Dr Morgan and I also did extensive work with APHA to establish the International Health Resource Consortium (IHRC). The IHRC was a nonprofit arm of APHA established for the purpose of delivering public health services overseas, working closely with the nonprofit and business sectors. Most of the IHRC's public health activities were targeted to Central America. I was pleased to serve on its board of directors, which consisted of a very prestigious group of international health leaders from the private sector.

Dr Roemer's letter inaccurately states that "the International Health Committee was established by the Executive Board in 1959 . . . at APHA Headquarters in Washington, DC." APHA was located at 1790 Broadway in New York City in 1959 and did not move to Washington until 1971. I also recall that Dr Morgan was hired in 1969 as the first full-time international health employee to work at APHA headquarters in New York City under a grant to APHA from the Milbank Memorial Fund. The grant was headed by Dr Hugh Leavell, who, with Dr Morgan, undertook definitive field research in the process of establishing APHA's role in working with nongovernmental organizations in international health.

In view of the current and future importance of international health to APHA, I suggest that further research be done to document the International Health Section's history more accurately and that a much more extensive and well-researched paper be written on the subject. Professionals from that era who should be consulted include Drs John Cutler, Lee Howard, Jack Bryant, Linda Vogel, James Kimmey, William McBeath, Russell Morgan, and Gerry DeFoe (president of the Canadian Public Health Association), to mention only a few.

I look forward to future papers in the Journal on the topic of international health. □

Clarence E. Pearson, MPH, CHES

Requests for reprints should be sent to Clarence E. Pearson, MPH, CHES, National Center for Health Education, 72 Spring St, Suite 208, New York, NY 10012-4019.

Reference

1. Roemer MI. International health and APHA. *Am J Public Health*. 1998:88:1727.

History of APHA's International Health Section

I am a longtime member of the International Health Section of the American Public Health Association (APHA), a former staff member of APHA's International Health Division, and a former executive secretary of the World Federation of Public Health Associations. My reason for writing is to inform readers of the Journal that there are errors and numerous omissions in the research letter "International Health and APHA," which appeared in the November 1998 issue.[1]

In 1970 I was hired by APHA as a staff member of the new international health program. At that time, the program was overseen by the International Health Committee, which was led by Dr John Cutler and Dr Carl Taylor. Because APHA had no additional space on the 14th floor, my office was located on the 10th floor at 1740 Broadway, in the offices of the American Lung Association. Dr Hugh Leavell was the first director of this project, called the Role of National Voluntary Health in Supporting National Health Objectives which was funded by the Milbank Memorial Fund.

Three APHA members were critical in the development of the International Health Section at APHA: Dr Eugene Campbell, Ms Mary Jo Kraft, and Mr Clarence Pearson. I had the pleasure of being the staff person who worked with them on this initiative.

The first headquarters of the World Federation of Public Health Associations was not at the Council for International Organizations of Medical Sciences in Geneva but at APHA, first in New York City and then in Washington, DC. I negotiated the arrangements for the establishment of a Geneva office in the early 1970s.

As a membership organization, APHA has the responsibility to maintain an accurate record of the events that led to its prominence in the field of international health. It would be difficult, if not impossible, for any one person to assume this responsibility, for there were many people and events involved. Therefore, I suggest that APHA approach a private foundation for funds to undertake a written history of the organization's involvement in international health. Furthermore, I suggest that the editor of this history be a professional researcher and writer, rather than someone who was involved in these events.

The history of APHA in international health is a history we should all know and be proud of; it is a history that involves many people who have committed their intellects and their energies to an important cause; and it is a history that needs to be accurately documented. □

Russell E. Morgan, Jr, DrPH

Requests for reprints should be sent to Russell E. Morgan, Jr, DrPH, SPRY Foundation, 10 G St, NE, Suite 600, Washington, DC 20002-4215.

