

# Course transcript for Day 2, September 7, 2012

Health and Disasters: Understanding the International Context  
Instructors: John Scott, MS and Patricia Bittner, MS

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**[Slide 1]**

**Presenter: John Scott**

**[DISCUSSION]**

Pat and I are extremely impressed with your commitment to this course. We both remarked that we really never thought about teaching, but we might think more seriously about it if we could be assured that we'd have students such as you.

Your homework assignments were very creative and thorough, and we took this as a sign of your commitment. Of course, after having said that, the next thing on my mind was "Well, of course, you guys are librarians." In my 20-year association with the National Library of Medicine I continue to be appreciative of the work and the interests of librarians. The fact that NLM and the regional libraries and essentially national libraries have taken on disaster risk management and response as a long-range initiative is fantastic. Librarians and libraries are as ubiquitous as 7-Eleven are. If one is in distress because of an event, you don't have to go far to find another. Librarians are committed to learning about information, storing it, protecting it, and finding out how to make it available. Getting back to the homework assignment, the work that you put in shows that you're serious.

It was of a variety of kinds. Some of you have researched some really new ideas. For example, the emergent Hantavirus Program in Yellowstone, I think somebody took that as a way to look at that issue from the resources that we gave. Others were interested in real-time things that have affected your communities. Some others really took the opportunity to delve into the Moodle site. You came up with bibliographies generated from the Moodle site as well as importantly, adding some ideas that we might add to the site. Both Pat and I as we got your responses made some individual e-mail responses back to you. Others we've integrated into our presentation this afternoon. Some things that you brought forward, questions that you've asked for suggestions you have made. We thought we'd take some time that was motivated by comments that you made in your homework assignments to address a couple of things that may not have been fully addressed yesterday or that we know might not receive the attention that you might be interested in today's presentation.

First, I'd like to acknowledge the observations made by Paul Drake regarding electronic information access. Certainly technology is not always accessible and this was one of the points that he made. Frequently it is not because there's a disaster that has affected the infrastructure. In many countries, the infrastructure is not sufficient to provide reliable communication or

information technology isn't developed to the point where you can reliably and comfortably just sit down and have as much time as you need to search the Web and the sites that we've given you. We recognize this going into the planning of the course, but we probably should have made it clear. This is an issue that should be paid attention to by all of you who have responsibility to ensure that people have access to information even if they don't have access to technology.

Some activities working towards that even if you don't have Internet accessibility include the National Library of Medicine and the Pan American Health Organization. Within our Region the Disaster Information Center in Costa Rica have worked to develop intraspecific CDs and DVDs where they've collected the materials that are available online and made it available free of charge for people who may not have Internet access, but may have computer access. Those kinds of things are important as well.

Moving on to another comment that Paul made was regarding pay-per-view materials. He happened to pick the one site, or at least as far as Pat and I can tell, the one site in the Moodle where it was a Journal of Pre-hospital Journal, that did require membership or payment for full-text articles. We made a concerted effort to make sure that everything was publicly available, but that one slipped through. I think you'll find it in that other sources of general information, in one of the slides yesterday. Be aware that's an issue.

What that brought to mind was Paul's particular question about his responsibility for providing materials among others to Republic of Palau, the Federated States of Micronesia, and the Republic of the Marshall Islands in the Pacific. It made me think of HINARI. HINARI is run by the World Health Organization. We will add a link to it from the Moodle. It is several-years-old maybe almost 10 years old and was developed or sponsored by the principal biomedical publishers of the world who recognized that there was a need to do something for countries that couldn't afford the journals. It was set up by WHO together with these publishers to gain access to the world's largest collection of biomedical and health literature. Now there are more than 8,500 journals and 70,000 e-books in 30 different languages available to institutions in more than 100 different countries. The U.S. is not one of them. Because we are talking about international work and we are talking about you making information available to constituents, if any of your constituents work with institutions in countries that earn \$1,000 or less per capita income, you may want to make them aware of the link for HINARI. Eligible categories of institutions are broad: national universities; research institutes; professional schools of medicine, nursing, and pharmacy; public health; dentistry; teaching hospitals; government offices; and national medical libraries. All staff members and students are entitled to access. If your institution is in Group A, which is the lower income countries free access is available. If your institution is in Group B, which is the next tier up, it is low-cost access and it is \$1,000 U.S. per institution per calendar year. All institutions registering in Group B countries are entitled to a six-month trial. If your institution is in Group B and you cannot choose or not pay an annual fee, your institution will still be eligible for free access to a number of information resources, just not the entirety of the library. And Paul, just to get back to you in particular, FSM is in Group A, so that's free access to those 8,500 journals. Marshall Islands is in Group B. I actually checked that WHO manages HINARI in Geneva and I

checked with the Geneva office this morning. There has been training in the Marshall Islands for HINARI so somebody there has a license.

HINARI just received approval from the publishing partners to expand the Group B category and we understand Palau will be eligible for Group B inclusion in 2013.

All of you might look for the resource and other databases like it. It is the Western Pacific Regional Office of the World Health Organization, website on yesterday Pat and I gave you if you look at the WHO slide that we posted with the various regional WHO offices. If any of your constituents are interested anywhere around the world, it is likely that a HINARI resource is available to them. There's also, by the way, and I would encourage you not to be confused by the name of the program. There's AGORA, which gives similar journal access for agricultural material and OARE, which is as an environmental focus of journal availability. This is the same mechanism that HINARI has, and if you use those three as cross-references, there's a lot of material either directly related to disaster and emergency work and some that is by extension. Certainly drought certification from the AGORA site and climate change through OARE.

Also you should be aware of the Emergency Access Initiative, EAI, which is a partnership of the National Library of Medicine, the National Network of Libraries of Medicine, the Professional Scholarly Publishing Division of the American Association of American Publishers, and other publishers. EAI provides temporary free access to full-text articles for major biomedical titles to health care professionals, librarians, and the public affected by disasters. This, by the way, is both available in the United States and internationally. Access to the biomedical literature through the EAI is only available to those affected by the disaster and for those providing assistance to the affected population. There are time frames and there is monitoring to make sure that the use is appropriate to the pledge to support disaster response.

I might say that with respect to both of these, another of my soapboxes, particularly because I'm interested in risk reduction, which includes early warning, is that we found over the years that many private sector partners have been more than willing to provide resources after events for response, yet they haven't been as receptive to providing the same resources for prevention preparedness including early warning. Again, that assumption that an ounce of prevention is worth a pound of cure if we are looking at trying to reduce vulnerability of the same kind of resources and attention put towards response should be put towards before a disaster.

