NYC HISPANIC/LATINX HEALTH ACTION AGENDA 2021-2025

Our Health-Our Future

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I. INTRODUCTION

The complex health and mental health needs of Hispanic/Latinx communities(*) are often rendered invisible or overlooked in the development of public health agendas and policies in the U.S., particularly because of the monolithic view of Hispanic/Latinx as a homogenous group and the lack of action on structural inequalities fueling health disparities and health inequity. The health of Hispanics/Latinx is shaped by structural and social position factors such as cultural values, immigration, education, occupation, language, social support systems, and access to health services. In addition to the broad diversity of Hispanic/Latinx communities, different experiences of racial/ethnic discrimination, acculturation, homophobia, transphobia, or structural barriers create variations in health care access and health outcomes among Hispanic sub-groups.[1]

Hispanics are the largest minority group in the USA. They contribute to the economy, cultural diversity, and health of the nation. Assessing our health status and health needs is key to inform health policy formulation and program implementation. Implementation of the Affordable Care Act has resulted in improved access to health services for many Hispanics, but challenges remain due to limited cultural sensitivity, health literacy, lowest health insurance coverage, and a shortage of Hispanic health care providers. Acculturation barriers and underinsured or uninsured status remain as major obstacles to health care access. Recommendations focus on the adoption of the Health in All Policies framework, expanding access to health care, developing cultural sensitivity in the health care workforce, ensuring participation of Hispanic/Latinx communities, and generating and disseminating research findings on Hispanic health. Hispanics are disproportionately affected by poor conditions of daily life. Furthermore, a significant segment, especially in big cities, are foreign born Hispanic/Latinx communities that require tailored strategies to engage them in some significant way. Structural and social position factors (e.g., macroeconomics, cultural values, income, education, occupation, and social support systems) determinate access to care and support services - factors known as social determinants of health (SDH).

(*) For the purpose of this document, we will use the term Hispanic/Latinx to refer to the diverse self-identifications within our communities, including those related to ethnicity and gender expression. When referring to information from specific publications the term used in the referenced document will be used. The populations these terms describe are actually composed of various racial groups, so using them as racial categories is inaccurate.

In New York City, Hispanics make up 31.2% of the city's population, and the largest minority group. With the current pandemic, Latinos have withstood the worst of this crisis. It is a tragic yet unsurprising reality. Hispanic populations have higher rates of coronavirus 2019 disease (COVID-19) hospitalization and mortality than White populations but lower in-hospital case-fatality rates. The New York City Department of Health and Mental Hygiene data, Latinos are still leading in cumulative confirmed case, hospitalization and death rates, with 8,031.25 cases, 1,305.98 hospitalizations and 346.95 deaths for every 100,000 people.[2]

While the number of New Yorkers newly diagnosed with COVID-19 continues to fluctuate and we navigate a historic vaccination effort contextualized by historic mistrust and cultural incompetence, we must focus on the bigger picture. What people eat, where people live, and where we direct resources are fundamental questions to addressing profound health disparities. For example, Latinos tend to have higher rates of diabetes,[3] which have been linked to far worse COVID-19 outcomes. The increase in food insecurity, which is prevalent in Latino communities, can make controlling diabetes more challenging, which can lead to significant complications like blindness and kidney failure. The health of Latino communities would benefit not only from more health care access points, but also from improving walkability and access to affordable healthy food in Latino neighborhoods and a built environment that supports mental and physical health flourishing.

We are exactly where we were before the pandemic, but with additional stressors and without a well-rounded public health plan for New York's diverse Latino communities. Our post-pandemic rebuild needs to take a holistic approach to what makes communities healthy so that Latino communities flourish and do not revert to recovery approaches steeped in structural racism. Clearly, traditional approaches have not worked and, in fact, have driven generations of health, educational and economic inequities. This will continue to be a struggle if we do not confront the fact that public health policy, particularly in Hispanic/Latinx communities and other communities of color, needs to be restructured and reprioritized. For those leading today and tomorrow New York City must make this a priority. To do otherwise points to a lack of regard for one of New York's foundational components of our city and nation: The Latino community.

Who We Are

The New York City Hispanic/Latinx Health Action Agenda is a result of a community-driven health policy process that brought together over 60 Community-Based Organizations/Agencies and 72 community leaders, faith-based leaders, experienced clinical and non-clinical service providers. Facilitated by the Hispanic Health Network, Hispanic Federation, and the Latino Commission on AIDS, the process started in October 2020 with a series of consultations with key public health leaders, community providers,

and members of health networks with expertise in the health field and Hispanic/Latinx communities. Soon after, steering and planning committees were developed to ensure a broader reach of Hispanic/Latinx community leaders and Hispanic/Latinx serving organizations throughout all NYC boroughs.

In the Spring of 2021, the steering and planning groups engaged in facilitated conversations aimed to reach consensus on key subpopulations and health issues to focus on for this health policy agenda. Additionally, this newly formed network of organizations and leaders sought to fortify Hispanic/Latinx health leadership with a health policy-focused perspective to guide decision-makers and impact legislation, particularly at a moment in which NYC is preparing for a critical municipal election scheduled for November.

Goals

The overarching goal of this NYC Hispanic/Latinx Health Action Agenda is to improve health outcomes among Hispanic/Latinx New Yorkers living throughout all the boroughs while ensuring Hispanic/Latinx participation and inclusion and impacting health policy decision making in order to address health disparities and inequities in New York City. To do so, participants in this process established a conceptual framework to guide the assessment of the health needs of Hispanic/Latinx New Yorkers and develop a set of health policy recommendations.

Framework and Need

This framework takes into consideration the racial, ethnic, economic, educational, cultural, migration history, gender, and linguistic diversity and heterogeneity in the Hispanic/Latinx communities in the U.S. This diversity should be considered when assessing health needs, developing health policies, and providing health services to Hispanic/Latinx communities. This framework also includes a deeper look at the intersections of multiple factors fueling health disparities in Hispanic/Latinx communities in New York City, including structural racism, xenophobia, poverty, language barriers, homophobia, and transphobia. By looking at health needs from this framework, we hope to more accurately capture the differential impact of health inequities among Hispanic/Latinx communities and present more focused health policy recommendations to address the disparate morbidity and mortality rates in our diverse communities.

Hispanic/Latinx Yorkers experience the disproportionate impact of a variety of health conditions such as HIV, viral hepatitis, STIs, diabetes, cardiovascular disease,

respiratory illnesses, cancer, substance use disorders, and trauma, among many other conditions. The COVID-19 pandemic has not only greatly impacted our communities but also exacerbated pre-existing racial and ethnic health disparities.