Reference

1. Roemer MI. International health and APHA. *Am J Public Health*. 1998:88:1727.

Roemer Responds

The information given in my research letter was gathered from consultation with sources suggested by a staff member at the headquarters of the American Public Health Association (APHA). These sources included an officer of the American International Health Alliance and national-level APHA administrative personnel—both of whom were said to have played key roles in the founding of the International Health Section in 1976.

As chair of the International Health Committee, whose members were appointed by the Executive Board of APHA to serve from 1977 to 1983, I vividly recall seeing the growth of the new section. I recall also turning over to the International Health Section the committee's responsibilities for international health field projects when the committee ceased to exist in 1983.

I regret that my account of these events contained inaccuracies, and I am indebted to Mr Clarence Pearson and Dr Russell Morgan for pointing them out. We all look forward to APHA's continuing contributions to international health work. □

Milton I. Roemer, MD, MPH

Requests for reprints should be sent to Milton I. Roemer, MD, MPH, UCLA School of Public Health, 10833 Le Conte Ave, Los Angeles, CA 90095-1772.

Childhood Lead Poisoning Prevention

The Journal received an unusual number of responses to an article, published in Public Health Then and Now in December 1998, called "Childhood Lead Poisoning: The Promise and Abandonment of Primary Prevention," by Herbert Needleman, MD. After the following 6 letters we present the author's reply, followed by a comment by the department's editors.

Ryan re Needleman

Herbert L. Needleman's article lamenting the abandonment of primary prevention of childhood lead poisoning[1] disserves history and all those working for prevention. Now is the time to put aside technical and tactical dif-

ferences to build momentum to end this disease. This letter seeks to clarify 4 points.

First, Dr Needleman misrepresents the Department of Health and Human Services' 1991 *Strategic Plan for the Elimination of Childhood Lead Poisoning,*[2] wrongly equating primary prevention with removal of all lead-based paint in housing. A rigid national program of full abatement would squander resources on homes with minimal or no hazards and fail to provide near-term protection to the children who are at highest risk. The current approach, which is focused on controlling lead *hazards*, particularly deteriorated paint and lead-contaminated dust, will provide greater health benefits than a preoccupation with the presence of leaded paint, the full removal of which would cost $500 billion.[3] The best and fastest path to primary prevention is wide-scale action to make all housing lead safe.

Second, many of the statistics on blood lead levels, cost–benefit ratios, and abatement costs cited in the article are erroneous or outdated.[4] Using obsolete data as a basis for criticizing current policy serves neither public debate nor children's health. Prevention strategies must continually be reexamined to be sure they meet the problem at hand and reflect current knowledge about sources and pathways of lead exposure and the effectiveness of hazard control measures. The Journal should ensure basic fact checking even in opinion pieces, which should be so labeled.

Third, while some may have viewed universal blood lead screening as an "article of faith," universal screening was never a reality. At the peak of screening efforts, only about 20% of children were being screened, which left the vast majority of lead-poisoned children unidentified and untreated.[5] The Centers for Disease Control and Prevention's 1997 screening guidelines helped focus attention on both the critical importance and the woeful failure of Medicaid screening and treatment, the reform of which must now be screening proponents' urgent priority.

Finally, the Alliance To End Childhood Lead Poisoning has worked since its inception to shift the approach to poisoning from belated reaction to primary prevention. To protect children's health and legal rights, the Alliance has sought to develop workable, protective, and enforceable standards that place responsibility for good maintenance and lead safety on property owners, not parents.[6,7] Catalyzing action to protect all children from lead hazards has always been the Alliance's goal—a goal that is now within reach. □

Don Ryan, MURP

Requests for reprints should be sent to Don Ryan, MURP, Alliance To End Childhood Lead Poisoning, 227 Massachusetts Ave, NE, Suite 200, Washington, DC 20002.