Note I'm switching off my soap box and going back to the program.

I also wanted to credit the comment from Mike Liddicoat, who talked about credentialing as an issue in his homework assignment. He looked at some of the sites that might be valuable for credentialing, privileging, and preparing volunteers to serve. In the United States, credentialing and accreditation for disaster workers in the medical professions is moving along, and it has more history in terms of the organizations that would accredit and pay attention to the issue than the international community, which is broader and involves more participants. Pan American Health Organization and World Health Organization are both working with others to try to develop

appropriate accreditation standards. With luck, there will be guidance on this that will be issued shortly, but it is a long process.

Thank you for bearing with me but we didn't have slides to entertain you for your homework assignment so you've looked at this first slide for long enough and now we will move on.

## [Slide 2]

### **Presenter: John Scott**

We will come back at the end of the day to talk more, if you wish, about what you found out during your assessments. We didn't highlight all 50 of yours, but all 50 we were impressed and learned something ourselves from them. Moving on to today's prepared slides we wanted to suggest that one of the things that you do and you can begin to do it now, but it is really for your own benefit is to conduct an environmental assessment of your institution and community. This would be a little more in-depth version of what we asked you early in the day yesterday: identify your constituents and their needs. A constituent is probably not the best of words, but who are the types of people that are likely to be interested in the resources that are available through your libraries. There are two ways to look at this: (1) people who ask for information and seek you out and (2) then to the extent that you are willing and interested, the constituents that you see might be interested in what you have but might not know that you are available or not know of the resources that you have and the kinds of information that you might push out into various communities.

We want you to think broadly. Many of you have already looked into who your constituents are. We've looked at the registration material that you sent in, that is who you are and what city you come from and what institution you work for. We see that there are community health libraries, university academic health centers, hospitals, NGOs, government agencies, research institutions, and public libraries just to name a few. You may have constituents who are health professionals interested and willing to support communities outside the U.S. affected by disasters. You may have clinical and public health professionals engaged in academic or practical research on trauma, reconstructive surgery, prosthetics, PTSD, and other mental health or as is called internationally psychosocial areas of focus. You may find that you have public health policy, environmental health and toxicology, international health, pandemic flu interest, and other sciences. Environmental science includes climate change and meteorological; for example, the relationship between weather and health. It is becoming increasingly important to, for example, predict heat waves or predict respiratory disease from wild land fires or look at even something as esoteric as upper atmosphere dust movement. Over the past several years, NOAA and other scientists have noted dust that moves in the upper atmosphere from the Gobi Desert east to the United States and from the Sahara Desert west to the United States and by extension, the Americas, and looking at the possibility over time of whether or not there might be more significant relationships between that dust or what that dust is composed of and health conditions in our area. So for those who are involved or work with academic health care settings, you might have association with broader

fields of learning, agriculture education, transportation, business, marketing, advertising, and public relations. For example, the role of the private sector social marketing and journalism includes how to write, illustrate, and promote disaster risk reduction strategies and best practices. It is not too hard once you get going to make disaster risk reduction relevant to everything, every profession, and everybody. I like the adage “If you are a hammer, the whole world is a nail.” You could come up with any profession or any interest and probably it wouldn't take too long between us to find some relation to disaster risk reduction and disaster risk management.

### **[Slide 3]**

**Presenter: John Scott**

We will move on, this is a little bit deeper to some of the things we talked about yesterday. The principal U.S. agencies involved in disasters outside the U.S. are involved in response. Of course, there are prevention, preparedness, and mitigation efforts as well.

## [Returned to slide 2]

### Presenter: John Scott

I'm sorry, I hadn't exhausted the first slide yet and one of the most important constituents that I forgot to mention is to consider within your community maybe the diaspora of an affected country. We have among you the folks from cities that are in the top 15 ranking for numbers of resettled refugees, for example New York, Los Angeles, Seattle, Washington, D.C., Philadelphia, and Houston are in the top 15 for the largest numbers of resettled refugees. Refugees tend to resettle where there are broad larger immigrant communities from their countries and cultures of origin. You can expect that if there are refugees, then there are immigrants. By the way, it is really a transparent term; "Refugee" is a term that identifies someone for the first year. After that year, they were refugees and they are immigrants. There's a broad community of people. Many refugees just by nature of what makes them refugees have escaped countries that are vulnerable either to complex emergencies or to natural disasters. Many are transplanted here and they hear in the news or they read in a paper about events that are taking place in their country and they are disturbed. They either want to know what's going on because they have families there or they want to support those families by finding ways to contribute. You can be a valuable resource to them, and by extension, since most of you are medical librarians, you can provide support to your sister libraries and public libraries which may have more outreach access to those populations.

If they don't come to you, you could go to them. When the press or other media outlets are looking for comment on foreign disaster events, you might be able to give them timely and accurate information about the event or about where to get timely and accurate information. As we know, media tend to get whatever they can get and to the extent that you can help focus their effort that would be valuable. As a final comment about your constituents and the community wanting to support an affected country, donations are still the most effective contribution that can be made, rather than sending things or people, donations meaning donations of funds, of money. If sending people or if people from any of your constituents' institutions want to participate, you should check first. You should do your homework and help them do the homework. You should have previous linkages or relationships established. Ideally with things such as sister cities or sister institutions if you are academic health centers.

## [DISCUSSION]

We just wanted to check, did Lola have a question she wanted to ask of John? We see her hand in the attendee list. Lola, if you did you can use the chat session place and we will monitor it and pass it on to John.

Thanks, Pat. As we mentioned with credentialing, there isn't quite the mechanism set up yet, but certainly places that you can check and better to check before a disaster than after a disaster would be the Office of Foreign Disasters Assistance or CDC, if you have contacts there, or the National Disaster Medical System within the Department of Health and Human Services. You also

may have access to supporting affected countries by your relationships with, for example, national medical universities in those countries or established NGOs. Again, we refer you to the interaction site that we showed you yesterday as a good example of where you can get your feet wet by looking at who is involved and maybe making an association with them before events happen and letting them know of your interest and availability should something happen in a particular region of interest to you.

## [Slide 3]

### **Presenter: John Scott**

Don't send people, send money. Once you send money, monitor where that money went and make sure it went for the purpose that you intended it. That's another reason to check the interaction site. Pat is going to go over some of the monitoring and advocacy sites that include sites to look at who is doing what with the money that's been pledged.

