



# Putting it into Practice: Pediatric Environmental Health Training Resource

## Advocacy for Pediatric Environmental Health

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### User Guide



Children's  
Environmental  
Health  
Network

April, 2014



# Advocacy for Pediatric Environmental Health

## User Guide

This module outlines the importance of advocacy efforts by practitioners in the field of pediatric environmental health, provides an overview of key steps to becoming an effective advocate, and directs participants toward resources and potential partners. This user's guide offers additional tips and resources.

Doctors, nurses and other health professionals are often sought out to join advocacy campaigns, speak to the media, and participate in other high profile roles because of their expertise and professional credibility. Silence from the medical or nursing community also makes a statement. Thus, health professionals need to understand not only their responsibility to be advocates but also how to be effective and responsible advocates. It is important to understand the power of this credibility and use it wisely.

*Below are topics that can be assigned or discussed when presenting this session.*

### ❖ **Health Care Professionals Unique Credibility**

1. Identify examples of some of the unique expertise that the health care profession brings to the environmental health arena.
  - a. Some general examples include scientific training, high credibility, and perspectives on health, prevention, long-term impacts of environmental exposures, and non-monetary impacts.
2. Identify examples of policy changes where the voice of health care profession was key in making changes in the environmental health sector.
  - a. Examples include: Decreasing exposure to lead in paint and gasoline, decreasing exposure to first and second hand tobacco smoke, elimination of some harmful pesticides.

### ❖ **Creating A Virtual Goal**

After the discussion of goals, the instructor could ask the students to quickly 'set a goal' for the purpose of this discussion. Once the goal was set, students would seek to answer each of the remaining 6 questions for that goal. A timely community topic may generate the most interest and discussion. Examples may be pesticide use in schools, a proposal to expand an area transportation or industrial facility that would decrease air quality, or the finding of a toxicant in local water supplies.

### ❖ **"What Scientific Information Do I Need?"**

Using the goal set, students can be asked to draft a fact sheet to be distributed to the relevant decision-makers they seek to influence.

1. Identify sources of scientific information relevant to your specific goals.



2. Locate specific studies, facts, etc., that are relevant to your goal. Summarize this information in a manner that would be effective in educating and persuading a non-scientist about your position.

❖ **“What other groups or individuals are involved in this policy issue?”**

1. Identify governmental and non-governmental organizations you might contact regarding your general and specific advocacy goals.
2. For each organization, identify their likely or proven stance in environmental health issues, their structure and the individual(s) with responsibility for your specific goals, and, if non-government, their sources of funding.
3. Develop questions you might ask these organizations about their involvement and position on the issue you have selected.

❖ **“Who are the relevant decision-makers?”**

1. Identify relevant decision-making parties with jurisdiction over your selected advocacy goal. Include all governmental, non-governmental, and community parties.
2. Outline the decision-making process used by these parties.
3. Report on the decision-makers’ most recent actions and anticipated next steps on the topic.

❖ **“Who are my potential partners?”**

Identify potential allies for the specific advocacy goals you have selected.

Note that for this question and the previous two questions, you are likely to find overlap and will need to research further to determine if an entity that you identify as ‘involved’ in the issue is a potential partner, a decision-maker, or both.

❖ **“How do I develop and implement a strategy?”**

Using the goal that was by the students, build on the information they gathered earlier and outline a suggested strategy. Or they could interview a participant in a current or past advocacy effort to learn the history and strategy of that effort.



## CASE STUDY: Lead Poisoning in Anytown, USA

This case study illustrates a hypothetical advocacy effort in Anytown, in state of OurState, USA. The case study addresses the seven steps to effective advocacy.

### i: What is my Goal?

Anytown advocates determine that their general goal will be to decrease childhood lead poisoning. With lead, as with other environmental toxicants, specific advocacy activities can take two main approaches:

- **Primary prevention** strategies to remove the hazard from the environment (such as eliminating lead from gasoline), and
- **Secondary prevention** strategies to mitigate the effects of the hazard (such as dealing with existing lead-based paint in residences or screening children to identify and treat lead-poisoned children).

