EPA Grant Report

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For the

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Environmental Protection Agency (EPA)
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EPA Grant Report

Introduction

The National Indian Health Board (NIHB) and the Environmental Protection Agency’s (EPA) Office of Pollution Prevention and Toxic Program entered into an agreement to provide lead education and awareness workshops at NIHB’s 17th Annual Consumer Conference. These workshops were intended to provide the opportunity to exchange information about the environmental and health issues of lead-based paint, soil/water contamination and other hazards associated with lead poisoning. Tribes and government agencies were invited to consider strategies to resolve issues of lead poisoning within American Indian and Alaska Native communities.

The National Indian Health Board held it’s 17th Annual Consumer Conference in San Diego, California, December 7-9, 1999. Approximately 933 people attended the conference, held at the San Diego Conference Center. The usual format of the Consumer Conference, which lasts two and a half days, is to have a general session for all conference participants each of the three mornings and two workshop sessions on Tuesday and Wednesday afternoons. The general sessions are formatted to have a keynote speaker followed by a panel of speakers who summarize some of the key issues in the workshops. About 14 workshops are offered in each of the four workshop sessions, with some workshops being repeated. Altogether 39 different workshops were offered at the 1999 Consumer Conference.

For the first time, lead poisoning featured prominently in the Consumer Conference program for 1999. At the opening general session on Tuesday, Jerome A. Paulsen, MD, made a presentation on lead poisoning to the entire conference. Later that day, Dr. Paulsen gave two workshops, called “Lead Poisoning Prevention,” expanding on his morning presentation. On the second day of the conference, two additional lead poisoning workshops were offered. A workshop called, “Effective Tribal Lead Poison Prevention Programs,” featured a presentations by Jeff Bousougloff of the Upper Sioux and Lower Sioux Tribes’ Office of the Environment, followed by information on a new tribal grants program presented by Darlene Watford, Grant Administrator, Environmental Protection Agency. Another workshop, “Tribal Lead Blood Screening: The Facts Behind the Program,” was presented by a team working in the tribal lead program at the Chippewa Cree Tribe of Montana.

After the Consumer Conference closed, a focus group was held on Thursday, December 9, from 2:00 to 5:00 pm. The purpose of the focus group was to assess the lead poisoning portions of the program presented at the 17th Annual Consumer Conference, to make recommendations for the next Consumer
Conference Program, and to develop some preliminary recommendations to reduce lead poisoning in American Indian and Alaska Native communities.

To assure participation in the lead poisoning program, 26 people, including 7 presenters, were provided stipends to cover a part of the costs for transportation, lodging and registration fees to attend the Consumer Conference. The following table summarizes the tribes and states of the 19 participants receiving stipends under the EPA grant who were not presenters.

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As the above table indicates, the stipend participants represented at least 12 tribes from 8 different states. The names and contact information for stipend participants and presenters are attached to this report.

The purpose of this report is to summarize and evaluate the lead poisoning program offered in association with the 17th Annual NIHB Consumer Conference.

**Message Dissemination: Awareness Raising, Participation and Attendance**

Prior to this meeting, lead poisoning was a mostly unknown issue for most American Indian tribes and Alaska Native communities. The announcement for this meeting was sent to a mailing list of 3,400, that included tribal leaders and tribal health directors. While lead was only one of several agenda items listed in the announcement, it was given greater visibility than other topics. The meeting announcement included a heading, "EPA LEAD-BASED AWARENESS AND
EDUCATION FORUM," followed by two paragraphs explaining the issue, program and stipend opportunities. This was the beginning to put the issue "on the radar screen" for tribal leaders and tribal health directors.

The general session in which Dr. Paulsen spoke was attended by most of the 933 conference participants. Thus, those who did not necessarily have a prior interest in environmental health were introduced to the subject of lead poisoning.