We talked a little bit about OFDA yesterday as part of the general category of disaster agencies representing donor governments. Specifically, here's how things work with formal U.S. response to foreign disasters. In the case of large-scale disasters, U.S. ambassadors to a country affected have a small but important discretionary fund that they can commit immediately to the governments of those countries. Of course, the U.S. ambassadors are in close contact with the cabinets and the governments of the affected countries, so this can be done very quickly and the ambassadors don't need to check with the State Department or with the other U.S. government authorities to make immediate contributions of a limited amount of funds for some immediate activity in the countries.

In the longer run, what happens is outside similar to the way we talked yesterday about FEMA and the U.S. Disaster declaration is required by affected countries before the U.S. can or will provide aid. Some countries are reluctant to declare a disaster for a variety of reasons, such as national pride. There have been cases where presidents of countries have not wanted to declare disasters near election times because they haven't wanted to appear as though they and their governments aren't able to respond to their own national crises. Some are reluctant to become overwhelmed with international assistance, for example, Fukushima and the tsunami in Japan. Japan, by the way, has the better long-lasting, long set up disaster management resources in the world. They were one of the principal sponsors of the early move to support the International Decade for Disaster Reduction both with its own technical expertise and with funds. But obviously, even a country like Japan can be overwhelmed as they were. Japan made it clear that they would take support, but the search and rescue teams had to be UN-sponsored and not lesser sponsored teams. For example, in the U.S., that limited the U.S. to only two sites. So it is possible for countries to be overwhelmed as Haiti was overwhelmed by U.S. and other countries assistance.

Haiti's airport was a challenge. Flights were just essentially commandeered, was chartered from all around the world just to fly in stuff and people to Haiti without prearranging their arrival.

Countries are aware of that. CDC which we also talked about yesterday and the Department of Defense are two active players. The Department of Defense is there to manage the humanitarian assistance program. Historically, the challenge is from the international perspective with DOD, and not just DOD, but most militaries in the world. They were trained essentially to circle the wagon, go in, bring in their resources, and do what they do without much input and involvement from others, including the affected country. Sometimes this was helpful, many times it wasn't. So over recent years, a lot has happened with the role of the U.S. and other militaries and the importance of pre-coordination, coordinating with the United Nations and regional organizations so that roles are identified and relationships are determined before the militaries come in. In fact, militaries of the world are particularly valuable for their large resources. In Haiti, for example, most of the brick-and-mortar of downtown, in Port-au-Prince, is brick-and-mortar that was destroyed. When I was down there, I saw brigades of people taking rock by rock and moving first of all, trying to find survivors, but more broadly, just removing the rubble so it could be picked up. The large equipment that is required for transporting is typically only available from the militaries, so they do play an important role.

## **[Slide 4]**

### **Presenter: John Scott**

We mentioned ISDR and the International Strategy for Disaster Reduction. Pat will go into a little bit of a focused discussion of UN ISDR and one of its current initiatives. I would just make a note to say that the UN ISDR is the principal organization within the UN system that focuses on risk reduction. Most of what you would find at that site has to do with the risk reduction strategies and resiliency. Its associations and alignments are with the institutions that focus on those. They are less interested in the response. Within the UN system, you look for OCHA, the Office for the Coordination of Humanitarian Affairs. We gave you the site yesterday as the link to more of the response focus.

PreventionWeb is a website of ISDR. It is a website that focuses on risk reduction broadly. We'd encourage you to take a look at that. The U.S. is a partner to ISDR. It is a partner and a participant to the Pan American Health Organization and the World Health Organization, and it is a member country. Frequently we consider ourselves; I say that collectively, as donors to these UN organizations, to ISDR, and to PAHO. We don't really recognize what we have to learn from these agencies and what we have to learn by participating with other member countries. That's a soapbox issue. In PreventionWeb you will find things with relevance to the United States and your communities.

The United Cities and Local Governments, the UCLG, and Local Governments for Sustainability are long-term institutions, but relatively new to the risk reduction arena or relatively new to the ISDR initiatives supporting risk reduction. Pat will talk about the Resilient Cities Program, but UCLG and ICLEI are two groups that you might look into for those of you who are from cities that may be participants in these two organizations.

## [Slide 5]

### **Presenter: John Scott**

Two others, I mentioned a couple times without showing you the site was the Regional Center for Disaster Information, CRID, which is in Costa Rica was started by the Pan American Health Organization and is still significantly sponsored by PAHO and the ISDR. In the past 10 years since Hurricane Mitch, the National Library of Medicine has been a sponsor and working partner with CRID. Much of the work that you have access to through the CRID website was made possible through the early work of PAHO/NLM to move CRID to what it was as a paper database to an electronic database that's very rich and materials. Many of them are in Spanish, but not entirely. There's a very large collection of English despite the fact its Latin American focused. So don't let that throw you from looking at the site.

The Center for Research on the Epidemiology of Disasters is at the Université Catholique de Louvain in Brussels. It is one of the oldest institutions for disaster epidemiology. They have a very credible website where you will find lots of historical statistics on health and disasters that are particularly good for making comparisons and doing research.

The National Library of Medicine's Disaster Information Management Research Center, DIMRC website is there and they have a Listserv that we linked to in the Moodle site. I hope you are already members of it. It is a very rich discussion and another Listserv that's available is PAHO Disasters. That website is on the Moodle site and you should go to that. There's a Listserv and there's also a publication. PAHO's many publications you will find there. You can sign up for many things, including situation reports, not just from PAHO but also from OCHA and other groups. If you're interested in following one or another event, you can sign up to get Listserv reports of situation reports and reports on the event from various sites that are available to you on the Moodle.

## [Slide 6]

### **Presenter: John Scott**

Let's move to another thing that we had listed, we already planned on talking about today. One of our participants did a scenario on a local church group for homework. The church group works on a mission in Africa. There are two sites that we wanted to make you aware of if your constituents are involved in disasters and will be going to disaster events. It was Mary Beth Shell; she mentioned a cholera outbreak in Haiti. Lauren Young, also one of the participants, had the assignment or the scenario of a local church mission doing work overseas. This next slide might help you with that. The first is the State Department Smart Traveler Enrollment Program (STEP). The purpose of STEP is to notify U.S. citizens in the event of a disaster, emergency or other crises

and for the coordination of evacuation if one is required. You can also subscribe to this site for travel warnings and alerts. You should note that State Department advisories are rather conservative. If you're going into a disaster situation on purpose, you should know that there are risks beforehand and it is likely that you will have to use this information as background information. For example, any disaster event introduces potential for problems and certainly any complex emergency. Many sites that you go to there is restriction of traveling overnight. If you're a formal contractor for the U.S. government or UN Agency, you are prohibited in some cases from traveling at dark. So I think this site or the next one will show you are valuable for you to do. There's no reason why if you have someone, for example, Lauren's scenario going over on a church mission why they should sign up for this. That way, at least, people know where they are and have a better chance of getting to them if anything should happen.

