factors and disease and given that gay males are part of the state of Vermont those are targeted at their needs, but not specific to their needs. And when we look at specific risk factors, we know that STD prevention and HIV are specific needs," said Jarris. "I guess the question would be, what are we missing? And what are the key health risks or indicators that we're not targeting either by working broadly at the population's needs or specifically at those needs."

In the mid-1990s, HIV prevention workers began talking about secondary factors to HIV transmission. These included things such as coming out, substance abuse, and domestic violence, among others. The idea was that a gay man who was addicted to heroin was more likely to become HIV positive than someone who wasn't. A man coming out of the closet was more vulnerable to HIV than someone who had been out for years. Using HIV prevention dollars, many of us worked to address these 'secondary factors' hoping that referral to a gay-friendly therapist would mean treatment for depression and a decrease in risky behaviors. The health and wellbeing of gay men was a means to the end of preventing HIV.

If you are HIV-positive in Vermont, you have access to housing assistance, health care, prescription drugs, mental health counseling, and substance abuse treatment. If you are a gay man, your addiction to alcohol, mental wellbeing, and access to health care are a concern to DoH because these factors may contribute to risky behavior. What DoH is not concerned with is gay-affirming substance abuse treatment or mental health counseling simply because sober, emotionally healthy gay people reflect a positive, healthy, happy gay community. As a result, all things gay are dealt with by the AIDS program.

Drawbacks of Disease-based Health Promotion

What's missing is an approach to health promotion that works for gay men.

Health promotion is a comprehensive social and political process. It not only embraces actions directed at strengthening skills and capabilities of individuals, but also actions directed towards changing social, environmental, and economic conditions so as to alleviate their impact on public and individual health. Health promotion, as laid out by World Health Organization, is the process of enabling people to increase control over and to improve their health.

The United States is one of the few nations that rejects this model in favor of one based on disease, rather than population. Health departments in the United States have AIDS programs, offices of substance abuse prevention, divisions of tobacco prevention, and so on. Add to that the hundreds of disease-specific interest groups and what you have is a nation of people bombarded with public health messages: Don't smoke, says the American Cancer Society. Take folic acid before you get pregnant, says the March of Dimes. Wear your seatbelt, says the American Automobile Association. Eat according to the four food groups, er, food pyramid, er, revised food pyramid, says the USDA.

We are bombarded with health prescriptions and directives, but what we are not provided is a means to integrate health information into a decision making process that results in actions consistent with our knowledge, values, and desire. We know our diet is not right, but we don't know how to change it. We know we don't exercise enough, but we're not sure how. We know we should have safe sex, but it's not what we want at 3:14AM after a night of partying with a hot guy in our bed.

This confusion has led to an industry of health information products: self-help books, magazines, exercise videos, Dr. Phil's Ultimate Weight Loss Challenge show and book. Their success is built on our inability to sort through the massive amount of information being dumped on us.

And minorities suffer the greater burden. Not only are we assaulted by information, we often dismiss the important information because of how it is presented to us. "Middle-aged, suburban fathers surrounded by wife and children get heart attacks and need to watch their cholesterol, not 29-year-old, overweight, gay smokers." Or messages are so out of context with the moment of our lives, we can't do anything about it. "Assuming I still have a place to live when my parents find out I'm gay and I'm not being harassed up at school and my boyfriend isn't cheating on me, I will quit smoking even though I'm depressed and don't believe I will live till I'm 30 years old anyway."

Anti-tobacco advocates routinely include gay AA meetings, AIDS hospices, and homeless youth shelters on lists of places to reach out to sexual minorities. I always find this amusing because folks who find their way to any of those service providers generally have more immediate concerns. Disease-based health promotion is less effective because it forces health issues to compete with each other. It's like having a flat tire, going to the garage, and finding the transmission guy, brake specialist, windshield installer, and tire man simultaneously talking to you.

