated by social media, as well as implicated in various citizen and volunteer responses to these tragedies. In this Perspectives article, I describe how social media and more traditional media outlets filled crucial roles in facilitating communication between grass-roots aid and earthquake affected communities.

When the first earthquake hit, I was sitting in Ramsterdam Café near my residence in Boudha. Everyone in the cafe got up and ran to the door to see what was happening outside. During my previous 30-year career as an adventure travel leader, I had experienced several other minor earthquakes before in Nepal, India, and southern Chile. During the December 2004 Indian Ocean tsunami, I was only 10 kilometers north of its furthest extent. On that day in Kathmandu in April 2015, I had the immediate sense that something out of the ordinary was happening. Bottles toppled off the shelves and crashed on the floor. Tables vibrated. The earth seemed ready to crack open. Fortunately, our immediate surroundings sustained little damage thanks to the forethought of Ramsterdam's owner Ram Ballav who had built the café with reinforced concrete and only one story high in anticipation of an earthquake. Ram let several of us sleep in the café that night because he was worried that our multi story residence might be unsafe. The next day, I read about the need for volunteers at the Bir Trauma Center on Facebook and decided to go there and see what I could do.

I took a taxi from Boudha to Bir Hospital and was surprised by the unevenness of the damage I saw en route. In some places, entire houses had been uprooted and were sitting at bizarre new angles. In other places, there appeared to be very little damage. People were driving and walking to the market like nothing unusual had happened. But it was obvious everyone was on edge. The slightest vibration would send people screaming, fleeing their houses and the rain of concrete and debris inside to seek the nearest patch of open sky. Many people slept outside, creating tarp and tent villages all over Kathmandu. It was difficult for anyone to sleep at night, let alone relax during the day. The slightest vibration—whether from a truck or someone's heavy footsteps on a wooden floor—triggered our collective sense that another earthquake was upon us.

Volunteering with I 2 We

Upon reaching the Bir Trauma Center I felt overwhelmed. The level of chaos was intimidating, as there appeared to be no specific Trauma Center staff person available to coordinate the volunteers in a way that reflected their skills and usefulness. To his credit, Sudan Gurung and his colleagues were doing an amazing job filling in this void as best they could. As Sudan explained, "I 2 We's aim is to create an environment where doctors and nurses can serve patients and carry out their responsibilities without worrying about anything else. We ensure that patients get all the help they require and don't suffer from the lack of food, medicine, blood and proper treatment" (Gurung quoted in Ojha 2015).

Their dedication and diligence was infectious. Bibek Man Singh, a visitor to the Trauma Center, describes it as follows:

> I was just a guy who was taking shelter at the Trauma Center with my family. But there I saw Sudan dai distributing noodles and water to everyone around. Seeing his selfless service, I too joined him. Gradually, my mother too started helping him distribute food and water to the needy. I had not known him before, but his tireless work and selfless service inspired me to lend a hand. That's

Figure 1. Sudan Gurung founder of I 2 We.

(Beazley, 2015)

> how we came up with the idea of starting I 2 We, a volunteer organization working for the earthquake victims. (Singh quoted in Ojha 2015).

When I first arrived at the Trauma Center as a volunteer, I was given the task of phoning the 40 other volunteers who, after hearing of the need, had come during the day to register their name and cell numbers—all Nepalis. The day shifts were already experiencing an excess of volunteers whereas the night shift had minimal coverage. As I began contacting people, I was surprised how many agreed to do at least a partial night shift. During my first day, I met many Nepali volunteers as well as a handful of foreigners. Most of the foreigners were trekkers on vacation; some had previous experience in first aid; one was a doctor on vacation from Sri Lanka.