Dr. Paulsen's message in the general session was reinforced by other speakers, including Tom Goldtooth of the Indigenous Environmental Network. In fact, the meeting placed a major emphasis on environmental issues. In addition to the lead poisoning workshops, there were two other environmental workshops: "Indoor Air – Health Risk Reduction" and "Persistent Organic Pollutants: Adverse Effects and Implications to Native Peoples." The workshop on persistent organic pollutants was offered twice. On the positive side, this gave more emphasis to environmental issues and offered a broader context for considering lead poisoning. On the other hand, the concurrent environmental workshops may have reduced attendance at some of the lead poisoning workshops.

Attendance at the lead poisoning workshops ranged from about 12 to about 30 people. Most of the people attending were those on stipends under the grant, federal agency people, and people who were associated with NIHB. Without the support from EPA, it is doubtful that the current level of awareness of this issue would have attracted people to the workshops. While the workshops provided the opportunity to review of the issues in depth and motivated those who attended to get involved, it is clear that a multiple strategies are needed to raise awareness about lead poisoning in American Indian and Alaska Native communities.

Content of Workshops

The following is a summary of the content of each of the three workshops that were offered at the 17th Annual Consumer Conference.

Workshop 3. Lead Poisoning Prevention. Jerome A. Paulsen, MD, Associate Professor of Medicine, Pediatrics and Community Health at George Washington University and fellow at the National Center on Environmental health at the Centers for Disease Control and Prevention, provided a pediatric environmental health approach to lead poisoning. He began his talk by sharing information about resources on this topic available to tribes. He noted the lack of information about lead levels in Native American children and stated that the number one priority is to get reliable data on the extent of the problem where you live. He said that screening should be done on 1-2 year olds – you can't wait until problems manifest themselves to screen. On a national basis, the amount
of lead poisoning has been reduced to .5 percent of children due primarily to three major public health interventions: unleaded gasoline, eliminating lead from indoor paint sold after 1978, and eliminating lead from the solder in cans that contain food. However, lead levels may be higher in some communities than the national averages. In general, doctors are not convinced that there is a lead problem, so they do not screen for it. "If you don't look," says Dr. Paulsen, "you won't find it."

Dr. Paulsen reviewed the typical sources of childhood lead poisoning that may be found in Native American communities. He said that 83 percent of houses built prior to 1980 have lead-based paint. Painters typically added lead to paint used on window sills, front doors and front porches. Friction rubs the paint off and the lead dust goes on the floor where children are crawling and are likely to get the dust from their hands to their mouth. Children may also gnaw on window sills or eat flaking paint chips because lead is sweet and it tastes good to them. Sanding floors and other forms of rehabilitation may create dust from lead paint. Lead paint that is pealing from the exterior of houses may contaminate the soil around the houses and may be picked up by pets who then transmit it to children. The goal is to make homes "lead safe," not necessarily "lead free." Even if a child's home is lead safe, they may be exposed to lead in other places, such as child care and homes of people they frequently visit, such as grandparents and friends.