## **[Slide 7]**

### **Presenter: John Scott**

The next site is a little bit different. The STEP site is for before you go. The next site is if you happen to be in the country that's involved in a crisis or disaster. This site tracks Americans affected by crises in foreign countries. I don't know if you can read the sites, I will step through essentially what it does. It is a monitoring by the Department of State and it is where you can go to get information about crises, how to contact your family in the U.S. to reassure them of your whereabouts and safety, how to contact the U.S. Embassy, how to register with the embassy or consulate, how to monitor the Voice of America or local media if you have access to that, and what federal government employees can do for country clearance. And conversely, if you are in the U.S. and you have relatives abroad, there are a number of ways to contact the embassy to find out how to learn about their safety or more about the situation.

So we would encourage you to go to that site or make your constituents aware that this is some information they should keep with them as they travel abroad.

## **[Slide 8]**

### **Presenter: John Scott**

Now I'm going to turn it over to Pat to take the next section.

### **Presenter: Pat Bittner**

Thank you. I know that we have given you a lot of information and I'm listening to this and I'm even having a bit of trouble assimilating everything even though I know these groups. I just want

to remind you that we do have all of the sources or I think 95% of them. I've seen a few where I may have omitted a URL on the website, but otherwise, the PDFs and most of the sources are on the Moodle site. I think it is a great resource that MLA and NLM have provided so you can go back and refresh yourself because it is a lot to take in one sitting. I will try to go through some of these other things quickly. Then I'd like to get your feedback on the second part about some of the myths and realities associated with disasters.

This particular slide on ALNAP continues the theme of “know the players” to talk about risk reduction and response. We want to touch on the issues of learning accountability and advocacy. One of the best ones for learning, the one I like because it is actually research-based is ALNAP or the Active Learning Network for Accountability and Performance in humanitarian action. ALNAP is a network of many humanitarian organizations and experts. Currently there are about 74 or 75 members. They include UN agencies such as WHO and UNICEF. They also have NGOs like CARE and Oxfam, universities and even bilateral aid agencies like USAID and Sweden's International Development Agency. So you can get an idea that the type of research and documentation that they have is broad-based and not reflective of the particular focus or bent of any one organization. It is able to draw on this very broad range of experience and expertise to produce the kind of studies and analysis that they do.

## [Slide 9]

### **Presenter: Pat Bittner**

I just wanted to show you one example. Across the top bar, there's a section on resources in the previous home screen I showed. If we drill down that a bit, we can look at the studies. I like it because they are using this word innovation. They are gearing a lot of the studies they are doing most recently on innovation. It is a word you don't hear too often in humanitarian circles, so I think it is kind of positive. This study that we highlighted here is on innovations in international and humanitarian aid. I've given you one of the key messages from it just because I think it struck me. I know ALNAP well, but I hadn't seen this particular study. The use of the word innovation, I found kind of refreshing at least in the circles that I've been accustomed to. We've included this particular resource in your Moodle classroom site, and not only the link to ALNAP as an organization but to the study too.

## [Slide 10]

### **Presenter: Pat Bittner**

As the example of accountability and I think John mentioned this, we have here the Central Emergency Response Fund of the UN. The acronym is CERF, but you're not going to find it easily on Google. You'll find a hundred other CERFs that come up above this, but it is Central Emergency Response Fund of the UN. It is really the first concerted effort to make humanitarian assistance better in terms of timeliness and effectiveness for the affected country.

So like the cluster system that we talked about yesterday, the CERF was born out of the aftermath of the tsunami in Southeast Asia. Prior to this time, you can imagine how long it took to get targeted and financial funding to a country affected by a large disaster. First, agencies had to make the request; for example let's say WHO made requests to the U.S. government and they had to be approved. Then, funds had to be transferred back to the agency; then the agency had to get it to the affected country. It was not useful at all for any kind of immediate purposes.

With the advent of the CERF, which is run at country level in the affected country and headed by the UN Resident Representative, there is one in every country that is a UN member state. That is most countries in the world; he or she is the head of the UN Agency. CERF is coordinated at country level by the UN Resident Representative and it is much more equally distributed; type of aid and the amount between agencies. The fund itself is replenished each year so it may start with I'm not sure the exact figure of how much but it tries to keep this much money in the fund. It is disbursed as necessary and replenished each year by contributions from governments, private sector foundations, and individuals. The interesting thing about CERF is that it has a financial tracking service attached to it so there is accountability.

## [Slide 11]

### Presenter: Pat Bittner

Here is the way funds are reported within the CERF. There is a section you can see on the top bar underneath the logo, reports and evaluation. Here is the quarterly report for the second quarter of 2012. There are links below if you scroll through to the complete annual report for 2011.

## [ACTIVITY]

If you want to use your chat session for a second—let me say before we start chatting, you can imagine we are not talking about a natural disaster; we are talking about 2011. There are many long and protracted crises that the general public is not even aware of. I know you are aware of these things. What country do you think was the top recipient in 2011 for funding from the CERF? In other words provide quick and sustained coordinated effort at the national level to alleviate the response. We've got Haiti. Okay. Then I would tell you something about this. China. Okay. I know we've got two correct answers I see so far. I didn't know this myself so we've got three correct answers. Okay. Good. Okay, the answer, the top recipient was Somalia because of the drought. And surprisingly enough, eight of the top 10 are countries in Africa. The other two outside of Africa are Pakistan and Sri Lanka but Somalia, because of the drought, was the top receiver in 2011. Because of the food shortages, the food insecurity, those kinds of things. I learned something too reading through the report. I would not have said Somalia and interestingly enough for those of you who said Haiti, even though in 2011 it was still the effects of Haiti and still today are still being tremendously felt, it did not even make the top 10. So I thought that was interesting. Probably because Haiti has a lot of foundation funding and other sources. CERF is used for emergency response and the critical first stages of a disaster. In the case of Somalia, it is constantly in an emergency and first aid situation. Haiti is doing well and one thing we have to remember about this, Haiti did receive a lot of money after the disaster and it is every bit as challenging to spend the money wisely as it is to mobilize the funds. Sometimes the tremendous outpouring of support the country will receive will cause internal problems and how the funding is spent. Anyway, I thought that was interesting.