Social media provided an invaluable platform for people to communicate with each other and the outside world about what was happening on the ground during and after the earthquakes. My own social media posts at the time reflect the chaos and shock I experienced when I first started working with I 2 We. After facing a particularly challenging experience on April 28, 2015, I wrote the following on Facebook:

> I was assigned to a nine-year-old girl when I arrived. She had two broken arms, a compound fractured leg, and what they call a 'ping pong' fracture in the top of her head. A huge rock had fallen on her head fracturing her skull. A piece of her skull bone had broken off and was pressing on her brain tissue. She is of the Tamang ethnic group from the village of Haku near where I do research in Rasuwa District. This area is very poor.
>
> This little girl, Tsering Tamang,[2] had to be evacuated by helicopter...There is no road to her village, only a trail, and the nearest roads are all blocked by landslides. If the nearest road had not been obstructed, they still would have had to carry her down a very steep trail, across a river, and then up another very steep hill two to three hours of walking to reach the road in Dunche and find a vehicle to Kathmandu. That road is bad in the best of conditions with three chronic landslide zones that have been active every monsoon since the road was built in the 1980s. Even if the road had been clear, it would have taken at least seven hours for her to reach Kathmandu—if she had been lucky enough to find a vehicle. If she had come by road, she probably would have died somewhere along the way. Her parents could not come with her on the helicopter because it was filled with the injured.
>
> Her parents are now trying to make their way to Kathmandu, but...there is no telling if and when they will be able to get out. Fortunately, several men from her village managed to get out before the road became impassable; they are here in the hospital with her along with another women from the same village who was injured. They told me that almost every village north of Dhunche has been leveled. (My paraphrased Facebook Post April 28, 2015)

Tsering became my main point of reference. I knew if she was able to survive, then there was hope for all of us. Her tenacity spoke to the ability of many Nepalis to endure chaos, hardship, and adversity in situations they had not created.

Medical Triage

My next Facebook post described what Tsering faced in the context of medical triage:

> I spent a lot of time sitting with Tsering and talking with her friends from the village in between working on other patients. She was amazingly resilient while she was poked for IVs and pricked with nee-

Figure 2. Nirmala on crutches in the Trauma Center.

(Beazley, 2015)

> dles for blood tests. The most painful moment was having her limbs temporarily set in casts until they could operate on her. This meant straightening her broken arms and compound fractured tibia (leg bone sticking through wound) with minimal anesthesia. Her crying and screaming for her mom was heart wrenching, but she persevered until about five hours later when, we took her up to the O.R. to clean and suture her head wound. This was another temporary measure to avoid infection until there was time to do the full operation. (My paraphrased Facebook Post April 28, 2015)

Tsering's ordeal was typical of many patients at the Trauma Center and other hospitals in Kathmandu. Overworked and understaffed doctors and nurses set up a triage system. After a quick assessment, patient priority was identified by either a red or green armband, red meaning immediately life threatening injuries and green indicating patients whose injuries were minor in comparison. Tsering was wearing a red armband. The skull bone resting on her brain tissue was obviously life threatening and a potential source of brain damage. But it would be twelve hours from the time I first saw her until she was actually in the operating room. This spoke to the steadily increasing arrival of injured in the aftermath of the first earthquake and to the understaffed and at the time not fully operational Trauma Center.

The Trauma Center was supposed to be a state-of-the art facility with a suite of services to handle almost any conceivable injury. These services included a trauma bay with 150 beds, fourteen intensive care units, six operating theatres, eight emergency resuscitation rooms, ten exam rooms, a triage area, and outpatient facilities. Staffing specialists were to be made up of neurosurgeons, orthopedists, cardiologists, general surgeons, anesthetists, radiologists, and physiotherapists (Gautam 2015). Opened in February 2015 with very limited services, the center was still far from fully operational when the first earthquake hit. Further, the sheer number of critically injured patients meant that even a patient potentially minutes away from death, such as Tsering, still had to wait until those that had arrived before her with equally critical life-threatening injuries were treated.

In general, the operating theater looked like a war hospital; patients moaned in agony as doctors and nurses wheeled one patient out and the next one in. Blood and dressings covered the floor. The volume of patients made the cleanup crews' jobs an almost impossible task. Doctors and nurses worked to the point of exhaustion. I worked closely with the doctor from Sri Lanka. I sensed her frustration as she offered her services but was never given a task up to her skill level.