Children may still be exposed to lead from gasoline that has contaminated the dirt near highways. Because they are so short, they are more likely to breathe the exhaust from vehicles. Other sources of lead poisoning are dishes and glasses. Pottery made with a lead-based glaze that is not fired at a high enough temperature may leach lead into acidic food, such as food containing tomatoes or chili peppers. Crystal containing lead may poison wine or other acidic liquid stored in it. Well water is often a source from brass fittings used in well pumps, old plumbing using lead pipes, and solder. The first water used in the morning that has been sitting in pipes overnight may contain a higher concentration of lead and this could be used for baby formula. Old water fountains with coolers have lead in their cooling tanks. Certain kinds of jobs expose adults to lead that can be carried home on their clothing and transmitted to their children. Some of these jobs or hobbies include working in smelters for lead, copper or silver; automotive repair, particularly working with batteries and radiators; and bridge repair, because lead paint is used on bridges. Lead sinkers are used in fishing and people often put them in their mouths as they are preparing their lines and nets. People may also be exposed to lead if they cast their own ammunition or fishing weights and sinkers. Lead is found in the wicks of scented candles, some types of cosmetics and some home remedies. Dr. Phil Smith of the Indian Health Service stated that some Yaqui and Kickapoo home remedies contain lead. While the United States has restricted the use of lead, food and other goods imported from other countries may contain lead.
Dr. Paulsen presented the results of an Indian Health Service (IHS) report published in 1997 by Michael Bartholomew and Craig Vanderwagon, MD, suggesting that lead screening had been conducted in only 6 of the 12 Areas of the IHS. The screening summarized in that report may not have been an adequate or representative sample, and the age groups screened in some Areas was not appropriate. Dr. Paulsen recommended that if you don't know if there is a problem, do universal screening of 1-2 year olds until you have enough data to justify a targeted approach. Dr. Phil Smith of the IHS stated that the IHS policy is to do universal screen of children up to 36 months old, but this is only really happening with children on Medicaid and the data are not being analyzed.

The health effects of lead in children vary with the amount of lead exposure. No amount of lead is considered safe. At the lowest level, lead has been associated with reduced intelligence, learning disabilities, attention deficit and hyperactivity disorder, hearing disability, and small stature. At higher levels, lead may cause problems with the nervous system and the formation of red blood cells. At the highest levels, lead causes encephalopathy, seizures, comas and death.

A blood test is the only way to screen for lead in people. Blood can be drawn using a finger prick or from the vein. To do a venous blood draw requires the use of lead-free glass vials and analysis in a lead free laboratory. The Centers for Disease Control (CDC) certifies laboratories for lead poisoning testing. The cost of lead screening can range from $5 to $50 per test.

If children are found to have lead in their blood, the interventions may be environmental or medical or both. At the lower lead levels, parents are advised to frequently wash hands, floors, window ledges and toys. It is a good idea to do an environmental assessment of the home to determine the sources of lead. Children with higher levels of lead may be given oral or intravenous medicine, and may require treatment in an intensive care unit of the hospital.

Dr. Paulsen provided the following handouts at this workshop:

a) An outline of the talk
b) Lead Poisoning Bibliography
c) Additional Resources (with specific emphasis on Native Americans)
e) "Treatment Guidelines for Lead Exposure in Children" from Pediatrics, the journal of the American Academy of Pediatrics, Volume 96(1), July 1995.
While he did not provide them as handouts, he highlighted the importance of the following additional resources:

a) *Little Moccasins*: a free video, CD-Rom and manual for tribal day care programs and families produced by the Houlton Band of Maliseet Indians in Maine as part of the EPA First Steps Program (call 1-800-564-8524).

b) *Pediatric Environmental Health* a publication of the American Academy of Pediatrics.

c) *Measuring Lead Exposure in Infants, Children and Other Populations*, a publication by the National Research Council.

**Workshop 4. Effective Tribal Lead Poison Prevention Programs.** This workshop had two parts. The first part was presented by Jeff Bousougloff, office of the Environment, Upper Sioux and Lower Sioux Tribes. The second part was presented by Darlene Watford, Grant Administrator Environmental Protection Agency.

Mr. Bousougloff described the Tribal Environmental Information (TEPI) System he has been developing and using for 6.5 years to manage tribal environmental data, including residential lead assessments. This integrated data system provides an interactive, GIS-based format to identify lead hazard sources, develop action plans and maintain lead program compliance. The EPA has granted a delegation of authority to tribe, which uses an approved enforcement matrix, tribal ordinances and the TEPI system to monitor and protect tribal members from lead poisoning.

Ms. Watford announced that over $2 million will be available soon from the EPA for tribal grants for blood lead screening and outreach. It is expected that 25-50 grants up to $50,000 each will be awarded for education and outreach. Another 25-50 grants up to $30,000 each will be awarded for blood lead screening. Federally-recognized tribes and tribal organizations are encouraged to apply for both grants.