While the Centers for Disease Control and Prevention (CDC) and state health reports on COVID-19 testing and hospitalization include little to no racial and ethnic data, researchers have analyzed race and ethnicity among those whose deaths are attributed to COVID-19 and found that populations of color are overrepresented.[2, 4, 5] A possible explanation for this disparity is the racial/ethnic and economic structures that increase the risk of exposure (e.g., inadequate paid sick leave, use of public transit, and place of work) and severity of illness (e.g., pre-existing conditions, inadequate access to care, underinsurance). The stark gaps in COVID-19 surveillance data speak to past failures to take racial, ethnic and socioeconomic health inequities seriously.

With the closing of businesses and income insecurity, the COVID-19 pandemic's economic impact has led to a reversal in a five-year trend of declining poverty rates.[6] The Poverty Tracker, launched in 2012 by the Robin Hood Foundation and Columbia University, focuses on four domains to assess poverty - employment and income, housing security, food hardship, and Internet access and remote Learning. In their 2021 report, Hispanics/Latinx New Yorkers had poorer indicators across the four domains when compared to other racial/ethnic groups.[6]

These issues illustrate the need to consider the synergistic impact of structural racism and structural poverty when analyzing causal pathways of health disparities and addressing health inequity. Within the aforementioned conceptual framework of intersectionality embodied in the experiences of our communities, we have aligned the policy discussion and ensuing recommendations with efforts to increase human rights protections, economic justice, racial and ethnic justice, healthcare justice, language justice, and dignity.

Communities are essential to building and overseeing strong healthcare systems, as noted in the 1978 Alma Ata Declaration. Participants and organizations from diverse Hispanic/Latinx communities contributed their expertise and voices to develop the below recommendations to address health disparities and set forth an action-focused health agenda to impact health policy as well as health delivery in New York City. Based on the expert consultations in October 2020 and the subsequent discussions of the steering and planning committees, the policy recommendations focused on the following overarching priorities:

a. Addressing structural poverty as a fundamental barrier for reaching holistic wellness in our communities;
b. Mitigating discrimination and stigmatization (e.g., racism, xenophobia, homophobia, transphobia) within health care systems;

c. Ensuring availability, accessibility, and affordability of health care and prevention services;
d. Ensuring health programs and interventions take into consideration the diversity of the Hispanic/Latinx communities; and
e. Striving for inclusivity and broader engagement of Hispanic/Latinx-led organizations and Hispanic/Latinx community leaders in the development of health policies and programs.

The steering and planning groups convened workgroups charged with articulating their perspectives on local issues, analyzing challenges, and providing recommendations focused on the following populations and issues:

Priority populations:

a. Youth and Younger Adults
b. Older Adults
c. Immigrants
d. Women
e. LGBTQ
f. Incarcerated and Recently Released Individuals
g. People with disabilities

Priority issues:

a. Prevention
b. Access to health coverage, care, and treatment
c. Mental health
d. Substance use
e. Structural barriers: racism, economic inequality, stigma
f. Research and data
g. Leadership in public health and need for inclusivity

II. WHO WE ARE

Latinos have a long and rich history in New York City. Latino cultural and racial diversity in NYC reflects a great number of distinct heritage groups, including Indigenous, African, European, Asian, and other ancestries Understanding the diversity of Hispanics/Latinx in NYC will increase our understanding of the variations in health outcomes among NYC's largest ethnic minority and will help us set better health policies to address the health needs of all New Yorkers.

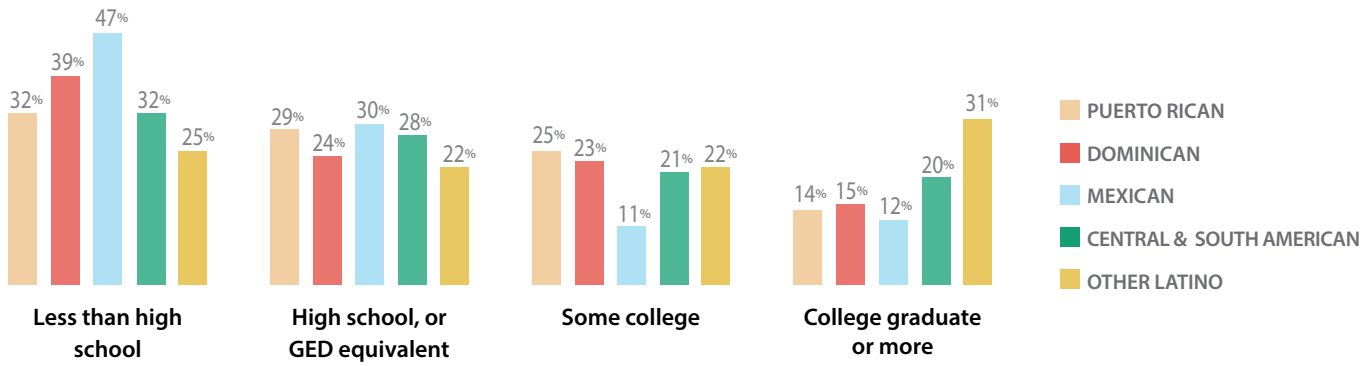
Demographics

- New York City residents who identify as Latino or Hispanic account for nearly a third of the NYC population (32.2% Latino or 2,485,125), a 14% increase from 2000 to 2015.[4]
- The largest Latino heritage groups in NYC are Puerto Ricans (30%), Dominicans (28%), Mexican (14%), and Central and South American (23%).[4]
- Four out of 10 Latinos (42%) were born outside the U.S., with 26% of them arriving in the U.S. in the past 10 years.[4]
- Latinos may identify by their country of origin or heritage rather than by race. In a 2017 NYC DOH report, 7% of Latinos identified as Black/Afro-Latino and 37% identified as White while 55% identified as other.[4]
- Latinos constitute a younger group than non-Latinos, with almost a quarter under 17 years of age (26% versus 19%), over a third under 25 (28% versus 28%), and over two-thirds under 45 years of age (69% versus 60%).[4]
- Given the high percentage of foreign-born Latinos, over 80% of Latinos ages five and older living in NYC speak Spanish at home and 17% speak English only.[4]
- English proficiency is low, even for NYC Latinos born in the U.S. 15% of U.S.-born Latinos in NYC report limited English proficiency compared to 68% of Latinos born outside of the U.S.[4]
- Non-Spanish-speaking immigrants from Latin America include people from Mexico who speak Mixtec, Zapotec, Totonac, Tlapanec, Nahuatl, or Mam depending on their town of origin; Paraguayans who speak Guarani; Ecuadoreans, Peruvians, and Bolivians who speak Quechua or Aymara; Belizean who speak creole; Guatemalan, Nicaraguan, and Honduran who speak Garifuna or Mayan languages; and Brazilians who speak Portuguese.
- While a lower percentage of Latino adults identify as gay, lesbian, or bisexual than non-Latino adults (4% vs. 5%), a higher percentage of Latino youth identify as gay, lesbian or bisexual (12% vs. 9%).[4]
- Most Latinos (77%) identify as Christian (Catholic, Evangelical Protestant, Mainline Protestant, etc.), 2% as Non-Christian (Jewish, Muslim, etc.), and 20% as Unaffiliated (Agnostic, Atheist, etc.).[7]

Social and Economic Conditions

Structural racism in housing, education, and employment opportunities creates concentrations of poverty, unemployment, and poor education outcomes in Hispanic/Latinx neighborhoods. These factors limit availability and accessibility to health-promoting and health care resources, ultimately resulting in poor health outcomes.