The Trauma Center has seven floors, but only the first three floors were being used. On the upper floors, many rooms looked neglected and abandoned; furniture covered with plastic and a thick coating of dust spoke to the political battle that had ensued after the Trauma Center's construction. The negotiation over which institution would be in charge of the Trauma Center had been ongoing since the end of the Peoples' War in 2006. After a lengthy

and controversial legal battle over jurisdiction, the Trauma Center jurisdiction was finally determined by Nepal's Supreme Court in favor of Bir Hospital.

As post-earthquake days passed, sanitation became a big concern. At one point, more than 100 decomposing corpses were stacked behind the Trauma Center waiting to be identified by a family member before they could be removed and cremated. Inside the Trauma Center, the staff could not keep up with the increasing number of patients. Again, institutional politics was to blame, as the staff had been hired exclusively by one of the administrators and, as in many institutions in Nepal, consisted mostly of his friends, relatives, family members, and those he owed favors to for helping him get his administrative posting. Most of these individuals were neither well trained nor able to cope with the situation in which they found themselves.

Outside the front entrance of the Trauma Center, a collection center was set up for donations of food, water, clothing, and medical supplies. Some medications were provided free of charge, but as supplies dwindled many volunteers used their own money to purchase essential drugs and other medical supplies, as well as food and water for the injured. Family members slept on the floor next to their loved ones. If there was no room on the floor, people camped on the stairs and in the lobby. Volunteers also found themselves sleeping on the floor when they neared exhaustion.

One day, I spent all afternoon logging the medical supplies and pharmaceuticals that had piled up at the I 2 We donation center. The next day, a female doctor organized a group to bring many of these supplies to outlying areas where medical teams had not yet reached. Soon, the number of volunteers reached more than 1,000. Some volunteers began organizing similar missions further afield. These improvisational efforts were particularly salient as they were based on context-specific information that was filtering in from patients and refugees arriving from mountainous areas where communication had been cut off and where state or large-scale humanitarian organizations' efforts had neither been focused nor prioritized.

The Role of the Media

Through both social media and conventional news platforms, word spread about compelling stories like Tsering's, often to the point where news teams began lining up to get their crack at a story. Some patients became earthquake-injured celebrities. Their stories were reproduced on different networks. News teams from around the world began arriving as more images reached the global public. A *Time* magazine correspondent pulled me aside to get the perspective of a volunteer. His hurried demeanor spoke to the focus of the media. I was his last interview, and he was racing against the clock. He needed to board a plane that afternoon to cover the next big story in some other part of the world. At one point, Dr. Sanjay Gupta, CNNs chief medical correspondent, arrived from the United States. This led to a televised interview with him as he performed brain surgery on a young girl.[3] Journalist Tim Hume (2015) described this moment as follows:

> The cries of 14-year-old Sandhya Chalise can be heard above the din of the admissions room at Kathmandu's Bir Hospital. Blood has collected on top of her brain, in the right frontal area, and she urgently needs surgery to remove the clots. "The wall of her house fell on her during the earthquake," says Dr. Bikesh Khambu, a resident neurosurgeon at the hospital. An hour later, she receives a craniotomy in a makeshift operating room. Dr. Sanjay Gupta, a practicing neurosurgeon and CNN's chief medical correspondent, has scrubbed in at the request of a Nepalese medical team to help with the operation.

The story turned controversial when it was discovered that Gupta had gotten the name and age of his patient wrong and had failed to get permission from the family to televise the operation. And yet, despite these serious ethical missteps and his celebrity stature, his comments below reflect the same desperate situation in all the hospitals in Kathmandu.

> I've seen a lot of situations around the world, and this is as bad as I've ever seen it. They need more resources, they need more personnel here right now, and they're expecting many more patients as these rescue operations go on. They're barely able to keep up right now. It's part of the reason they asked me [to help]; I think they're asking anybody to try to pitch in. (Gupta quoted in Akkoc 2015)

Despite its at times intrusive, insensitive, voyeuristic, and exploitive nature, the media coverage of the earthquake *did* the get the word out. As is often the case in Nepali health care settings, patient privacy was neither a concern nor, at times, an option. And yet in some cases patients were put in an awkward position of grabbing their 15 minutes of fame at a moment of crisis. We are left asking how to balance these elements with the good they did by drawing global attention to Nepal.