## [Slide 12]

### Presenter: Pat Bittner

We talk about accountability. Let's look at the advocacy side of things. I can remember when the UN and specifically the agency that I used to work for used to think that advocacy was distasteful—not a dirty word—but distasteful. You didn't do anything to put forth your own interest or what it is you've done or “toot your own horn,” if you will. Things have come around and times are different. Everybody has a presence on the Internet and a Listserv and a Facebook page and many other things, so things are changing. A number of agencies do a very good job at

some of the strategies that they use for advocacy, not for themselves necessarily, but for the causes that they are espousing. This is the UN ISDR. I have to say there's little bit of a disconnect between the acronym that John and I keep using, which is ISDR, and the actual name which is now and has been for only a few months, the UN Office for Disaster Risk Reduction. The ISDR refers to the old name, but the acronym became so well-known after 12 years that they didn't change it. But what is now known as the UN ISDR is now the UN Office for Disaster Risk Reduction.

They do a very good job of advocacy and their latest campaign, which is now running through 2012, is on making cities resilient. The theme is “My City is Getting Ready”. They have done a good job of targeting municipal level and local level mayors and other local authorities but not the national level. They realize this has to start from the decentralized local or municipal level and build up. So they are targeting these local authorities with this campaign and now today more than 400 cities have signed up for the campaign. They pledged and made a commitment to four major areas. They've made a commitment to know more about and commit to this idea of making their cities resilient. They've agreed to invest more wisely and to build more safely. A lot of this is done through city learning and capacity building efforts. They've developed handbooks and guidelines. They do reporting; this is very important. I will show you an example of the reporting that they use and the tools. They build partnerships, another critical thing.

On the next slide you can see to the bottom of the slide where it says “Toolkit.” This is not the entire home page of the website, but we will go to the toolkit.

## **[Slide 13]**

### **Presenter: Pat Bittner**

Two or three things I wanted to point out. I have a circle around this latest report and below that is a handbook for mayors and local government leaders on exactly step-by-step how they can make their cities more resilient. John was one of the authors of this handbook and I worked on it as the technical editor. Both of those resources are available on this website. To the far right is the self-assessment tool, which is used as kind of a checklist. The countries themselves are, rather municipalities themselves, at a local level can use to set a baseline in terms of disaster risk reduction and identify what still needs to be done. It is important because using that tool by 400 municipal level local authorities will give an idea of the standardized data that we can collect within an area. Then we can measure these advancements over time with the same type of information.

ISDR published the progress report that is circled there in red and I'll talk about that in a moment. I think John had something he wanted to add to this discussion.

### **Presenter: John Scott**

I want to reiterate what Pat was saying and take it to a higher level in terms of the value of ISDR. ISDR works both on the national government level and community level. So you have, if you look at their resource, a lot of community initiatives in risk reduction and again, that borders on or relates to development as well in multiple sectors. But they also work in their partnerships with national governments looking at trying to improve legislation and the promotion of risk reduction at that higher cabinet level.

Again, with respect to ISDR and now Pat mentioned that the Office for Disaster Reduction, the importance of that remember in one of my earlier slides, it started off Frank Press used to be the head of the National Academy of Sciences. He and that group back in the late 80s recognized that risk reduction needed to be promoted. Then the UN established this international decade. Frequently the UN picks times of year, this Resilient Cities Program started out as a two-year initiative and it was so successful now it is been extended to five years. Pat will tell you about the Safe Hospitals Initiative that was similarly developed. INDR was a ten-year initiative initially and it was so important that it became the ISDR which then standardized it within the UN system and had no timeline. Coincidentally, there was a major earthquake in Japan just as the review was coming up and this was the Kyoto earthquake of some 15 years ago, just as the reevaluation for INDR-ISDR was coming up. At the time I was working closely with them and everyone was worried because the signs looked grim for whether or not the initiative would be supported. It was the earthquake in Kyoto that galvanized, which was a significant event particularly because Japan was so prepared and it was such a devastating earthquake. That was really one of the events that changed around people and recognized that risk reduction was important. ISDR was institutionalized and now even more institutionalized by making it an office. The secretary reports to the Secretary-General of the UN.

## **Presenter: Pat Bittner**

The slide that's up on your screen you can see the report is highlighted. It is in your Moodle site. I thought it was interesting because they are doing a good job of the timely production of information. They are not waiting 12 months to publish a report with information that was quickly outdated.

## **[ACTIVITY]**

I just wanted to explore that report for a second and ask you what you think. We can use the chat session. What do you think is the number one prerequisite that they identified as necessary for effective risk reduction? In other words, of all the factors that go into making risk reduction effective in a city, in a municipality, in a town, what do you think is the number one prerequisite, the most important thing?

Okay. That's great. Keep going. That's good. All of these things I would not have actually guessed because we worked on the publication, but prior to this. Okay, several people have put down variations of what the answer is. These are good. This is not a personal opinion or an institutional

opinion of MLA or NLM; this is what they discovered in the research they did for production of this publication. Mary Beth led off with political leadership and I'm thinking she's either really smart or she did her homework and a look at all the slides last night. Either way is great.

## **[Slide 14]**

### **Presenter: Pat Bittner**

As you can see by the title on the left-hand side, the study identifies political leadership as the number one issue. Many of you put commitment. You're going in the right direction for all of those other things are very, very important. Planning, communication, technology—all of these are building blocks. They found the number one issue when it comes to managing risk successfully was having the commitment and the political leadership at the local level. Take a look at this. It is in the Moodle site and I think it might give you something that you could quote to management in your own institutions about when you want to institute perhaps a special section in information management on risk reduction. You can point to the need for political leadership.

## **[Slide 15]**

### **Presenter: Pat Bittner**

In this whole realm of advocacy I'm going to touch on this quickly because this whole area of hospital safe from disasters or safe hospitals is something that we've done three courses around. It is really impossible to touch upon it in depth. But I just wanted to point out that it was one of the most successful topics of an international global campaign and really did so much to raise awareness of the issue of what it means for hospitals to be safe.