- ***Poverty:*** While a third (34%) of non-Latino New Yorkers have incomes below 200% of the federal poverty level, over half (56%) of Latinos have incomes below this level, including 66% of Mexicans and 62% of Dominicans.[4] A high percentage (62%) of recent immigrants (10 years or less in the U.S.) also live under this poverty level.[4]
- ***Education:*** Over a third (35%) of Latino adults in NYC 25 and older do not have a high school education compared with 14% among non-Latino adults, and 84% do not have a college degree compared to 58% among non-Latino adults.[4] The table below shows education by country of origin or heritage.[4]



- ***Food Insecurity:*** Food insecurity is expected to rise by 54% citywide during the pandemic—and 64% among children, according to Feeding America.[7] However, hunger does not fall equally across the city. It hits particularly hard in the communities of color that have been disproportionately harmed by decades of policy inequities and systemic failures.[7]
- ***Incarceration:*** Incarceration has a detrimental impact on mental and physical health, not only for those incarcerated but also for their families and communities. Latino New Yorkers are more likely to be incarcerated than all New Yorkers (168 per 100K versus 141 per 100K).[4] In particular, young Latino males continue being the target of police, including through the stop-and-frisk policy.[9] Latinos also experience higher rates of detention and lengthy pretrial confinement in jail.[10]

III. HEALTH DISPARITIES

Health insurance: More than one in five (22%) Latino adults have no health insurance compared to 1 in 10 non-Latino adults.[4] In particular, close to a third (30%) of foreign-born Latino adults, 45% of recent immigrants, and over half (54%) of Mexicans do not have health insurance.[4]

Health care access: Limited or no access to medical care, including visits, procedures, prescriptions, and hospitalization, is higher among Latinos than non-Latinos (12% versus 9%).[4] Similarly, Latinos are less likely to have a primary care provider than non-Latinos (24% versus 16%), particularly among foreign-born (31%), recent immigrants (40%), and Mexicans (48%).[4]

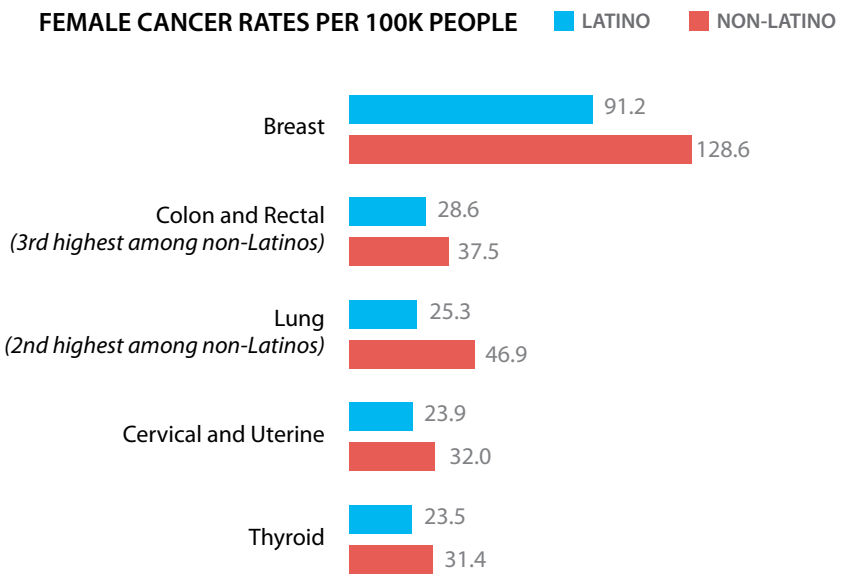
Dental Health: While oral health is an essential part of overall health, only over half (54%) of Latinos have visited a dentist in the past year, including less than a third (32%) of Mexicans.[4]

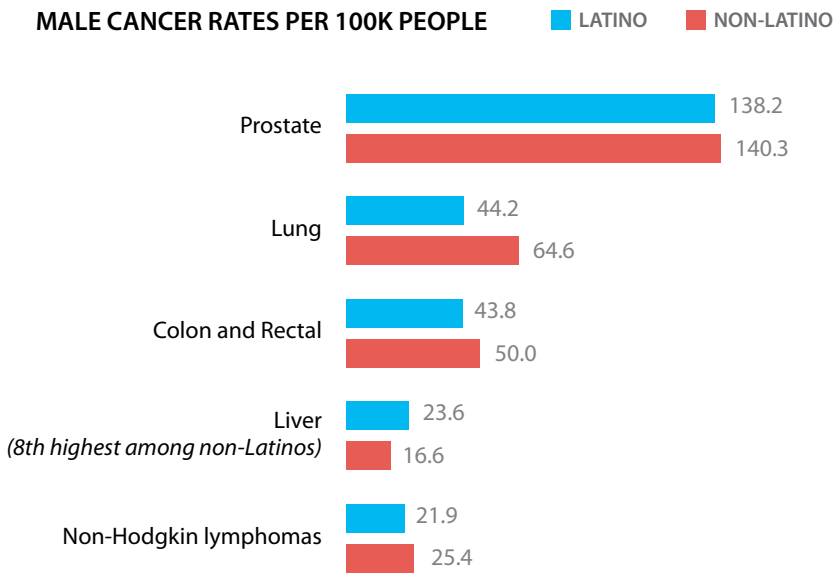
IV. HEALTH INDICATORS

- ***General Health:*** Self-reported general health, people's perceptions of their physical, mental and emotional health, is a good indicator of overall health. Fewer Latinos reported their health as being "excellent," "very good," or "good" than non-Latinos (65% versus 81%).[4]
- ***Obesity:*** Obesity often leads to serious health problems, including diabetes, high blood pressure, and heart disease. Nearly a third of Latino adults are obese compared to about a fifth of non-Latinos.[4] Similar disparities are seen among NYC public high school students (approximately 15% vs. 11%).[4]
- ***High Blood Pressure:*** While Mexican and Central and South American Latino adults have similar prevalence of high blood pressure to non-Latinos (about 26%-27%), Puerto Rican and Dominican adults have a higher prevalence of high blood pressure (37% and 38%).[4]
- ***Asthma:*** The prevalence of adults who have ever had asthma is lower among Mexicans compared with non-Latinos (6% versus 10%). However, the prevalence of asthma is nearly three times as high among Puerto Ricans (27%) and U.S.-born Latinos (27%) than among non-Latinos (10%).[4] One in six Latino children ages 0-12 (15%) and over a quarter (28%) of Latino high school students have asthma.[4]
- ***Leading Causes of Death:*** While most causes of death are similar between Latinos and non-Latinos, there are some differences in the death rates. See table below.[4]