Amputation, Disability, and 'Celebrity Victims'

The number of patients at the Trauma Center that had sustained injuries that required amputation was staggering. Many of these were children. Handicap International's

Figure 3. NANA nurses (left to right) Nima Sherpa, Unita Magar, and Sunita Bhandari from New York City visit Bir Trauma Center.

(Beazley, 2015)

presence was strongly felt at the Trauma Center with their staff training patients how to use crutches, adjusting prosthetics, teaching patients how to walk again, and offering support and comfort.

I met Nirmala and Khendro, two eight-year-old amputees, while volunteering at the Trauma Center. They became media personalities. Despite the amputations and the disaster, they both appeared to be adjusting to their new situations quite well. Khendro, a little ball of energy, would zoom around the room on her crutches as if nothing had happened to her. She was charming, gregarious, and loved make-up; she told us that she aspired to be an actress. Khendro, who occupied a bed not far from Nirmala, was more reserved but equally charming. The two became best friends and 'star' patients of Handicap International.[4]

Their stories were so compelling and their personalities so charismatic that they were featured in more than 20 media articles. Here is one example from a traditional media source, and an example of a powerful "victim" narrative that created a sense of virtual participant-experience for the consuming public:

> The sounds in the trauma ward of Bir Hospital two months after the Nepal earthquake were hard to take: The screams of patients suffering with fractured bones, or mourning for amputated limbs, as helpless family members attempted to comfort them. I couldn't bring myself to take out my camera and point it at people here, so instead I tried to comfort them, too, and listen to their stories. I was drawn to a corner of the ward where a young girl missing a leg was smiling while doing physiotherapy. She was the only patient with a smile. That was the first time since the earthquake I felt such deep contentment. Nirmala Pariyar, now just 8 years old, lost her right leg. A few days after my visit, I returned to see Nirmala and her family. "Uncle, you're back again," she said, flashing me that smile.
>
> I followed Nirmala and her family over several months. One day, I saw another 8-year-old girl, Khendo Tamang, lying in the bed next to Nirmala. She was crying and holding her mother, whose faced showed her anxiety. Khendo had lost not only her left leg, but her elder sister and grandmother. (Shrestha 2016: para. 1)

While these stories had many graphic compelling details and may have ultimately helped Nirmala and Khendro, they ignored countless other patients with similar or worse conditions, even as it would have been virtually impossible to report all such stories. And yet, apropos of 'celebrity victims,' Khendro ended up getting full boarding school sponsorship from abroad, while Nirmala's father searched his notes for the email address of the young European couple who had visited Nirmala in the Trauma Center and promised to help but had not contacted him

Figure 4. Rising Cricket for Women founder Aarati Bidari (back) & team member Sadiksha Pandey (fore) offering Tsering an official Nepal cricket jersey in the Trauma Center.

(Beazley, 2015)

since then (Sullivan & Shrestha 2016). Here too, the unevenness of celebrity victimhood was apparent. And, fifteen minutes of fame is not much consolation for a life as a disabled person living on the fringes of an already marginalized existence (Lord et al. 2016).

Mobilization in Areas of Social and Institutional Neglect

It was truly impressive to see the worldwide response to the earthquake. A total of 54 search and rescue (SAR) teams (2,080 personnel including staff) arrived in Nepal to help with the response (Shenhar et al. 2016). While I was volunteering, search and rescue teams from India, Israel, Japan, and the United Arab Emirates visited the Trauma Center. And yet, much of the immediate response to the earthquake centered largely on the Kathmandu Valley. Within days, however, a second wave of response from Nepali volunteers emerged, as several groups of talented, dedicated, and resourceful Nepali citizens began the process of supplying aid and resources to communities in earthquake-affected districts across their country.