The blood lead screening grants will target children 12-36 months. Screening may be done with portable, hand-held devices or off-site laboratories. There are data collection and reporting requirements that will enable the EPA to provide a consolidated data base and analysis. The education and outreach grants may be used to develop new materials or use existing ones. Grants may not be used for lead reduction activities, equipment more than $5,000, consultants more than $10,000, or case management.

EPA expects to publish grant application information in January with 90 days to submit. Information will be on the EPA web page: [http://www.epa.gov/lead](http://www.epa.gov/lead). Pre-applications will include a work plan of less than 10 pages and a budget. Tribes and tribal organizations can submit simultaneous proposal for
both grants, but they cannot combine the two programs into a single application. Ms. Watford welcomes calls for technical assistance in the preparation of grant applications.

Workshop 5. Tribal Lead Blood Screening: The Facts Behind the Program. This workshop was presented by the Tribal Lead Program at the Chippewa Creek Tribe. Loretta Rousette, Child Health Program Director and Tribal Lead Program Director, coordinated the presentation. Other workshop presenters included Brooke St. Pierre, Program Manager, Child Health Champion; Janet Runion, Rocky Boy Clinic Field Nurse; Alberta St. Pierre, Rocky Boy Clinic Field Nurse, and Gilbert “Gibby” Russette, Tribal Environmental Department Compliance Officer.

This workshop began with an introduction to the Chippewa Creek Tribe of the Rocky Boy’s Reservation Child Health Program. The “Child Health Champion Program” on the reservation is funded by the EPA to reduce hazards for children 0-7 years old. This introduction was followed by the 27 minute video, “The Trouble with Lead.”

Ms. Rousette explained that reservations are accepting BIA and military housing built in the 1950’s with lead paint and asbestos. Abatement is too expensive for the value of the homes. Lead paint is also found in low rent public housing and in older homes where the residents cannot afford to maintain them properly. On the Rocky Boy reservation, the community water supply is high in lead, contaminating even the newer homes built after 1980. It is believed that the lead leaches into the community water supply from uranium deposits on the reservation. Studies done in 1992 and 1994 concluded that homes were lead free, but in 1997 those same homes were found to have lead. The tribe is concerned that the high rate of children diagnosed with attention deficit disorder may relate to the effects of lead. In addition to the concerns identified in Dr. Paulsen’s workshop, Ms. Rousette discussed the association of lead with dental caries.

Blood lead screening were conducted by the State of Montana in 1995 and 1997. A total of 61 children were screened in 1995 and 39 in 1997. The tribe had difficult getting data from the state on the 1995 screening, but subsequent analysis showed an average blood lead level of 2.36. The 1997 screen indicated the average blood lead level rose to 2.64.

The Chippewa Cree Tribe has decided that lead contamination is the highest environmental health threat to children. The tribe formed a Child Health Team in the Water Resources/Environmental Department and invited participation from other agencies. The Child Health Team interacts with the Tribal Environmental Workgroup, Health Board Lead Task Force, and Montana State Lead Advisory Committee. A Memorandum of Understanding was developed between the Tribal Child Health Program and the Rocky Boy Health
Board that allows public community health nurses, the WIC coordinator and the WIC office assistant to help with blood lead screenings. The Montana State Lead Program provides supplies and laboratory analysis of blood samples.

Using capillary draws provided through the WIC program, the tribe conducted an initial survey of 41 children indicating that 39 had some level of lead in their blood. A survey of 146 children showed an average blood lead level of 2.82, which is the same average found in children living in urban areas.

Tribal housing authority winterization programs are problematic for two reasons: 1) renovations can create hazardous lead dust; and 2) resources from the Department of Housing and Urban Development (HUD) that could be used for lead control and abatement are expended instead for what is generally considered the higher priority of winterization.