Except that metaphor falls apart, as does disease-based health promotion, because people are not machines. You cannot fix just one part and send the person on their way. Organic beings are meant to be dealt in a holistic manner, as are communities.

The DoH does not know how many gay men smoke, how many lesbians have breast or ovarian cancer, or whether or not heavy drinking is an issue in the transgender population.

Minority Health Matters

"If you're a small enough minority, you may not make it onto the big radar screen, but that doesn't mean there aren't specific needs we have to go after," said Jarris.

Health departments across the country have created offices of minority health to address disparities and to ensure just and equal treatment of minorities. Vermont has one too, although few people have heard of it.

When asked about the Department of Health's Office of Minority Health, and specifically what they do for sexual minorities, Dr. Jarris said, "My understanding is that in Vermont, the Office of Minority Health was originally conceived as racial and ethnic minorities and we broadened that scope in Vermont to include racial, ethnic, cultural, and sexual minorities."

But what does the office do?

"That is an office that is active and we're working on," said Jarris. "The office is there, it is supported."

The stated goal of the Office of Minority Health is "to increase access to health services for minority Vermonters by improving the level of competency of Department of Health staff; encouraging minority-specific programming by public and private sector health care providers; and assisting minority community-based organizations to participate in programs and advocate for their constituents." The office has one staff person and has not published a report of its activities.

I spoke to a number of gay community-based organizations. Some of them were not aware an Office of Minority Health existed; none had a relationship with the office. It's not clear exactly what this office does. This seems contrary to Dr. Jarris's vision for the DoH.

"What I'm looking for from folks working in different areas is very specific measurable outcomes," he said. "How do I know in a year that you've done anything? That this population is better off? I want both process measures as well as outcomes. Motion without achieving anything is not good enough."

Sexual minorities in Vermont need a public health infrastructure to keep us safe and to provide the means with which we can live healthier, happier lives. The Department of Health needs to demonstrate it is meeting its legal obligation to serve all Vermonters equally.

"If it's the issue of, are we missing things between our directed approach and our general population approach that's going to be important," said Dr. Jarris. "If we don't figure it out, I hope someone will let us know about it."

In the lack of data on sexual minorities, DoH misses an opportunity to develop a picture of sexual minorities. At best, this is an oversight. At worst, it is institutionalized indifference towards gay and lesbian people.

"We are genuinely interested in input from the community on how we can do better," said Dr. Jarris.

A Prescription for the DoH

To adequately serve sexual minorities, DoH would need to focus on four areas. First, the department needs to conduct a review of health surveillance tools and ask respondents to report whether or not they identify as heterosexual, gay, lesbian, or bisexual and, when appropriate, ask about the gender of their sexual partners.

Second, Dr. Jarris should call a meeting of lgbt community leaders working on health and community issues. All of the community organizations I spoke to expressed an interest in developing a relationship with the Office of Minority Health. Third, the department needs to review its funding policies in order to better serve a diverse population.

Finally, the Office of Minority Health (OMH) needs to begin serving sexual minorities in earnest by working internally to address the Department of Health's failure to monitor and improve their health and wellbeing. For example, the OMH could conduct a review of the department's health surveillance activities and produce recommendations for gathering data on sexual minorities. The OMH, with a mandate from the commissioner, could fund and manage an independent council on sexual minority health. The role of this council could be to make recommendations for gay-specific, culturally competent programming. OMH could manage grants to community organizations to fund programs to reduce health disparities among sexual minorities. Examples of these activities can be found in Massachusetts, Washington State, New York City.

The sexual minority communities must step up to the plate as well. To do the work of improving community health, we must first prioritize 'real' movement issues – the happiness and wellbeing of gay people – over prove-a-point legislation or judicial rulings that often serve a narrow subset of the community. We need to prioritize how government works over who government is.

And finally, we need to be open to taking a look at ourselves and asking, "How can we be a better community?" ▼

Ric Kasini Kadour is a gay men's health activist living in Shoreham. He can be reached at kasini@ix.netcom.com