One example of such mobilization—and its intersections with the social media as well as diasporic Nepal—came in the form of the Nepalese American Nurses Association (NANA), a group based in New York City that, via Facebook, began collecting funds and medical supplies in Jackson Heights. In May 2015, NANA nurses flew to Nepal, where they not only volunteered at the Trauma Center but also hard hit areas outside the Kathmandu Valley. A NANA Facebook post describes the sense of urgency and frustration that these nurses felt in reaction to the government's lethargic and ineffective post-earthquake response.

> Njima [sic] Sherpa, a Nepal-born Manhattan nurse, said what's desperately needed in Nepal is more medical trauma experts—and helicopters to reach remote villages in a landlocked nation topped by the forbidding Himalayas. Emergency funds from abroad must counter the political instability, poor infrastructure and poverty that make recovery difficult. Hospitals are running out of supplies and beds. "We can't wait because people aren't being treated, and they're dying," said Sherpa, who comes from a totally wrecked village under Mount Everest. She lost a cousin. As for others, "I have no idea what's going on...Out of frustration," she said, Sherpa plans to fly to Nepal with a medical crew organized by the Nepalese American Nurses Association. The earthquake has changed relations in the U.S. Nepali community, roughly divided into ethnic Sherpas and Tamangs."Before, everybody was on their own, rushing and running," said Indra Tamang. "Now, everybody feels united." (NANA Facebook post April 28, 2015)

I met three of the NANA nurses (including Nima Sherpa) while volunteering at the Trauma Center, and I continued to follow their activities outside Kathmandu through Facebook. This is just one example of the ways bonds were created between people near and far, and how social media helped to galvanize response to what was widely felt to be government inaction and neglect.

A final example of such a grassroots and social media-inflected response was an initiative called Rasuwa Relief, in which I was directly involved (see *Becoming Rasuwa Relief*

in this issue). Working with a group of other volunteers, mostly Nepali friends, we began organizing interventions to help address areas of social and institutional neglect in Rasuwa District where three of us had spent several months doing ethnographic research (Murton, Lord, and Beazley 2016). Through our work as Rasuwa Relief, we pursued a variety of collaborations with various other grassroots humanitarian initiatives such as the Himalayan Disaster Relief Volunteer Group[5] (a.k.a. "Yellow House"), Kathmandu Living Labs,[6] and the Phulmaya Foundation,[7] led by Rajeev Goyal, another colleague from Cornell and founder of KTK-BELT.[8] Most of these connections were facilitated through Facebook and other social media networks. We used online crowd-sourcing technologies to raise funds, reflecting a pattern of self-organization that has become increasingly common in the wake of disaster as in everyday life.

While working as Rasuwa Relief, we also became aware of the many areas that were overlooked by both state and other volunteer organizations. Connections through social media helped us map and respond to grassroots needs in neglected areas. From my volunteer experience with ActionAid India[9] in the aftermath of the December 2004 tsunami, I had learned how relief efforts that are not well organized and non-collaborative can be ineffective and wasteful. I remembered watching truckloads from various relief organizations arrive in coastal Tamil Nadu—with the same supplies. While many of these supplies were important, the overlap led to stockpiling supplies to sell later on the black market. The most disturbing aspect of this dynamic was that every organization deployed interview teams that went house-to-house with a questionnaire to document supply distribution. Practically speaking, this meant that families had to relive their experiences each time in order to be the recipients of aid.

In the case of Nepal, despite the tremendous worldwide response, the competitive nature of large donor organizations and the country's geographically and politically challenging landscape meant that significant gaps in response existed. A great deal of effort was directed at the delivery of immediate material aid, while the need for psychological aid and counseling was largely overlooked by the government in the first few months following the earthquakes (Bhusal 2015; Kathmandu Post 2015a, 2015b; Maharjan 2015).