Janet Runion, Public Health Nurse and member of the Child Health Team, presented a more detailed description of the tribal lead blood screening program. Children from 6 months to 7 years old are screened through the WIC program, Headstart and the schools. Parents are asked to sign permission slips for the lead screenings. Transportation is provided to the clinic where the screening is done. The capillary blood technique is used. If it indicates that follow up screening is needed, then venous testing is done with the sample sent to the state lab. The tribe is considering purchasing a $2,000 machine to do the blood analysis.

In addition to screening, the program is educating parents about lead poisoning. Part of the education includes assuring that children have a health diet to reduce the effects of lead. They recommend a diet high in iron and protein, Vitamin C and calcium, and low in fats and oils. They want parents to teach their children to wash before meals. They recommend that parents wash toys and pacifiers often, store foods properly, and protect children against eating paint.

When children are found to have elevated lead levels, referrals are made to the tribal Environmental Health Department for risk assessment and to physicians for physical exams.

Gilbert Roussette demonstrated the portable XRF Lead Analyzer, a device used to measure the level of lead in paint, soils, dust and objects. It also analyzes mercury. The data may downloaded to a computer. He displayed dishes that he found in a thrift shop that had high lead content. He also tested a board with lead paint. Mr. Roussette also discussed the specialized training that he received for lead monitoring.

The following handouts were provided in this workshop:

a) List of workshop presenters
c) Workshop outline.
d) Chippewa Cree Child Health Program Phase Two Action Plan (Aug 1, 1999-July 31, 2000)
e) Memorandum of Understanding Between Rocky Boy Health Board and Chippewa Cree Tribal Lead Program
f) Chippewa Cree Child Health Program FY99 Report of Findings
h) Rocky Boy Reservation Blood Lead Screening Program
i) Copies of overheads used in the public health nurses' presentation.
j) Lead Regulation
k) Lead Programs, from the Office of Pollution Prevention and Toxics
l) Chippewa Cree Tribal Lead-Based Paint Ordinance
m) Chippewa Cree Tribe Child Health Champion Newsletter
n) Childhood Lead Facts
o) Respiratory Health Effects of Passive Smoking

**Evaluation of Workshops by Conference Participants**

The NIHB prepared, distributed, collected and analyzed evaluation forms for the workshops and general sessions. The following table summarizes the level of response to the evaluation questionnaires, according to the NIHB.

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<td>39 (20 + 19)</td>
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<td>Effective Tribal Lead Poison Prevention Programs</td>
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<td>5</td>
<td>Tribal Lead Blood Screening: The Facts Behind the program</td>
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A summary of the comments from each session prepared by NIHB is attached to this report. Most of the comments on the individual evaluation forms were also presented in the Issues Forum.
Focus Group: Lead Based Paint Poisoning Issues Forum

Overview. A focus group was held Thursday afternoon, December 9, from 2:00 to 5:00 p.m., after the NIHB Consumer Conference had ended. Altogether there were 16 participants in the focus group, of whom 14 were American Indian. The purpose of the focus group was to evaluate the programs at the 1999 Consumer Conference, to make recommendations for the 2000 Consumer Conference with regard to lead poisoning prevention information, and to make preliminary recommendations regarding the reduction of lead contamination in American Indian and Alaska Native communities.

Focus group participants included 4 people representing federal agencies (IHS and EPA) and 11 representing tribes. Among the tribal representatives, 6 people were associated with the lead poisoning prevention programs of 4 tribes (Chippewa Cree, Upper Sioux and Lower Sioux, Cherokee). Three tribal participants were employees of environmental programs that do not currently have lead programs (Salish and Kootenai, Camanche, and Confederated Tribes of the Umatilla). Three tribal participants provided consumer perspectives. The non-federal participants were from 5 states (Minnesota, Montana, New Mexico, Oklahoma, Oregon). Most of the focus group participants were recipients of scholarships to attend the lead poisoning prevention sessions at the Consumer Conference and most had attended the workshops on lead poisoning.