CONDITION	LATINO RANK	LATINO RATE PER 100K PEOPLE	NON-LATINO RANK	NON-LATINO RATE PER 100K PEOPLE
Cancer	1	139.5	1	181.5
Flu/Pneumonia	2	111.6	2	139.4
Diabetes	3	22.9	3	24.1
Stroke	4	20.9	5	19.1
Lower Respiratory Disease	5	18.4	6	17.8
Lower Respiratory Disease	6	16.8	4	19.3
Alzheimer's	7	11.1	10	7.4
Unintentional *(non-drug-related)*	8	10.2	8	10.2
Hypertension and hypertensive renal disease	9	10.1	7	10.7
Unintentional *(drug-related)*	10	9.5	9	8.2

- ***Cancer:*** The most common types of cancer among Latinos and non-Latinos are similar, except liver cancer, which is more common among Latino than non-Latino men. See table below.[4]





- ***COVID-19:*** Hispanics/Latinx in NYC have the highest number of COVID-19 cases, hospitalizations, and deaths throughout the city and per borough.[2]
- ***HIV:*** The rate of new HIV diagnoses among Latinos is higher than the rate among all New Yorkers (36.3 versus 29.2 per 100K).[4] Latinos are also less likely to have achieved viral suppression than White New Yorkers (87% versus 94%).[11]
- ***Diabetes:*** Latino adults present higher rates of diabetes than non-Latino New Yorkers (17% versus 10%), with higher rates among Dominicans (20%) and Mexicans (24%).[4]
- ***Mental Health:*** Similar percentages of Latinos and non-Latinos report needing mental health treatment but not receiving it (4% versus 3%).[4] On the other hand, a higher percentage of Latinos (8%), particularly Puerto Ricans (12%) and U.S.-born Latinos (11%) report serious psychological distress than non-Latino adults (5%).[4]

V. RECOMMENDATIONS BY POPULATION

1. YOUTH AND YOUNGER ADULTS

When addressing health among youth and younger adults, it is important to take into consideration social determinants that will have an impact on their health outcomes. According to Pew Hispanic,[12] 32% of Latinos are less than 18 years old, and 26% are Millennials, between 18 and 33 years old. This group has unique challenges that span not only the impact of fast technological advancements on their mental and physical health, but also the impact of economic and social issues. Improving safety, education access, air quality, and income are some of the important factors that influence health outcomes. While there are many recommendations that can make an impact, we have selected those that we feel are feasible, concrete, and provide positive results in our efforts to increase positive health outcomes.

NUTRITION AND PHYSICAL ACTIVITY

According to the CDC, students who are physically active and have high physical fitness tend to perform better. Yet "less than one-quarter (24%) of children 6 to 17 years of age participate in 60 minutes of physical activity every day.[13]" In the United States, there has been a significant increase in obesity, which has brought along a significant increase in type 2 diabetes. Physical activity and healthy eating can delay the onset of type 2 diabetes.

1. Conduct a needs assessment to help develop programs that address racial/ethnic disparities in access to green spaces, including walking areas, public parks, roof or vertical gardens, and community gardens/urban farms.
2. Provide hands on nutrition education along with healthy food options in schools. Learning to make healthy snacks and meals can increase the uptake of health habits. Reducing unhealthy options will also increase intake of healthier foods.
3. Increase safe green spaces in low-income neighborhoods, increase affordability of bike share programs to incentivize physical activity, and increase safety measures and bike lanes in low-income neighborhoods.
4. Reduce Food deserts and increase access to fruits and vegetables by providing funding to build community-run farm stands. Provide fresh food vouchers for green markets.

ACCESS TO CARE

The economic impact of the COVID-19 pandemic has especially affected young adults. With unstable jobs and/or the loss of jobs. Many have also lost their health insurance and have delayed engaging with medical providers. Regular and easy access to care, including preventative care, is imperative to maintaining healthy communities.

1. Expand built-in clinics within schools to provide comprehensive and holistic services, including those related to sexual health, mental health, and transgender health.
2. Increase promotion of mental health texting, chat rooms, and telehealth for youth, such as *NYC Well*. Due to limited health insurance access and low provider engagement among youth and younger adults, these newer modes of engagement are an asset to improving health outcomes.
3. Increase awareness of existing programs and safe spaces for youth through social marketing campaigns and in-school promotion.
4. Ensure that name or gender changes among Trans and Gender Nonconforming (GNC) youth do not create barriers to accessing preventative and mental health care.

MENTAL AND BEHAVIORAL HEALTH

The pandemic has had a devastating impact on mental, social, and emotional well-being among youth and younger adults. There is an urgent need to address mental and behavioral health, and the domino effect it will have on our communities.

1. Allocate resources for addressing anxiety, depression, self-harming behaviors, bereavement and grieving, and trauma among youth.
2. Increase and improve access to acute mental health services, including for those without access to health insurance.
3. Update sex education policies to mandate general sex education, enhance mandated HIV/AIDS instruction, and include harm reduction in addition to abstinence.
4. Assess and address the impact of COVID-19 on youth with special physical, mental, and educational needs, particularly due to inability to access services, complete coursework, or participate in after-school programs.
5. Increase/expand substance use and prevention programs within schools, including making educational materials on vaping, tobacco, and alcohol and substance use readily available.

2. OLDER ADULTS

In New York City, the 65 and over population is expected to increase by almost 16% over the next ten years. It is essential that NYC has services in place to meet the pressing needs of this growing segment of the population. Out of the 1.1 million older adults in NYC, 12% identify as Latino; nearly 50% of older New Yorkers are immigrants, with the second most common country of birth after China being the Dominican Republic.[14]

Immigrants make up the fastest growing group of the elderly, and many have limited English Proficiency and live in poverty.[15] With 20% of older adults in NYC speaking Spanish at home, the need for culturally competent and linguistically relevant services and information is critical.[14] Having translated materials available is not enough. There must be intentional outreach to ensure translated information is reaching those that need it. New York must create an expansive health campaign focused on disseminating information about available health services/benefits and education around preventable diseases. This will help increase access to health coverage, care, and treatment. Additionally, the city must employ professionals within at-home care and in nursing homes that are fluent in Spanish.

The next mayoral administration must ensure elderly Latinos obtain medical care, prevention services and information, and work to destigmatize mental health to safeguard the overall health and wellbeing of the aging population. Creating a city where Latino New Yorkers can age with dignity will require a holistic approach. Meeting their needs will require that successful programs are scaled up and new programs are created with the input and partnership of community-based organizations.