When we talk about safe hospitals we are not talking about things like the loss of medical records or patient errors or things like that. We are talking about protecting hospitals from disaster situations. It is geared around three pillars: we ensure that the health facility itself is structurally sound to protect the lives of the patients and people that work in these facilities. We showed you yesterday what happened in Haiti when they lost administrative health, which is technically not a health facility but it was a health building. But I mentioned about the tremendous loss of life of not only patients but health workers in Mexico. So building codes and things like that are big part of the inclusion of structural engineers in any kind of planning work for safe hospitals is very necessary. It is not at full problem of the health sector; it is much broader than that.

Then we look at the issues of even if buildings themselves don't collapse, if they are apparently still standing, they are often not able to function. So we have to make sure that the health services can continue to be offered when they are most needed. Finally, we have to build the capacity of health workers, the people in the institution themselves in terms of preparedness and emergency management. A well trained workforce is really critical in this regard.

## [Slide 16]

### **Presenter: Pat Bittner**

Under the part of your Moodle site you will find all of this information. This is the definition that is internationally accepted for the “safe hospital” or a hospital safe from disasters.

## [Slide 17]

### **Presenter: Pat Bittner**

I just wanted to include one example here, and there are several, about how social media is being used to promote advocacy. This is called the Click a Brick Campaign. Everybody who clicked on a brick expressed their support for safe hospitals. They keep track here. I didn't see anything yesterday as I was going over some of the contributions you made in the assignment. I'm wondering if anybody found any other social media campaigns or if they thought to use it. Is it something that you think would be interesting? Perhaps we don't have to use the chat session right now because it would probably take a while. But when we look a little bit at kind of a take-away exercise we were going to give to you, maybe it is something you can think about. I would like to collect impressions of people about the effectiveness and the use of these kinds of campaigns.

## [Slide 18]

### **Presenter: Pat Bittner**

Finally, this portal contains a great deal of information on all aspects of safe hospitals.

## [Slide 19]

### **Presenter: Pat Bittner**

Rather than including all of the documentation in your Moodle site that has gotten unwieldy to begin with, we gave the link to this portal; here are some of the things that you will be able to find. I'm not going to go into great detail about this because it is something that could occupy several days. Notice in the middle in red, the hospital safety index. This is one of the most successful products and actually what the campaign was built around; it is an assessment tool that can be used by a team of evaluators in a hospital. It is low-cost, easy to apply, can be done in a

day or two, and yields a score based on about 150 questions that you ask personnel and administrators in the hospital. It yields a score on your level of safety and it points to areas in which the hospital needs to improve in order to raise it. It has become the guide for evaluators and evaluation forms; they're technical but not too technical for any layperson to understand. That's exactly the package that's used but there's a lot of other information in here about how you working in hospitals can sell those concepts to the people that you work with.

## **[Slide 20]**

### **Presenter: Pat Bittner**

I included here, and all of this is in the Moodle classroom, a guide from the International Federation of the Red Cross and Red Crescent Societies on a global advocacy guide. You can see here there are many different areas that sometimes it is good to have as a reminder. How do you demonstrate the benefits of disaster risk reduction? What is public advocacy versus private advocacy? How can you craft these messages so they will get to the largest audience? And then actually, they will be acted upon? So that is in the Moodle site.

## **[Slide 21]**

### **Presenter: Pat Bittner**

This is the final part that I wanted to talk to you about. For as long as most of us can remember there have been myths surrounding the causes and the aftermath of disasters. For the most part, many of these have been dispelled over the years thanks to advocacy and thanks to a growing body of research. On the good side, the advent of the Internet has made it easier and quicker to publish and disseminate information so we have this body of literature. Also, the rise in use of the Internet and its unregulated nature, which is good on the positive side, have also led to new myths that must be consistently dispelled.

## **[Slide 22]**

### **Presenter: Pat Bittner**

Let's take a look at some of those myths. The first one is this myth: epidemics are inevitable after disasters. While there has been a lot of work done to correct assumptions about this, you still hear things in the aftermath of major disasters, especially major sudden onset disasters.

Unfortunately, this was a scene from after the tsunami in 2004. The topic itself is an emotional topic to begin with because people associate the presence of dead bodies with epidemics. It has led many countries to perform mass burials or cremations; this has caused serious problems when

disaster victims are hastily buried without being able to make a positive identification. Families that are left behind are unable to mourn and this does contribute quite a bit to the mental health and psychosocial support issues that we see after disasters. On a less human scale, there are also legal and financial implications when there is no body and then no death certificate. There's a whole series of problems. Certainly the most serious problem is the human loss of being able to bury the dead.

## **[Slide 23]**

**Presenter: Pat Bittner**

The reality is this has to be made clearer; cadavers themselves don't pose a substantial public health risk. If you have sudden onset disasters like the earthquake in Haiti or the tsunami, and yes, there was a warning period for the tsunami, but it was still because many people either didn't hear it or didn't receive it, was still considered a sudden onset disaster. But those sudden onset disasters will claim many more lives than slower onset disasters. If we assume most earthquake victims died from trauma injuries or lack of facilities or whatever, then at the same time we can assume the majority of people that are walking on the street at one minute are healthy. There's really no correlation between a cadaver itself causing a communicable disease. It just stands to reason that the presence of any acute infection in a victim of a disaster is about the same as in the general population. So actually, the survivors still walking around on the street are as much or more of a threat. The problem is when public health systems break down in the wake of a disaster. People become more and more ill.

## **[Slide 24]**

**Presenter: Pat Bittner**

There is a good body of research on this and there's a section in the Moodle site on the management of cadavers. The publication on the right is an industry standard. It was produced by PAHO, WHO, the Federation of Red Cross Societies, and the International Committee of the Red Cross. It is widely used and quoted by international sources. There are several articles that we have obtained and included here, such as the one on the myth of epidemics caused by dead bodies, which I hate to say, but it would be interesting reading but is sometimes things people don't think about and you may be asked about this afterwards.

## **[Slide 25]**

**Presenter: Pat Bittner**

Here's the section in the Moodle site. This is precisely why I put it here because we ran out of categories in the Moodle site so it is under disaster myths. You will see articles and you'll see that the second from the bottom is that publication that I showed you on the screen.

## [Slide 26]

**Presenter: Pat Bittner**

Another myth that we see: medical teams from outside the affected area with any kind of background, we need medical teams. You can see why this happens. We see these dramatic images on the screen and the myth itself has become pervasive. It is clear that there is a real desire for people to help and that's what really makes it difficult to dispel this myth. It is a really difficult balance.