The focus group facilitator was Pamela E. Iron, a consultant to NIHB and a member of the Laguna Pueblo and the Cherokee Nation. She was assisted by Mim Dixon, Ph. D., a consultant to NIHB, who took notes of the proceedings, wrote recommendations on flip charts, and summarized discussions for the group to validate at the end of the meeting. Sue Savage (Navajo Nation), an NIHB employee and coordinator of the EPA grant activities, participated as an observer.

The focus group was held in a room at the San Diego Conference Center. The tables were arranged in a U-shape and two flip charts were used. Refreshments were available for participants. The activities were not tape recorded. Two participants had to leave to catch an airplane before the focus group ended.

The focus group provided an opportunity to draw on a wide range of opinions from novice to expert. It included diversity in representation from tribes and states. Both federal agencies and tribes were represented. While this focus group provided a beginning to identify issues, future activities should probably include additional federal agencies (HUD, CDC) and representatives from all the Areas of the Indian Health Service.
Evaluation of 1999 Consumer Conference Lead Program. The following is a list of what people in the focus group said that they liked about the 17th Annual Consumer Conference lead program:

- Practical information on testing.
- Tribes sharing their experiences about what worked and what did not work.
- The comprehensiveness of the program, including sources of lead poisoning, effects and how to protect people.
- Something for everyone — the opportunity for novices to become motivated and for people who are already doing programs to learn new information (about things like quality assurance and certification for training).
- Discussion of statistical data that will help in writing grant proposals
- Networking and sharing between tribal programs and with federal agencies. People involved in tribal health programs said that they often feel isolated and it was good to be able to relate to other tribal programs.
- Handouts

Aspects of the 17th Annual Consumer Conference lead program that focus group participants felt needed improvement:

- There were so many sessions offered at the same time that interested people that they were torn between attending the lead sessions and other sessions.
- Materials need to be more culturally appropriate:
  - Visuals, such as pictures of buildings, need to reflect conditions on reservations rather than inner city housing.
  - More data should be presented, and data should be presented more accurately, about lead in American Indian and Alaska Native communities.
- People left with some unanswered questions (such as potential lead poisoning from ammunition plants where American Indians have been employed and artillery bases on or near reservations) and without some key information (like the need to retest children because lead only stays in the blood for 30 days and they may have moved to different housing after an initial test that shows no lead in the blood).
- More tribal lead programs could be featured in workshops (examples: Maliseet, Cherokee, and Ft. Peck).
- The video shown in one workshop was a little long.

Some other observations about the 1999 program include:

- It was a little repetitious, but this was considered to be helpful because it was new information.
- The people who were involved in environmental programs like the presentations of medical information and would liked to have seen more involvement from IHS and tribal health staff.
Recommendations for the 18th Consumer Conference in 2000 in Billings.

For the most part, the recommendations for the 2000 Consumer Conference are a direct reflection of what people liked or did not like about the 1999 Consumer Conference. These recommendations do not represent a consensus, but rather the suggestions of individuals:

- Do more outreach to tribal environmental health programs in announcing the Consumer Conference.
- Other groups that should be encouraged to attend are medical staff, WIC and Headstart directors and staff.
- Workshops should include people representing tribal lead programs and the following federal agencies: IHS, EPA, CDC, HUD.
- Invite someone from the Indian Office of HUD at the national level to address the Consumer Conference in a workshop or general session.
- Include more tribal lead programs (examples: Houlton Band of Maliseet Indians, Cherokee Nation, and Ft. Peck).
- Provide some successful models of tribes and federal agencies working together at the local level.
- Include medical information again, like the workshops provided by Dr. Paulsen, but add more tribally specific information and more culturally appropriate slides of housing. Consider a workshop presentation on how to get doctors more involved.
- Ask HUD and/or tribes to explain how lead abatement activities can be funded on reservations and in tribal communities.
- Have a booth or a separate room where people can review available resources for their tribal programs, including videos, and demonstrations of the XRT machine.
- Have a summary of the workshops or handouts available for those who cannot attend the Consumer Conference or cannot attend all the lead workshops at the Consumer Conference.
- To resolve the "problem of too many concurrent sessions," it was suggested that lead workshops be held during the general sessions.