Mental Health and Emotional Support

Mental health has been a chronically underdeveloped and underfunded part of the Nepal healthcare system (WHO 2016; WHO-AIMS 2006). As Seale-Feldman and Upadhaya (2015: para. 4) explain:

> Nepali policymakers and international donors see this moment as an opportunity to strengthen what has historically been a weak mental health system, where less than 1 percent of the government's total health budget has been allocated to mental health and there is one practicing psychiatrist per million people. (WHO and Ministry of Health and Population Nepal 2006).

This gap was largely filled by NGOs, Buddhist monasteries (Lions Roar Staff 2015), and other grassroots initiatives. However, these efforts were largely unreported by the media.[10] One novel approach to addressing this gap brought traditional healers such as *amchi* (Tibetan doctors) who could provide spiritual and psychological support to Buddhist regions across Nepal. As one example, Amchi Tenzing Bista[11] organized a series of mobile amchi camps designed to bring traditional Tibetan medicine (*sowa rigpa*) to Buddhist populations in earthquake-affected regions (Craig 2015). This included a series of camps facilitated by Rasuwa Relief, which brought Tibetan Medicine and ritual practice to 1,097 patients in Upper Rasuwa one year after the devastating event that leveled Langtang, in a community still struggling with chronic physical and mental health problems. This initiative provided a sense of comfort as well as direct medical intervention to people in Rasuwa.

Emotional support was another vital service that volunteers supplied not only in the Trauma Center but with other volunteer groups I observed as well. Many patients had no family members present at the Trauma Center; the care and compassion the volunteers showed was invaluable. One group of young Nepali women arrived and spent days and nights comforting patients as if they were their own family. It was both inspiring and heart wrenching to see the compassion that poured out of them so selflessly. This group also took discharged patients who had no one to take care of them to their group home to provide further care.

Much has been written about the efficacy of team sports in dealing with psychological trauma including posttraumatic stress disorder (PTSD) (ACPMH 2013; D'Andrea et al 2013; ESSA 2014; Radley 2015). In a comprehensive report on the efficacy of sports as a treatment for PTSD from both manmade and natural disasters including earthquakes, Henley (2005: 31) concluded:

> The true effectiveness of using sport as an intervention to help children overcome suffering and distress is not in competition but in cooperation, not in winning or losing, but in the process of participating in a supportive group. That coaching can be about sports, about values, and about giving emotional support to children. These aspects of

Figure 5. Rising Cricket for Women team members Sadiksha Pandey (fore) & RCW founder Aarati Bidari (back) in Trauma Center with young boy fitted with external fixator.

(Beazley, 2015)

> psychosocial sports interventions all point to the crucial element of relationship and connectedness as a community, which feeds both the individual's and the community's resiliency and strength to recover.

Rising Cricket for Women[12] (RCW) is the brainchild of Aarati Bidari, a seasoned women's cricket player who had already won numerous cricket awards even though she was only 24 when I first met her in early April 2015. After telling her about my volunteer work with I 2 We she and others from RCW came to the Trauma Center to help.[13] RCW brought encouragement and donations to patients in the Trauma Center, and offered to teach them how to play cricket after their recovery. I could see evidence of this sort of positive impact through RCW's in Nepal's post-earthquake moment, particularly in relation to mental and emotional health.

I had begun working with RCW in the context of my research on gender and mobility in Nepal. After reconnecting with them in the Trauma Center, I helped RCW organize a series of cricket training camps in communities where I had conducted research in Nuwakot and Rasuwa, and at camps for internally displaced persons (IDP) in Nuwakot and Bhaktapur. These cricket camps helped young people deal with the psychological trauma of the disaster and its aftershocks, bringing together family members and friends from different communities to cheer them on. During these camps, RCW also spent time talking to community members about their experiences of the earthquake, as well as wiring and distributing solar units to villages without electricity. Involvement in community activities like this helped people feel as if a sense of normalcy was returning to their lives—contributing to emotional and psychological healing.