POST COVID-19 CARE

While many seniors have stayed safe during the pandemic by remaining at home, they have faced increased social isolation and loneliness, which can result in anxiety, depression, and other mental health conditions.

1. The Department for the Aging's Geriatric Mental Health Initiative requires more city funding to provide linguistically and culturally relevant services to:
    a. Screen individuals for depression and provide on-site counseling and referrals to mental health practitioners; and
    b. Address bereavement related to intense anxiety and depression due to lack of traditional grief or appropriate closure related to loved ones lost to COVID-19.
2. The city must also make investments to increase COVID-19 health literacy and vaccination campaigns in Spanish and other native languages through traditional media as well as within senior centers.

ACCESS TO LINGUISTICALLY AND CULTURALLY COMPETENT IN-HOME CARE

There are countless benefits to allowing individuals to age in their homes as opposed to nursing facilities. It is better for the individuals' mental health, and it saves millions of dollars in health care expenditures. However, the demand for home care workers currently exceeds the supply. Home care work is poorly paid and emotionally and physically exhausting. NYC needs to make public investments to incentivize the field in addition to hiring workers that can meet the linguistic and cultural needs of the aging population.

1. The NYC minimum wage for home care workers should be increased to $27.50 per hour ($50,000 annually). The city's economic gains through income taxes will make this a worthwhile investment.[16]
2. With Chinese and Spanish being the most in-demand languages for home health care, creating a modest sign-on bonus ($1,000) for home care workers that can speak these languages will further incentivize this work.
3. Many home care workers currently receive Medicaid and any increase in wages would leave them without health coverage. Therefore, it is crucial the city ensures any wage increase is met with expanded health insurance.
4. Lastly, to enhance culturally competent care for the Latino elderly population, NYC must increase its funding for Expanded In-home Services for the Elderly (EISEP) so there are more linguistically trained case managers to help older adults and their families arrange for non-medical supplementary services.

COMMUNITY EDUCATION & ENGAGEMENT

NYC has over 250 senior centers and 27 Naturally Occurring Retirement Communities (NORCS) throughout the city providing social services, health care, mental health services, legal and financial services, benefits screenings, educational and cultural opportunities, recreational trips, and hot meals. These centers are a home away from home for many seniors. The presence of these centers across the city can serve as a vehicle for increased culturally relevant community education programs on a variety of health topics such as nutrition and preventable diseases. Facilitating workshops on health and mental health issues and chronic conditions, providing connections to health screenings, and helping individuals select a primary care physician and/or specialist are crucial prevention services the elderly Latino community desperately needs. The city must invest in the expansion of these centers, increase community partnerships, and strive to meet the needs of the elderly in every borough.

1. Sixteen of the city's senior centers are considered "innovative senior centers." These centers provide expanded programming and services and expanded hours to serve the broader community. The Department for the Aging (DFTA), which oversees senior centers, spends about 45% of its budget on senior center programs. Studies show that the top reason why seniors do not participate in

their local senior center is due to location, with further research showing that many senior centers are located in areas without a high concentration of the elderly. The city must increase DFTA's budget by 10% to create additional innovative senior centers in convenient locations for the elderly that can provide the following:

   a. Multilingual health workshops, classes, and services to:
      i. Increase community awareness on Alzheimer's, diabetes, cancer, and other chronic health conditions.
      ii. Link seniors with routine screenings for cancer, Alzheimer's, chronic health conditions, and infectious diseases.
      iii. Address the technology gap so seniors can utilize their digital devices to access tele-health services.

2. Senior centers leverage community partnerships with nonprofits to provide services. The city should partner with houses of worship to increase reach and services to the elderly Latino community.
3. To further bolster community education and engagement, the city must increase funding to CommunityCare Link, created by the Aging in New York Fund, the Department for the Aging's nonprofit arm. This program links health care providers with community partners to treat patients, provide self-management classes, and provide holistic medical care. Partnerships with community-based organizations that already work to meet the needs of the community can help provide increased culturally competent health services to the elderly.

3. IMMIGRANTS

Immigrants are vital to the fabric of New York City. During the height of the COVID-19 pandemic, they were the essential workers keeping our city running. However, undocumented essential workers—many of them Latinos—were largely left out of the aid they desperately needed such as stimulus support, unemployment assistance, and other benefits. Among the disparities highlighted during the pandemic, lack of appropriate access to healthcare in immigrant and Black and Brown communities was at the top of the list. The hardest hit communities were those where large percentages of immigrants lived. To this day, access to healthcare remains the largest barrier for undocumented immigrants leading healthy lives.

There is a myriad of challenges that immigrants face when accessing healthcare, from immigration status to lack of culturally competent services. To ensure that immigrants, particularly undocumented immigrants, live full and healthy lives, New York City must **(1)** address social determinants of health, including structural barriers that specifically affect immigrants; **(2)** think thoughtfully about access to healthcare and prevention strategies; and **(3)** build deeper knowledge of additional barriers and needs of immigrant communities through data and research. We have outlined several recommendations within each category that will take the first step toward creating a New York City that will safeguard the health of all New Yorkers, not just those who were born here.

ADDRESS SOCIAL DETERMINANTS

For immigrants, particularly undocumented immigrants, social determinants are the main barrier to health. Of these barriers, immigration status is the largest. According to the Mayor's Office of Immigrant Affairs 2020 Annual Report, 46% of undocumented immigrants are insured compared to 93% of NYC's total population.[17] Other barriers include financial stability, access to immigration legal services, lack of affordable housing. Below are recommendations to address some of these barriers.

1. Increase legal and financial resources for immigration services, including assistance with paying high application fees for naturalization, DACA, and TPS. Paying for these applications is a barrier for many immigrants. Providing financial assistance and awareness about fee waivers offered by USCIS will encourage many to take the next step toward applying for immigration benefits.
2. Provide economic relief to communities, particularly undocumented immigrants, by expanding access to New York City cash assistance, food stamps, and other benefits for which they are currently ineligible.
3. Increase tenant protections and provide additional free legal services for immigrants facing illegal evictions, especially during and after the pandemic. It is also vital to increase and expand rent relief programs across the state to support families who have lost their primary earners or their livelihoods during the pandemic.
4. Close the technology gaps by increasing access to free hotspots and computer training for low-income immigrant communities so that everyone can have access to the internet.

ACCESS TO HEALTHCARE & PREVENTION METHODS

Immigrant communities need proper access to healthcare. This includes executing targeted and linguistically appropriate community education campaigns about health resources available to immigrants, particularly undocumented, in New York City.

1. Continue to support and expand NYC Care public health insurance options that cover undocumented and low-income immigrants.
2. Increase efforts and resources to assess and address food insecurity among immigrants. This should be coupled with educational programs and nutrition interventions that promote healthy eating and access to healthy foods within immigrant communities.
3. Increase health literacy about routine screenings and prevention care to ensure that immigrants take preventive action with their health. The city should create and deploy large scale, community-based, culturally and linguistically appropriate campaigns regarding annual health screenings, particularly for cancer and dementia, as well as preventive services, such as annual vaccinations.