Preliminary Recommendations for Monitoring and Reducing Lead in American Indian and Alaska Native Communities. The workshop presentations by Dr. Paulsen and Ms. Watford stressed the need for blood lead screening and data analysis in Native American communities and provided a plan, including grant opportunities to accomplish that goal. While there appears to be consensus support for these activities, data collection was not a topic of discussion in the focus group. Instead, the focus group participants were asked to suggest what could be done to monitor and eliminate lead poisoning. Participants were asked to suggest recommendations for tribes, for IHS, for the NIHB, for EPA, for HUD and for other organizations.
The following is the list of preliminary recommendations generated for each of those entities. This list was generated using a brainstorming process. There was no attempt to evaluate, prioritize or edit the list. It is anticipated that this list could be used to set agendas for future discussions, to help develop workshops for future NIHB Consumer Conferences, to do education and outreach that would raise awareness in Indian Country, and to provide a framework for developing future position papers and advocacy activities.

**Tribes**

- Start the planning and coordination process (including memorandums of understanding between agencies) to develop a blood lead screening program and environmental testing program for the tribe. It is important to have a plan for what to do if lead is found prior to doing the testing.
- Apply for EPA grants to develop education, outreach and testing programs.
- Provide education on lead poisoning at several different levels to health programs, the tribal council, and the public.
- Enact and enforce tribal ordinance regarding lead contamination measurement and abatement.

**Tribes and/or the Indian Health Service (whichever is operating clinical programs)**

- Provide consistent training for medical and nursing staff, to include:
  - Interviewing techniques to determine possible lead exposure
  - Well-baby protocols to include blood lead screening
  - Protocols to include blood lead screening if the following symptoms are presented:
    - Low iron
    - Hyperactivity
    - Stomach aches, nausea
    - Kidney diseases
    - Symptoms similar to viral meningitis
  - Coding lead poisoning
- Do quality assurance studies to determine whether lead blood screening protocols are being followed.
- Provide case management for families with children who have elevated blood lead levels.

**Indian Health Service**

- Include lead issues in children's health initiatives and women's health initiatives.
National Indian Health Board

- Information dissemination: serve as a clearing house for information on lead and grant programs, using Consumer Conference, newsletter and web page.
- Serve as a catalyst for bringing tribes and agencies (EPA, IHS, CDC, HUD) together to develop better policies, programs and standards for lead testing and control.
- Advocacy: raise concerns regarding lead poisoning, increase funding for childhood environmental health programs, and change the HUD regulations on lead abatement funding by working cooperatively with NCAI, AAIP, IHS, Western Governors Association, and others.

Environmental Protection Agency

- Put Indian issues on the agenda for the quarterly federal task force meetings between EPA/HUD/CDC/DOD.
- Invite IHS to observe meetings between EPA and tribal advisory groups.
- Develop and maintain an American Indian web page for information dissemination with links to IHS, NIHB, and the lead pages.
- Provide better notification of funding availability to tribes.

Department of Housing and Urban Development

- Develop a process for tribal consultation on lead policies.
- Create a tribal set aside for lead abatement. Currently, there are too many competing priorities for maintenance funds and too little funding for tribes to address lead abatement.
- Reduce the barriers for tribes to access lead abatement funding, including formulas and authorization and certification policies.
- Participate in the NIHB Consumer Conference and other venues that provide the opportunity to increase understanding of Indian issues.