The Volunteer as Patient

I had not expected to find myself in the role of patient. However, I became a patient at the Trauma Center after an accident in which I fractured my upper right femur on May 12, 2015. This accident and subsequent surgery gave me a deep sense of appreciation for the challenges faced by so many of the earthquake-affected people that arrived at the Trauma Center and a profound gratitude for the selfless dedication of the doctors and nurses. As I was recuperating in the outpatient room, it was heartwarming to be chided by my fellow I 2 We volunteers about how Americans are always turning the tables in foreign countries: once a volunteer and now a patient being cared for by the same volunteers with whom I had worked. After my surgery, a volunteer, Phil Sheppard, from Handicap International helped me adjust my crutches and reminded me of how to use them since I had not been on crutches since I was teenager.

On August 25, 2015 I was involved in another more serious vehicle accident, fracturing my upper and lower right leg. Twelve hours after being transferred to four different hospitals for evaluation, and searching for a hospital with a neurologist, I entered the operating room. The second accident was an intense study in the long-term recuperation that so many earthquake-affected had to endure to heal to the point where they were able to start to take care of themselves and begin to return to 'normal' life. This is something I am still struggling with, six operations and two years after my second accident.

It is really difficult to understand the many hurtles Persons with Disabilities (PwDs) have to overcome just to go shopping, until you are a PwD yourself. In the global North, we have the resources and technology to make a PwD's life relatively easy. In places like Kathmandu, where the streets are anything but wheelchair and walking-aid friendly, I found that only my finely tuned sense of humor and of the absurd sustained my daily street expeditions. I was truly surprised when, on the streets of Kathmandu, I was actually drawing attention to myself by hobbling down

the road on crutches with five pounds of metal including ten inches screws, carbon fiber stabilizer rods, and accompanying adjustment nuts sticking out of my right tibia. This contraption is called an external fixator. It is used to stabilize bones from the exterior while they heal internally. I had seen numerous children in the Trauma Center, including Tsering, fitted with these Robocop-looking paraphernalia. Now, once again, I was getting a lesson in what it felt like to be a socially marginalized PwD, despite the benefits still afforded me by virtue of my Americanness.

Virtual Mobility in the Post-Disaster Context

All of these case studies speak to the importance of the role that technologies played in responding to disaster; they also heighten the virtual mobility pathways of the volunteers, relief workers, and earthquake affected people. Here I follow Adey (2006: 77) who defines virtual mobility as "how physical movement (is) related to communication systems." Hannam et al. (2006: 4) further elaborate:

> In addition to physical travel, both the Internet and mobile telephony are allowing new styles of communicating on the move...new forms of co-ordination of people, meetings and events...and a re-arrangement of the relations between domestic and public space...There is increasing convergence between transport and communication, 'mobilizing' the requirements and characteristics of co-presence into a new kind of mobility nexus.

Since April 2015, many people have written about the vital role virtual mobility technologies played in earthquake relief efforts (see Busso et al. 2015, Carpenter 2015, Schorr and Warner 2015). The use of virtual mobility technologies—social media, smartphones, radios, and open source mapping—was instrumental in getting the word out, recruiting volunteers, raising funds, networking, and organizing logistics. The day of the earthquake Mark Zuckerberg CEO of Facebook activated Safety Check on Facebook—a way by which individuals in Nepal could notify friends and family that they were safe. Within hours, a team of volunteers led by Mark Turin (University of British Columbia) translated this into Nepali, making the function many times more effective in Nepal. More than seven million people were marked safe and more than 150 million friends received notifications informing them that their friends were safe during this period (Thapa 2016: 567; Zuckerberg 2015; Wikipedia 2016).

Many volunteers gave friends and family real time updates on Facebook, Twitter, SMS, and phone calls from the Trauma Center, creating a virtual participant-observer experience and prompting support and donations. As these virtual mobility pathways spread, they began intersecting with actual pathways in ways that proved to be mutually beneficial. However, in the first two days of the earthquake power and Internet were sporadic—often non-existent. During this time, cell phones were essential technologies for locating family members and connecting with the injured. One of the most commonly requested and donated items for earthquake affected people was cell phone recharge cards. Cell phone flashlights were essential tools given disruptions to power supplies.