For the goal of decreasing childhood lead poisoning, specific goals may take primary and/or secondary prevention approaches. Examples include:

#### Local:

- Testing of children
- Residential mitigation requirements for lead-based paint in housing
- Soil mitigation

#### Federal:

- Prohibiting lead in paint
- Prohibiting lead in gasoline
- Prohibiting lead in children’s toys
- Prohibiting lead in consumer products (such as mini-blinds)
- Requirements for disclosing leaded paint in residences upon sale
- Requiring reporting of lead emissions from industrial facilities and mines

#### State:

- Testing of children
- Prohibiting use of leaded paint in schools
- Licensing lead abatement contractors, risk assessors and inspectors

#### International:

- Prohibiting lead in gasoline
- Prohibiting lead in paint

Anytown advocates decided that their specific goal would be to “test blood lead levels of all children under age 6” (a secondary prevention effort).



## ii. What scientific information do I need?

Sources of scientific information about lead include the National Center for Environmental Health at the Centers for Disease Control and Prevention (CDC), the National Institute of Environmental Health Sciences, the U.S. EPA, the Hispanic Health and Nutrition Examination Survey, and many others.

The Anytown and OurState public health departments should be contacted to find out how many children in the community have been found to have elevated blood lead levels and the percentage of children under age 6 who have been screened.

The following texts, excerpted from the National Center for Healthy Housing's *Issue Brief: Childhood Lead Exposure and Educational Outcomes*, is an example of an effective educational summary of scientific information. The full brief, including references, can be downloaded from

[http://www.nchh.org/Portals/0/Contents/Childhood\\_Lead\\_Exposure.pdf](http://www.nchh.org/Portals/0/Contents/Childhood_Lead_Exposure.pdf). When developing materials for advocacy and education efforts, it is important to provide information in the manner that suits your audience. For example, the writing style you would use for policy makers and the general public would be very different than for a journal article. Information should be summarized. If possible, use brief bulleted statements. Rather than including footnotes in a hand-out, you may want to maintain a version of the document with all of the references that you can provide in the event they are requested. For many layreaders, documents with footnotes or endnotes are off-putting.

Two versions of a potential hand-out are presented on these next 2 pages:



Version I:

## **Childhood Lead Exposure Remains a Serious Public Health Problem**

Childhood lead exposure, even at low levels, remains a critical public health issue. Tens of millions of U.S. children have been adversely affected by lead exposure in the years since its negative effects were first discovered. It is also a costly disease, with recent estimates putting its price tag at over \$50 billion in a single year due to lost economic productivity resulting from reduced cognitive potential. Children are exposed to lead in their homes from deteriorating lead paint and the contaminated dust and soil it generates, lead in water from leaded supply lines or plumbing, and other sources. Once a child's health or cognition has been harmed by lead, the effects are permanent and continue into adulthood.

Over the past 50 years, a growing body of scientific evidence has documented the connection between elevated childhood blood lead levels (EBLLs) and neurological damage, decreased IQ, increased blood pressure, anemia, gastrointestinal issues, stunted growth, seizures, coma, and—at very high levels— death. Recent research has found that even very low levels of lead exposure can have a detrimental impact on a child's IQ, likelihood of having a learning disability, and educational attainment. Compared to adults, children are at greater risk for two main reasons: First, they are more likely to ingest lead and absorb a higher percentage of ingested lead. Secondly, their rapidly growing minds and bodies are more susceptible to lead's harmful effects. Children of color and children living in poverty are disproportionately at risk for EBLLs.

No safe blood lead level in children has been identified, and there is a direct relationship between childhood blood lead levels (BLLs) and the severity of resulting health and educational problems. Since lead poisoning is an asymptomatic disease at low levels, the only way to find out if a child has lead poisoning is to test his or her blood. The extent to which testing occurs varies greatly around the country. . . .