## [Slide 27]

**Presenter: Pat Bittner**

But the reality is, and I'm sure you know this, that communities themselves need the most immediate and lifesaving needs. Really, it is only the highly skilled specialists that are needed after the first 24 hours. If there are life-threatening injuries or life-threatening attention that needs to be taken, the community in affected areas is not going to be able to wait for external aid because it takes too long. In other countries there are exceptions to this rule, but in Latin America, for example, there are more than sufficient numbers of highly trained medical staff. In fact, in some countries there is even medical unemployment. Sending physicians to do routine care, the person at the top was vaccinated against tetanus after an earthquake and routine care like that really is not needed.

## [ACTIVITY]

On the contrary, over here on the right-hand side of the screen, can anybody use the chat session and tell me what they think that might be a picture of?

I will give you a hint, it was in Haiti. So we say communities meet the immediate needs. We need highly skilled specialists. The picture on the right, what do you think that is or where do you think that is? It was in Haiti. Any idea? Looks like a pretty sophisticated hospital for Haiti itself so?

Did somebody get it? Okay, very good, Pricilla.

That is the U.S. Naval Ship Comfort that arrived in Haiti from Norfolk, Virginia, about a week after the earthquake. Look at that picture. Is that not amazing? You would think you were in Fairfax

County, Virginia, or any one of our major medical centers. That is the USNS Comfort which arrived there. Look at the quality of care that was being provided. In Haiti, the problems were the number of amputations that had to be performed on, the victims of crush syndrome, were tremendous in number. This hospital ship and many other skilled professionals dealt with that particular problem in Haiti. It was amazing. I think that is very good.

## **[Slide 28]**

**Presenter: Pat Bittner**

On the left, you have care in an improvised facility. This was a tent because there were so many hospitals that collapsed or could not provide services. Care in improvised facilities and there was the deck of the ship, USNS Comfort, in Haiti receiving helicopters. Those are the type of medical personnel that are needed.

## **[Slide 29]**

**Presenter: Pat Bittner**

This section we will have to go through quickly, but we've got the myth about everything is needed and it is needed now.

## [Slide 30]

**Presenter: Pat Bittner**

You know the reality is that unsolicited or unneeded donations can clog the system and lead to chaos than they can actually benefit things that are going on.

## [Slide 31]

**Presenter: Pat Bittner**

Let's quickly just take a look and these. You have all of the slides in the Moodle site and the presentations. If we think about three simple rules of donations: the right thing, at the right place, at the right time. Then we will be able to put in perspective this whole issue.

## [Slide 32]

**Presenter: Pat Bittner**

The rule of thumb regarding donations: when it comes to the right thing, it is that which is being donated should be required and appropriate for the situation and it should not be available locally. Imagine, and this is the case in most disasters, that the disaster does not decimate an entire country. It will do more harm to a small local economy to import many items that are available locally than it would be to actually purchase them there.

A few of the things that we talk about not donating: are clothing, food, blood, and volunteers. I will come to that in a moment because we did have a couple of people who've made some interesting observations on the assignment last night with regard to that.

## [Slide 33]

**Presenter: Pat Bittner**

Nothing is completely black or white. That issue of volunteers is a very good one because volunteers are needed. What is not needed are volunteers that show up spontaneously in a country on their own with no affiliation to an organization that's already been present working in the country that was affected. And that may require housing or something that will actually divert attention from taking care of the disaster victim. So there is a lot of movement underway to either get volunteers, or in the case of medical personnel, to certify foreign medical teams to ensure that they are actually contributing to the situation. In terms of volunteers or foreign medical teams, I

remember a case where a medical team from a highly developed country, and it wasn't the U.S. but it was a highly developed country, went to the Minister of Foreign Affairs in a disaster affected country, Jamaica, and they said we want to send a team. At the level of the Ministry of Foreign Affairs, the diplomatic level, they brokered this arrangement after the Ministry of Health had said we don't want any foreign volunteers here. But the Ministry of Foreign Affairs, the State Departments felt it couldn't turn this down. So the team from this developed country showed up in Jamaica and the Ministry of Health did put its foot down. Language was an issue, cultural issues, and the state of Jamaica at the time was an issue, so they put the foreign team that was highly skilled to work cleaning the hospital. And they willingly did it, but it is an example of you got to know when you're needed and when it is going to cause more problems.

## **[ACTIVITY]**

I think John stole the thunder a bit but let's see if people were listening to him earlier. What might be the best thing you could donate? Do you want to use the chat function for a moment? He did mention it earlier at the beginning of this presentation.

John's very happy. Money, it is one of the most flexible things that you could give. Very good. Money, Money, Money.

## **[Slide 34]**

**Presenter: Pat Bittner**

So if people ask, "What about pharmaceuticals? What about medicines? What about things like this?" Kathy mentioned blood. That's great in the U.S. It is not so great in an international context. So yes, you're right if we are thinking about a disaster in your community, definitely could be thinking about a disaster in the country I should've specified that's what we are going after. If anybody asks you about donations of pharmaceuticals, here are two publications, both of which are in the Moodle site under humanitarian aid and donations. Look at the WHO list of essential drugs because while you may not think that a certain drug is necessary to treat the disaster, what happens is that a country depletes its normal stock of drugs dealing with the disaster. Anything that can be done to replenish them is what is needed. You know that what you donate that's on these lists will always be needed.

## **[Slide 35]**

**Presenter: Pat Bittner**

Here is a PAHO site with some core principles and guidelines for drug donations and other information. I'm going through this quickly because we wanted to give you time to speak. We talked about the right thing. You've got the resources for that.

## **[Slide 36]**

**Presenter: Pat Bittner**

The right place and this is to make the point that in the country itself that's affected people are there and immediately to help. On the left is the international assistance that's arriving in terms of supplies. It is held up at either the border crossing or a port or an airport and it is not getting to where it is needed. Here are inevitable bottlenecks and that's what that slide represents. We have to take that into consideration when we think about what to donate.

## **[Slide 37]**

**Presenter: Pat Bittner**

Finally, at the right time. Remember the delays you can get within the affected country. You can get assistance to the site within two hours. In a neighboring country, which is well-positioned to help because they usually share a language and a culture, is within 24 hours. The international community is going to take longer to get things there.

## **[DISCUSSION]**

I have a question. Sometimes I don't mind making a cash donation, but with all the agencies I would never be able to stop from being bombarded with requests for more money. That happens in non-disaster situations too. Is there any way I can donate one time and not receive continuous requests for more donations from the agencies? Not likely.