References

1. Needleman HL. Childhood lead poisoning: the promise and abandonment of primary prevention. *Am J Public Health.* 1998;88:1871–1877.
2. Binder S, Falk H. *Strategic Plan for the Elimination of Childhood Lead Poisoning.* Atlanta, Ga: Centers for Disease Control; 1991.
3. Weitz S, Clickner RP, Blackburn A, Buches D. *Comprehensive and Workable Plan for the Abatement of Lead-Based Paint in Privately Owned Housing. Report to Congress.* Washington, DC: US Dept of Housing and Urban Development; 1990.
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5. *Medicaid: Elevated Blood Lead Levels in Children.* Washington, DC: US General Accounting Office; 1998. GAO/HEHS-98-78.
6. *Framework to Make Private Housing Lead-Safe.* Washington, DC: Alliance To End Childhood Lead Poisoning; 1993.
7. *Blueprint For Prevention.* Washington, DC: Alliance To End Childhood Lead Poisoning; 1994.

Jacobs re Needleman

Herbert L. Needleman's recent article,[1] in sharp contrast to his earlier studies of lead toxicology, fails to meet his normally high standards of scholarship. Dr Needleman states that "primary prevention of lead exposure has been abandoned," yet he cites only policy documents to support the claim, ignoring actual data. The fact is that primary prevention is now a reality across the country.[2] It is noteworthy that Dr Needleman says nothing about what the US Department of Housing and Urban Development (HUD) has done since 1995, choosing to focus instead on a 1980 General Accounting Office report and a 1995 task force report.[3] Instead of distancing itself from its findings, as Dr Needleman charges, HUD chose to send the task force report to every member of Congress and continues to believe it is a useful consensus statement.

With the assistance of HUD grants, thousands of neighborhoods across the country are conducting the business of primary prevention that Dr Needleman claims does not exist. Since the early 1990s, hundreds of thousands of public and privately owned housing units have been made lead safe.[2] To accomplish this, thousands of parents, nonprofit organizations, inspectors, abatement contractors, local government employees, and others have worked long and hard to move real lead hazard control off the pages of dusty strategic plans and task force reports and into the homes of American families. By September 1999, HUD will have committed half a billion dollars to cleaning up lead-contaminated private housing and hundreds of millions more on public housing, *regardless of whether these houses have already-poisoned children* (i.e., primary prevention). Because of this success, HUD won a $20 million increase in this year's appropriation for the Office of Lead Hazard Control.

In his article, Dr Needleman implies that nothing short of complete removal of lead paint is effective. But he fails to provide evidence in support of his statement. He ignores the substantial evidence that wholesale removal of lead paint may actually *increase* exposure, a risk that was first identified by Farfel and Chisolm years ago.[4]

To evaluate modern lead hazard control methods, HUD has launched a rigorous longitudinal study of nearly 2000 dwellings treated under its grant program, the largest scientific study of residential lead hazard control ever undertaken.[5] Interim reports have been sent to Congress annually for the past several years, and the final report is due in 2001. Analyses of preliminary data show that median blood lead levels declined by more than 25% in the children living in these units 1 year after hazard control had been completed. No previous study has demonstrated this magnitude of effectiveness in a population with a median blood lead level near 10 ug/dL. HUD is funding other research by Farfel and coworkers in Baltimore (initially funded by the EPA) showing that modern lead hazard controls are associated with both significant reductions in blood lead levels in children with baseline blood lead levels above 15 ug/dL and significantly reduced dust lead loadings through 2 years of follow-up.[6]

Dr Needleman states that the now outdated cost–benefit analysis performed for the Centers for Disease Control (CDC) in 1991 proves his point that complete removal is cost-effective, even though that analysis did not include the costs of complete removal.[7] The harsh truth is that lead hazard control actually costs more than CDC estimated in 1991. The total cost of Needleman's total-removal paradigm would be at least $600 billion.[8] Nevertheless, an updated analysis of the benefits and costs of modern lead hazard control still shows a large net benefit of investments to make homes lead safe—$1.1 billion in HUD-associated housing alone.[9]

Does the CDC's strategic plan need to be updated? I believe we now have sufficient knowledge, based in part on HUD-sponsored research, to make well-informed changes to CDC's statement on the prevention of lead poisoning. HUD and CDC have worked