CDC has gradually lowered the blood lead level of concern (the BLL where intervention is recommended) from 60 micrograms of lead per deciliter of blood ( $\mu\text{g}/\text{dL}$ ) in 1960 to 10  $\mu\text{g}/\text{dL}$  in 1991. Most recently, in January 2012, the Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) recommended dropping the term "level of concern" entirely and using a "reference value" to provide a way to compare an individual child's blood lead level to a population of children the same age. CDC concurred with this recommendation in May 2012. An accumulation of evidence showing negative health effects at very low levels of exposure supported this change. The current reference value is 5  $\mu\text{g}/\text{dL}$  and will shift with population blood lead levels. More than 500,000 U.S. children ages 1–5 have BLLs greater than 5  $\mu\text{g}/\text{dL}$ . The ACCLPP report highlighted the importance of primary prevention, "a strategy that emphasizes the prevention of lead exposure, rather than a response to exposure after it has taken place."



Version II:

## **Childhood Lead Exposure: A Serious Public Health Problem**

No safe blood lead level in children has been identified.

Childhood lead exposure:

- Has harmed tens of millions of U.S. children
- Is costly, with an estimated price tag of more than \$50 billion/year due to lost economic productivity
- Lowers children's IQ and increases the likelihood of having a learning disability
- Occurs when children are exposed to deteriorating lead paint, contaminated dust and soil, lead in water, and from other sources.
- Causes permanent harm to a child which continues into adulthood.

More than 500,000 U.S. children ages 1–5 have blood lead levels greater than the current CDC reference dose of 5 µg/dL.

Children are at greater risk, compared to adults:

- they are more likely to ingest lead and absorb a higher percentage of ingested lead.
- their rapidly growing minds and bodies are more susceptible to lead's harmful effects.

The only way to find out if a child has lead poisoning is to test his or her blood. The extent to which testing occurs varies greatly around the country. . . .

Children of color and children living in poverty are disproportionately at risk for elevated blood lead levels.

The Advisory Committee on Childhood Lead Poisoning Prevention (ACCLPP) recommends primary prevention, "a strategy that emphasizes the prevention of lead exposure, rather than a response to exposure after it has taken place."

Q. For this particular advocacy effort, can you identify the main problem with using this excerpt?

A. The conclusion of the piece has a respected national entity calling for primary, not secondary, prevention efforts. The leaders of the Anytown effort must develop their own materials and personalize them for their community, including local demographics, and their reasoning for secondary prevention efforts.



### iii. What other groups or individuals are involved in this policy issue?

Some of the national organizations involved in childhood lead poisoning issues are the American Academy of Pediatrics, the National Safety Council, and the National Center for Healthy Housing. Most states and many communities have agencies and non-profit organizations dedicated to fighting lead poisoning; in our hypothetical example of Anytown, they include a state agency, the Columbia Bureau for Public Health, and a non-profit organization, Lead-Free Anytown.

*Sample questions to consider for the organizations serving the mythical city of Anytown:*

- What are the primary and secondary lead poisoning prevention programs in our area?
- Does your organization place an emphasis on prevention, screening, or treatment?
- What are the resources available for screening?
- How many children under the age of 6 have been screened?
- What are your organization's current priorities and activities?
- What efforts have you undertaken in the past and how well have they worked?

### iv. Who are the relevant decision-makers?

At the national level, the U.S. Department of Housing and Urban Development (HUD) provides the most resources to communities and states for lead poisoning prevention programs. HUD also allocates funds to support lead abatement in residences. The CDC's Healthy Homes Lead Poisoning Prevention Program (HHLPP) has provided funds to state health departments and their local partners to monitor blood lead screening and respond to every child who has an elevated blood lead level with a home inspection and referrals for medical intervention and lead remediation. These agencies and programs are subject to Congressional oversight and rely on Congress for funds. The HHLPP program, in particular, has been severely cut in recent years. As of this writing, the Administration's proposed budget for FY2014 would eliminate funds for state lead poisoning prevention grant programs.