4. Increase availability of linguistically and culturally competent mental health services to address grief, family separation, and other indirect impacts of the COVID-19 crisis. Implement campaigns and education programs to address mental health and substance use stigma and enhance coordination and integration of physical health and behavioral health services.

RESEARCH & DATA

Immigrants are not a monolith. What affects one group of immigrants may not affect another. It is vital to fully understand the needs of each immigrant community by conducting necessary research and data collection.

1. Conduct community mapping to identify the needs of different Hispanic/Latinx subgroups, for instance based on place of birth, language, and immigration status. Conduct a thorough assessment of Census 2020 data for NYC to assist with this mapping and accurately reflect the diversity of the Hispanic/Latinx population.
2. Evaluate the cost-effectiveness of providing universal preventative healthcare to immigrants, particularly undocumented immigrants, through the Mayor's Office of Immigrant Affairs.
3. Examine and address disparities in availability of services in immigrant communities, including pharmacy locations across NYC, food desserts in particular neighborhoods, and locations of health centers.
4. Examine domestic and interpersonal violence within immigrant families.
5. Examine how immigrant families are coping with grief and separation during and post the COVID-19 pandemic, and evaluate what kinds of culturally relevant mental health services are available and needed.
6. Obtain data on homeownership among Hispanics/Latinx from the Census 2020 and the number of unhoused immigrants pre-and post-pandemic to further understand the impact that lack of housing has had on immigrants.
7. Assess the economic fallout the COVID-19 has had on individuals and identify the various kinds of economic support needed.

4. WOMEN

Latinas are an integral part of the fastest growing minority group that makes up the City of New York. Latinas are also an important part of NYC's workforce. Given that health and illness are differentially and culturally experienced by men and women, a comprehensive understanding and account of health and healthcare disparities that considers gender differences is needed.[18] Health information specific to Latinas and distinguished by gender holds promise for a targeted and refined understanding of health disparities. Describing health disparities based on ethnicity and gender can impact professional and public awareness and raise important considerations for health and social policy. Collecting and analyzing data on the barriers affecting women will inform efforts to overcome these barriers and increase the overall quality of health among Latinas in New York City.

Disparities in healthcare are prevalent for Latinas. This rapidly growing segment of the population has not equally benefited from the remarkable advances in healthcare. Latinas, furthermore, have historically played an invisible role in the policy arena. This invisibility must be rectified. Health and social policy designed to take action against health and healthcare disparities for Latinas is long overdue. It is critical to frame health and healthcare disparities for Latinas of NYC as a social justice issue and encourage legislators to catalyze political action in a humanistic and justice-oriented manner.

COVID-19

1. Evaluate the long-term health consequences of COVID-19 and the availability of treatments for our community.
2. Increase public awareness of the benefits of being vaccinated for COVID-19 rather than focusing on the negative side effects.
3. Assess the long-term impact of COVID-19 diagnosis on women's health.

ACCESS TO CARE

1. Expand health care for low income and undocumented women.
2. Increase transportation assistance for health appointments
3. Establish NYC Women's Clinics similar to the Sexual Health Clinics and Teen Clinics

COMMUNITY EDUCATION

1. Address community fear and concerns regarding certain diagnoses, including mental disorders, substance use, and HIV.
2. Increase community health education outside the consultation room.

3. Address domestic, gender-based, and sexual violence and launch public education efforts regarding available resources specifically targeted to reach women.
4. Increase health literacy, particularly with engaging in preventative health, minimizing symptoms, and obtaining routine screenings.

LANGUAGE AND CULTURE

1. Ensure the health care system takes into consideration a patient's needs, language access, language justice (the right to have their voices heard), health literacy, holistic approaches, religious practices, childcare, and gender specific needs.
2. Include and increase cultural and language appropriate training components for the mental health workforce.

5. CHILDREN AND FAMILIES

Many of the health related disparities among children and families are related to access to safe spaces, learning spaces, and support services. One in 10 students in NYC public schools are experiencing homelessness, which impacts access to healthy meals and health care, and creates barriers to learning.[18]

According to the Centers for Disease Control (CDC), the national average rate of childhood obesity has tripled since the 1960s,[20] and over 43% of public elementary school children in New York City were overweight or obese.[21] Poverty correlates with single parent homes, and studies have concluded that children who grow up with continuously married parents have better access to resources than children who grow up with single or separated parents. Hence, it is important to address the family health needs as a whole. The below recommendations aim to address not only the state of family health but also those factors that impair positive health outcomes among children.

COVID-19

The COVID-19 pandemic has greatly impacted children and families. From changes in schooling and learning to safety within homes, and even loss. In order to address the impact that this will have in our society, New York City must:

1. Develop research tools and conduct studies to assess the pandemic's impact on mental health, school success, and behavior.
2. Address the impact of COVID-19 on children's isolation, addiction to social media and video games, and peer socialization by developing incentivizing and engaging programs and activities.

ADDRESS SOCIAL DETERMINANTS

An array of factors will determine health outcomes for children and their families. Addressing these factors at an early age will help determine the future of our society.

1. Address language and cultural barriers for navigating the school system, providers, and services by enhancing multilingual communication between parents and the school system.
2. Increase community education on parenting and Child Abuse Prevention to prevent families from becoming involved with ACS.
3. Increase support for parenting programs within local communities (e.g., Familias Unidas program "Escuelita en Casa").
4. Make vacant housing units available to families while they relocate, resolve housing complaints in a timely manner.
5. Implement stricter policies to increase/strengthen housing protections, particularly concerning safety conditions and reporting property owners.
6. Provide in-person and online training for parents on using virtual platforms to access education and health care services.
7. Conduct a comprehensive and complete study on child trafficking that will address this ever-growing concern.

NUTRITION AND PHYSICAL EXERCISE

According to the New York Lawyers for Public Interest, "less than 30% of Kindergarten through third grade students are not receiving enough PE instruction. On average, only one in 5 third graders in New York City receive the required amount of physical education instruction.[22]

1. Emphasize the importance of physical activities during school days and increase resources for physical activities within the school system and after school programs, including funding for certified physical education teachers
2. Ensure that schools follow physical activity requirements for all students through regular, ongoing monitoring.
3. Expand parks and open spaces in marginalized neighborhoods in order to address the high rates of Asthma and early childhood obesity.

COMMUNITY EDUCATION

Health information saves lives and many families do not have access to it. Aside from language and cultural barriers, isolation and service agency red tape create additional obstacles to accessing health information.

1. Support community-based navigator programs that help with accessing benefits and health services.
2. Increase substance use services for parents to ensure families remain healthy and safe, and expand awareness campaigns on substance use across the city, including alcohol and tobacco and its impact on family health.
3. Provide comprehensive trauma-informed behavioral health services to all immigrant children who have crossed the frontier and relocated to the NYC area.

6. Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, and Asexual (LGBTQIA+)

LGBTQIA+ Latinos face health disparities linked to societal stigma, discrimination, homophobia, transphobia, xenophobia, and denial of their civil and human rights from society as a whole as well as from the non-Hispanic/Latinx LGBTQIA+ community.

Discrimination against LGBTQIA persons has been associated with higher rates of psychiatric disorders, substance abuse, and suicide.[23] Experiences of violence and victimization are frequent for LGBTQIA+ individuals in the U.S.[24] For those coming from outside the United States, their own experiences of fleeing their countries of origin have long-lasting effects on the individual and the community. Personal, family, and social acceptance of sexual orientation and gender identity affects positively the mental health and personal safety of LGBTQIA+ individuals.[25]

1. Increase research that seeks to understand the U.S. and foreign-born experiences, racial/ethnic make-up, reasons for coming to the U.S., and the national origins of our LGBTQIA+ communities.
2. Research the intersectionality of being a member of the LGBTQIA+ community and medical and mental health, the judicial and criminal justice system, health decisions, and resulting health outcomes.

HEALTH DISPARITIES

LGBTQIA+ individuals are more likely to experience heart disease, certain cancers, substance abuse, suicide attempts, and sexual behaviors that place them at higher risk for poor health.[26] For instance, while heart disease remains a significant concern for all, factors that raise women's risk for heart disease include physical inactivity, obesity, and smoking—all of which have been found to be more prevalent among lesbians than other women.[27] Gay men are at increased risk for several types of cancer—including prostate, testicular, and colon cancers.[28] In addition, gay men are at higher risk for anal cancer due to an increased risk of acquiring human papillomavirus (HPV) through anal sex.[28] Lesbians are at a significantly higher risk for developing breast cancer than heterosexual women with risk factors such as fewer full-term pregnancies, fewer mammograms and/or clinical breast exams, and being overweight.[29]

The fact that men who have sex with men (MSM) are at an increased risk of HIV infection has been well documented. In 2019, 70% of new HIV infections in the U.S. were among gay and bisexual men.[30] The HIV/AIDS epidemic has had a significant effect on transgender people. However, due to a lack of systematic surveillance and reporting of HIV, the exact prevalence of HIV among transgender people remains unknown. Prevalence rates of other infectious diseases among transgender people are not well known. However, limited studies have found high rates of hepatitis B and C among specific samples of transgender women.[31]

However, access to screening and treatment services may be severely limited or compromised due to concerns about receiving culturally sensitive and appropriate care.

1. Work to eliminate disparities in HIV and non-HIV health care access of Latino LGBTQIA+ communities by increasing the availability and quality of culturally and linguistically sensitive health care services.
2. Provide supports for effective behavior-based comprehensive sexual health that includes alcohol, substance use and mental health counseling to address the needs of Hispanic/Latinx gay men/men who have sex with men (MSM), lesbians/women who have sex with women (WSW), persons who have sex with multiple genders, and transgender individuals.
3. Provide capacity building to clinical and non-clinical service providers on health and mental health issues affecting LGBTQIA+ Hispanics/Latinx
4. Increase community awareness of the health and human services for LGBTQIA+ Hispanic/Latinx communities across New York City.
5. Establish a Center to specifically address health disparities in LGBTQIA+ Hispanics/Latinx and other communities of color.

DOMESTIC, GENDER-BASED, AND SEXUAL VIOLENCE

LGBTQIA+ report experiences of harassment and physical violence more often than their heterosexual counterparts. For instance, lesbian or gay and bisexual adults are more likely to report experiencing intimate partner violence when compared to straight adults.[32] Violence against transgender people, especially transgender women of color, continues to occur in the United States at high rates. Intimate partner violence has also been found to be a prominent concern for transgender people.[34] Social stigmatization and other factors may additionally lead to under-reporting of violence against transgender people.

1. Expand public education efforts regarding existing resources that address domestic, gender-based, and sexual violence.
2. Provide programs that increase job readiness targeted for the LGBTQIA+ community to promote financial freedom and economic self-sufficiency
3. Ensure implementation of laws that protect LGBTQIA+ individuals from employer discrimination
4. Ensure providers serving the LGBTQIA+ community routinely assess all clients for a history of domestic violence and/or victimization.

MENTAL HEALTH AND SUBSTANCE ABUSE

Many factors affect the mental health and substance use of LGBTQIA+ individuals, including traumatic reactions from parents and caregivers in response to coming out, daily social stigmatization, overt discrimination, and violence.[35] Often, overlapping experiences of discrimination, including those based on race/ethnicity, sexual orientation, and gender identity, have an exacerbated detrimental impact on mental health outcomes among LGBTQIA+ communities.[36]

A variety of factors are associated with lack of access and/or utilization of behavioral health services among Latinx/Hispanic indivuals, including limited availability of services or insurance coverage, limited English proficiency, stigmatization of mental illness and substance use, family and community views on behavioral health, and lack of social support to engage in services.[37] In addition, those who are LGBTQIA+ may experience additional prejudice and discrimination in accessing and using these services due to assumptions and heteronormative in the health care system.

1. Increase access to culturally and linguistically appropriate mental health and substance use services.
2. Provide trainings to mental health and substance use providers about cultural sensitivities for working with the LGBTQIA+ population.

7. INCARCERATED, RECENTLY RELEASED AND RECIDIVISM

Incarcerated individuals and those recently released from the criminal justice system are disproportionately affected by substance abuse, mental illness and chronic health conditions. Unfortunately, they receive inadequate health care before, during, and after incarceration. Delivering improved health care services upon reentry and in detention and correctional facilities can improve the health outcomes of this population. Incarcerated and formerly incarcerated individuals have often experienced traumatic events that lead to substance abuse and mental illness; their contact with the criminal justice system further exacerbates these existing issues. The next mayoral administration must allocate funding and resources to support the health and wellbeing of this population while incarcerated and after release.

ACCESS TO CARE AFTER RELEASE

New allocations to programs currently administering critical services to this population can increase the city's capacity to meet these needs. NYC Health + Hospitals' Correctional Health Services (CHS) program is a pivotal partner in the city's criminal justice reform efforts, providing reentry services and alternatives to incarceration. CHS's Point of Reentry and Transition (PORT) program was created to help support and sustain successful community reentry. This program includes community health care workers who help patients connect with health care at partner hospitals and clinics specifically for this population to promote the continuity of care after release.