Tribal Colleges

- Provide training for lead monitoring technicians.
- Offer information about lead hazards to people who are being trained for construction trades.
- Provide training for careers in lead abatement.
Bureau of Indian Affairs

- Develop a mechanism for lead and asbestos abatement for BIA buildings that were turned over to tribes prior to the laws regarding notification of these hazards.

States and Counties

- Assist tribes in lead screening by providing laboratory testing.
- Where tribes do not have lead screening programs, provide education for American Indian clients, testing and case management.
- When American Indian Medicaid clients are screened for lead by private providers, assure that there is a mechanism to coordinate with tribal environmental programs.

Other focus group recommendations. Focus group participants were in unanimous agreement that there needs to be a mechanism to research and develop a position paper on lead abatement in American Indian and Alaska Native communities. While a draft paper could be developed by an individual, perhaps under the auspices of the National Indian Health Board, a group effort is needed to develop a consensus position. To provide technical assistance, participation is needed from HUD, EPA and IHS. Tribal participation is needed from each of the IHS Areas, to include tribes that have experience managing lead programs. This workgroup could meet a day before the next Consumer Conference and present their paper at the conference for broader review and comment. It is likely that such an effort will lead to recommendations to change policies at HUD. Those changes will likely require advocacy efforts by NIHB and others, possibly even including changes to laws. The position paper is needed as a first step to provide a blueprint for advocacy efforts. While this effort is not currently included in the grant from EPA to NIHB, an addendum should be considered to support this activity.
## EPA Grant Participants

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<tr>
<th>Name</th>
<th>Tribe Represented</th>
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<th>Agency Represented</th>
<th>Presenter</th>
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*These federal employees did not receive any funding under the grant.

NOTE: Other people who did not receive funding under the EPA grant attended the workshops.
WORKSHOP SESSIONS A & B, #2 -

PERSISTENT ORGANIC POLLUTANTS: ADVERSE EFFECTS AND IMPLICATIONS TO NATIVE PEOPLES

# of participants ______  # of evaluations 14

COMMENTS:

"Too many workshops to choose from"

"need more on traditional healing/herbs, native medicine & foods – incorporating w/ modern medicine"

"repeated the session – video was not available at 1st session"

"Info. Presented OK – sorry to have missed the video"

"very good video presented"

"The future generation in this new millennium (involving our young generation in the new century. Priming them teaching them about issues involved in the Indian health care & involving them on Health Boards. I don’t see enough young people concerned or involved. What will our children do? What will we do? When our elders are gone? The elders that are so involved on these boards and issues in Indian Health"

WORKSHOP SESSIONS A & B, # 3 –

LEAD POISONING PREVENTION – DR. JEROME PAULSON

# of participants ____  # of evaluations 9

COMMENTS:

"perhaps bring in some new ideas from the private sectors and get sponsors from companies we get equipment and supplies from to operate our hospitals"

"very important topics & information for the public"

"it was a good workshop but I could have understood more better if it was explained easier"
WORKSHOP SESSION C, #1 –
INDOOR AIR – HEALTH RISK REDUCTION

# of participants _____  # of evaluations 7

COMMENTS:

"Next year – herbs & medicine person – talk about respect, honor, etc."

"indoor air- excellent presentation with expert presenters. Info. Is invaluable, which will be shared with health programs, families, friends, etc.

"more preventative care workshops"

WORKSHOP SESSION C, #4
EFFECTIVE TRIBAL LEAD POISON PREVENTION PROGRAMS

# of participants _____  # of evaluations _____

COMMENTS:

"more tribes need to be aware of lead poisoning. More information to each tribe would be greatly appreciated"

"too many good workshops, too little time had alone to myself. Need to invest in time management"

WORKSHOP SESSION D –
TRIBAL LEAD BLOOD SCREENING: THE FACTS BEHIND THE PROGRAM

# of participants _____  # of evaluations

COMMENTS:

"more tribes need to be aware of lead poisoning. More information to each tribe would be greatly appreciated"