In many states, the public health department is the key player in identifying and treating children with elevated blood lead levels. State programs are subject to legislation passed by state legislators and signed by the governor. In Columbia, the "Columbia Bureau for Public Health" is under the jurisdiction of the State Assembly's Committee on Public Health and Safety and the State Senate's Committee on Corrections and Health and Human Services. Two members of the Assembly committee represent Anytown districts.

The city or county health department usually implements lead programs in local communities, at the direction of the county board of supervisors, city council, or other governing or advisory bodies. Low-income housing programs are often administered by government-controlled agencies or non-profit, community-run housing authorities. In our example, a non-profit



organization, Lead-Free Anytown, receives some city funds and is run by an executive director supervised by a board of directors.

#### **v. Who are my potential partners?**

For a lead-screening program in our hypothetical example of Anytown, potential allies include Lead-Free Anytown, parents groups, other health professionals, child care providers, teachers and learning disabilities specialists, employers, the Anytown Community Hospital and Assembly members on the relevant committee.

Potential opponents may include owners of rental properties and others concerned about the cost of lead paint abatement in homes, or decreases in housing values. The Anytown Housing Authority, which administers low income housing programs, was identified as a particularly important factor. The Authority's support is difficult to predict. It may support a lead-screening program, or may oppose a program because of concern about its legal responsibility to mitigate lead paint in its units. More research will need to be done.

#### **vi. How do I develop and implement a strategy?**

Depending upon the status of the situation in our example of Anytown, a range of strategies could be appropriate. For example:

*Goal:* Provide funding for testing Anytown children under age 6 for lead poisoning

*Message:* Budget and approve funds for testing our children

*Messenger:* Letters from and visits by Anytown constituents and institutions; editorial column by head of local learning disabilities association

*Audience:* State legislators (especially those on relevant committees, especially those representing Anytown), governor

*Context:* In advance of the annual budgeting and appropriations process

-- OR --

*Goal:* With adequate funding available, inform and engage health care providers in testing program

*Message:* Children under 6 should be tested — and can be tested free of charge through the SafeAnytown program of Lead-Free Anytown. Urge parents to take advantage of this test.

*Messenger:* Newsletters of Anytown chapters of health professional associations, Anytown Hospital employee newsletter and employee bulletin boards, paycheck inserts for hospital and HMO employees, grand rounds



**Audience:** Health care providers; emphasis on pediatric and family practice providers

**Context:** On-going peer-to-peer educational process for the program's duration

-- OR --

**Goal:** Convince care-givers to have their children tested for lead poisoning

**Message:** Test your child. It's easy, it's free, it's important

**Messenger:** Materials in waiting rooms, HMO newsletters, direct contact with health care providers, mailings to day care centers, door-to-door distribution of information in targeted neighborhoods

**Audience:** Parents and other caregivers of young children

**Context:** Educational program targeted at specific subpopulation of the general public

## KEY RESOURCES FOR FURTHER READING

Alliance for Justice, "Bolder Advocacy" website <http://bolderadvocacy.org/>, provides knowledge and tools to support nonprofits in advocating effectively.

Landrigan P, Carlson J. Environmental Policy and Children's Health. *The Future of Children* 5,2:34-53 (1995).

Lozano P, Biggs V, Sibley B, et al. Advocacy training during pediatric residency. *Pediatrics* 94,4:532-536 (1994).

Michaels, D. *Doubt is Their Product: How Industry's Assault on Science Threatens Your Health*. Oxford University Press, 2008. Alternatively, "Doubt is Their Product," *Scientific American* article in the June 2005 issue which led to the book.

Sullivan, J V. *How Our Laws Are Made Revised and Updated*. Washington DC: U.S. Government Printing Office, 2007.



***Note: This User Guide is intended to accompany the PowerPoint module of the same name. It elaborates on some material which may require more in-depth information than what is provided on the slides. However, the contents of all slides in the module are equally important to present.***

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*“Putting it into Practice: Pediatric Environmental Health Training Resource”* made possible by support from the W.K. Kellogg Foundation