I think it's the sign of the times. We have so many more sophisticated databases. I get this just when I give not in disaster situations. I give to a number of charities I'm called every week and I just have to say to them, I set up a timetable for myself, I know how much I give each year. So I don't know what the answer is to that, but it is a very valid question.

## **[Slide 38]**

**Presenter: Pat Bittner**

When we talk about considering what you're going to donate and making sure it arrives at the right time, this is probably one of the best examples. It is the foreign field hospital. These highly sophisticated field hospitals are dispatched to a country, no doubt are worthwhile, but you have to remember they are not going to arrive in time to save lives. This is the page from within the publication. It is a very good guide, but it is not often used because this is not the same, these are for governments. We're not going to have individuals donating to a field hospital but you can take a look at this and people may be asking you for advice or for sources of information on this. It illustrates what to think about for the donation of field hospitals. A country has to be able to maintain this hospital. There was an occasion in El Salvador where a country left a very elaborate field hospital and it cost the government \$7,000 a month just for the electricity to cool it. This was in a very warm climate and the government couldn't pay for that. As they say, every gift has a cost to the recipient country and those are things we might have to think about.

### **[Slide 39]**

**Presenter: Pat Bittner**

Here is a very good website on how to be a better donor. It is on the Moodle site under humanitarian affairs.

### **[Slide 40]**

**Presenter: Pat Bittner**

The last myth: things are back to normal in just a few weeks. Fortunately, this is true in most disasters. You can see here pictures of the vegetation, tourists have returned, and people are going about their everyday business.

### **[Slide 41]**

**Presenter: Pat Bittner**

The reality is that the effects of a disaster linger long after we stop seeing those dramatic images. Many of them are just because they are not something that sells news. Water systems that is broken. On the left is ash from a volcanic eruption still plagued Quito, Ecuador, for months afterwards and caused severe respiratory infections in children. All of this brings us back full circle to the issue of risk reduction. In these periods of reconstruction and recovery, we have windows of opportunity to put the measures in place to make these cities and countries themselves less at risk. And hope it doesn't happen again.

## [Slide 42]

**Presenter: Pat Bittner**

So I know we threw quite a bit there in terms of information and many different websites. This is the report we had there.

## [Slide 43]

**Presenter: Pat Bittner**

We did want to leave you with an exercise and a couple of questions.

**Presenter: John Scott**

Hello again. This is really the earlier one, an exercise for yourself. We think you've gone a long way, so essentially you've already done this. It is kind of finalizing your view. We'd like to think that by the end of these two days your view of who your constituents might be and what their interest might be have expanded. Maybe play around with that list a little more. Certainly go to and use the Moodle resources as most of you did with your homework. We would be happy to continue to communicate with you. The last slide has my e-mail address and Pat's e-mail address. We'd be happy to continue to communicate with you if you have questions about that exercise. We also would encourage you for your benefit and frankly for our benefit as well, for the benefit of the class, we include them on the Moodle site. If you can come up with some of your own additional myths and realities about disasters, send those to Pat. But if they get to any of us we will make sure that they get to Pat. We will synthesize those and make sure they are on the Moodle site and they might even find their way into the next publication on myths and disasters.

## [Slide 44]

**Presenter: John Scott**

We have minus five minutes of time so this will be a challenge. But as we did yesterday, if those of you, we understand that some of you have to leave, but if we can answer any additional questions, some of which we've had some interesting questions here on the chat site, we will follow up, some of those deserve following-up. Others we've answered. If you'd like to add anything, or any ideas from you and some feedback. We presume there will be some sort of feedback loop to let us know what you thought of the course and any additions that you think might make it more valuable for the next time. We're happy we can use the technology. In the former life back when I used to work for AID and the Rural Satellite Program, I worked with AID

and NASA on the development of the communication technologies that led to distance learning. This is frankly the first time that I've given a course and used it myself. It is great; it is what we had hoped would come to pass, but it certainly doesn't substitute for being in physical proximity with the 50 of you. You've been great participants as judged by your chat and your homework assignment. We hope that sometime we might meet you individually. That's all from me, Pat?

## **Presenter: Pat Bittner**

I also want to say thank you very much. I hope you will think about some of these questions and I know Deb will be sending out a formal course evaluation. From a one-to-one or one-to-two standpoint, if you want to add anything else that we can help you with, or identify any other sources. Things we glossed over too quickly. We really appreciate the sources of information you included.

## **[DISCUSSION]**

I see there's a comment that Bill said about sharing the homework assignments. You know what, I will do that. I will take them out of e-mail that we have so that they won't have people's names. And I will probably erase the name if it is on a Word document and I think that would be a very good idea to share those because there were some very nice suggestions on there.

I have a couple of questions for Deb. This is Siobhan, there were questions about how long the Moodle site will be up and then also someone wants to know if we — are happy to put the PowerPoint on the Moodle page, if Moodle can accept PowerPoint that are that big.

Right now we have plans to keep the Moodle site up through the end of the year and also into next year. There isn't really a plan to take it down because we are offering the course on demand. So we will have that Moodle site up for as long as you need to use it. You just need to make sure that you use it on a regular basis, otherwise your name might be bumped off of it but you can still get access to it. You just login and again as a guest.

Ok and the other question we will have to deal with and we will get back to people.

Right now, the slides are up as a PDF, is that correct, Pat?

Yes.

And they look good because they are in handouts forms but you want PowerPoint for people to reuse, is that correct?

Some people are saying some of the things on the PDF are hard to read. So we will deal with that issue and try to get a clean copy onto Moodle.

Sure, we can do that.

Yeah, okay.

Yes, we will put up a cleaner copy perhaps one by one and the reason they were compressed as a PDF was because of the size. Many of those pictures are several megabytes large and it just made such an unwieldy size. I think each PowerPoint of day one and day two were each in excess of 26 or 28 megabytes so we compressed them and PDF files. We can do it better by not doing three per page and you're right, you can see some of the URLs and all that are in there.

We can put that together and put them back up there and have that.

So again I reiterate that we would be glad to keep in touch with anybody.

**[Slide 45]**

**Presenter: Pat Bittner**

The slide here is with our e-mails at the end. We'd be glad to hear from any of you.

**Presenter: John Scott**

Have a great weekend.

**Presenter: Pat Bittner**

Okay, thank you very much.

**[Event Concluded]**