Still, technologies and virtual mobility networks were not a 'magic bullet.' At the Trauma Center, for example, it was the hard work of the volunteers who recorded vital information from the patients and then sifted through reams of haphazardly documented patient admittance records to reconnect people who had been wrenched apart by the disaster and its aftermath.

Conclusion

The Nepal earthquakes of 2015 and their aftershocks exposed gaps in the state's institutional ability and willingness to address catastrophe, despite the work that has been done on earthquake preparedness. The events which have unfolded in the aftermath of Spring 2015 have exacerbated the lack of trust between Nepali citizens and the state. While the government has made efforts to organize earthquake reconstruction through the National Reconstruction Authority, the success of the government's claim to 'build back better' remains to be seen. In this Perspectives piece, I have highlighted the ways that different kinds of citizen and volunteer responses to the 2015 earthquake helped fill gaps created by institutional dysfunction, and how social media and more traditional forms of media played crucial roles in these efforts. The government would be wise to study these grassroots responses as a model for rebuilding and strengthening the state's disaster response framework and institutions.

My time at the Trauma Center also highlighted the state of health care in Nepal, revealing specific problem areas such as mental health care and services for persons with disabilities (see Acharya et al. 2016; Maru et al 2016; Sharma 2013). To its credit, the Bir Trauma Center provided free services to any earthquake affected patient, filling a vital gap left by other expensive private hospitals. A majority of Bir Trauma Center's patients came from traditionally poor mountainous areas of Nepal. And yet, the quality of healthcare was extremely uneven. High quality medical care typically remains expensive by Nepali standards and out of the reach of most earthquake-affected patients.

As a way of illustrating these points, let us return, in closing, to the example of Tsering Tamang. Upon discharge from Bir Trauma Center, she was refereed to an improvised rehabilitation facility run by an organization called the Nepal Healthcare Equipment Development Foundation (NHEDF). Tellingly, this home, organized by volunteers and supported through informal networks, was a citizen response to non-functional and non-existent state institutions. Despite the free treatment Tsering received at the Trauma Center, she did not have access to any state-funded rehabilitation center. When I last visited Tsering at the NHEDF rehabilitation center,[14] she was all smiles, having taken her fist tentative steps on her newly healed leg. This moment represented the collective first steps of all earthquake-affected people in Nepal: tentative, hopeful, forward looking, and with a strong sense of determination.

Robert E. Beazley (M.S. Natural Resources, Cornell University, 2013) is a PhD candidate in the Department of Natural Resources, Cornell University, USA. His M.S. research focused on the impacts of expanding rural road networks in the Annapurna Conservation Area. His current research involves an investigation of gendered mobility and borderland infrastructure in Rasuwa district, Nepal. His most recent book is *Himalayan Mobilities*: An Exploration of the Impact of Expanding Rural Road Networks on Social and Ecological Systems in the Nepalese Himalaya (Springer, 2017).

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Endnotes

1. See <http://www.seismonepal.gov.np/>.

2. Pseudonym.

3. See <http://www.cnn.com/2015/04/27/world/nepal-earthquake-bir-hospital/>.

4. See <http://www.handicapinternational.us/from_nepal_quake_injury_to_acting_dreams_nirmala_stands_tall/>.

5. See <https://www.facebook.com/hdrvg/>.

6. See <http://www.kathmandulivinglabs.org/>.

7. See <http://www.himalayanconsensus.org/kavre-earthquake-relief/>.

8. See <http://www.huffingtonpost.com/rajeev-goyal/creating-an-8000-m-vertic_b_9289050.html>.

9. See <https://www.actionaidindia.org/>.

10. See <https://www.youtube.com/watch?v=t9GlztPipVM>.

11. See <https://www.facebook.com/tenjing.bista.7>.

12. See <https://www.facebook.com/Rising-Cricket-for-Women-RCW-476199939197379/>.

13. See <https://thehimalayantimes.com/sports/rising-cricket-women-outplay-apf-claim-attariya-cup-womens-cricket-tournament-crown/>.

14. See <https://www.facebook.com/NHEDF/>.

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