Research indicates that the formerly incarcerated population has higher rates of morbidity than the general population. Incarceration has been linked to anxiety, depression, post-traumatic stress disorder (PTSD), self-harming behavior, sleep disturbances, and social withdrawal. Upon release, individuals with mental illness are 12.5 times more likely to visit the emergency room or die within the first few weeks of community reentry. They experience various barriers to health care such as lack of health coverage and supportive reintegration services. These gaps can be met by:

1. Ensuring continuity of health insurance coverage.
2. Providing comprehensive health care to people who have been incarcerated in NYC, including screenings, treatment, and medications.
3. Providing mental/behavioral health resources to people who have been incarcerated and their families to address the ensuing trauma of incarceration.

HEALTH EDUCATION & SCREENINGS TO ADDRESS MENTAL HEALTH & REDUCE CHRONIC DISEASES WHILE INCARCERATED

NYC Health + Hospitals' Correctional Health Services (CHS) program has become a direct provider of health care in city jails. CHS's Jail Health Services offer a full range of health care to those in the custody of the NYC Department of Correction including medical and mental health care, substance use treatment, geriatric care, dental care, pharmacy services, social work services, and discharge planning and reentry services.

Yet, incarcerated individuals still have a higher burden of diseases such as hypertension, diabetes, asthma, tuberculosis, HIV, hepatitis, substance abuse and mental illness. Heart disease and HIV are the leading causes of death in NYC jails (23% and 18.7% respectively) followed by suicide (11.4% of deaths) and substance abuse (10.2% of deaths).[39] NYC must allocate significant resources to in-prison treatment and prevention of these issues by:

1. Ensuring informational materials that provide linkage to care on behavioral health are provided in all prison centers.
2. Increasing workforce and pharmacy capacity to provide health care within the justice system, including health care/insurance navigators and case managers.
3. Expanding mental health and chronic diseases screening, treatment, and management within the justice system.
4. Allocating additional resources to the NYC's CHS program.
5. Providing additional funding to the NYC Department of Correction to support nonprofit organizations and programs that can collaborate with the NYC Health + Hospitals' Correctional Health Services program to further enhance its capacity and services.

CURBING RECIDIVISM AND EASING MASS INCARCERATION BY CREATING ALTERNATIVE RESPONSES TO MENTAL HEALTH CRISES

NYC must assess the range of responsibilities that fall on the police; mental health, substance abuse, and homelessness are issues that require alternative responses. Between 2017 and 2019, just 13% of calls to the NYPD were for "verifiable crimes in progress," nearly 50% were for low-level or ambiguous incidents.[40] This greater share of 911 calls should be sent to emergency response teams outside of the NYPD. Doing so will provide individuals in need more thoughtful and helpful responses to their emergencies. The next mayoral administration can create alternative responses by:

1. Training NYPD to recognize and respond to situations related to mental health and substance use as health issues rather than as criminal acts.
2. Transfer homelessness, mental health, substance use, wellness checks, and other 911 calls and responsibilities to non-police crisis response teams at a newly formed NYC agency or agency department that liaises with community-based organizations and mental health professionals.

COVID-19: THE INCARCERATED AND RECENTLY RELEASED

COVID-19 in NYC jails was incredibly prevalent, with a high number of infections among the nearly 6,000-person incarcerated population.[41] Additionally, the rollout of the vaccine at correctional facilities has lagged, and nearly five months after vaccinations started being administered, not all of the incarcerated individuals have been vaccinated. To rectify these issues the administration must boost funding to the NYC Department of Corrections to:

1. Make personal protection equipment (PPE), COVID-19 information, testing, and vaccination readily accessible to inmates as well as create enough spaces to practice social distancing.
2. Assess the impact of COVID-19 on the inmate population.

VI. GENERAL RECOMMENDATIONS

New York City is facing the worst economic crisis in at least a generation. More than half of City households have experienced a lost job or lost wages during the pandemic. One in 5 New Yorkers have had serious trouble affording food since the pandemic started, and an estimated 1.2 to 1.3 million residents are unemployed.

People of color have suffered the most during this uncertain time. Black and Latinx households have had much higher rates of food and housing insecurity, and Asian households and women have experienced record job loss. Nearly a third of households with incomes below $50,000 were food and housing insecure. In addition, businesses owned by people of color have had the hardest time accessing aid and have been the most likely to close during the pandemic.

TARGET AND EXPEDITE JOB CREATION:

- Promote local hiring of residents in communities with high unemployment and poverty rates and support programs that diversify the workforce.
- Build robust workforce training sites in impacted neighborhoods and partner with neighborhood-based organizations to run training programs.
- Streamline workforce development spending to ensure these new jobs go to the New Yorkers who need them most.
- Expedite and target these investments to ensure that recovery happens quickly and equitably, targeting underserved communities throughout the city to boost employment and improve infrastructure in these neglected areas.
- Target and expedite job creation by implementing policies that promote local hiring, especially in communities of color.

The COVID-19 pandemic exposed many of the inequities and challenges facing our city, none more so than the need for quality, affordable and accessible health care options for all New Yorkers. During the pandemic, hospitals and health centers were overwhelmed and understaffed and far too many New Yorkers were left with staggering medical bills due to lack of health insurance.

As we work our way out of this crisis, we must take steps to ensure access to health insurance for every single New York City resident, regardless of wealth, zip code, or status. While NYC has a rich network of public hospitals and community health centers, their services do not fully close the gap. Despite the mental, physical, and social toll of being uninsured, cost is still a barrier and health insurance is beyond the reach of many families.

Currently, at least 600,000 New Yorkers are without health insurance, 350,000 of whom have no pathway to affordable care. Many of these uninsured New Yorkers live in low-income areas and communities of color, where health care disparities are the most pronounced. At the height of the pandemic, nearly 88% of all deaths in the city were New Yorkers of color, a staggering and shocking statistic that emphasizes the need for change.

- Establish a Universal Health Coverage Plan that will cover health, substance use and mental services, that could include a sliding fee scaled, a City-sponsored plan to offer affordable health insurance.
- Enable affordable coverage to all New Yorkers, including those who currently have no pathway to acquiring health insurance, regardless of income or immigration status, to meet the immediate needs of uninsured New Yorkers.
- Enroll more people in a government-sponsored plan, moving us closer to realizing health care as a right.
- Encourage greater participation from undocumented New Yorkers wary of participating in publicly run programs.

VII. AGENDA PLANNING PROCESS

WHY COMING TOGETHER TO DEVELOP A NYC HISPANIC/LATINX HEALTH ACTION AGENDA:

We recognized the timely importance of launching a New York City community-led process to develop "Setting our Agenda," a Health Action Agenda that effectively meets the health challenges faced by the Hispanic/Latinx communities in our beloved city.

Our community-led model created a space for communities to reach broad consensus on key health issues, and our action-driven process allowed us to design a path for improved health and wellness in our diverse and growing communities. Our mission was to develop an inclusive community-led and action-driven health policy agenda by and for the Hispanic/Latinx communities of New York City. The process engaged clinical and non-clinical professionals, faith-based representatives, community leaders, and advocates from throughout all five boroughs.

Setting our Agenda was a community-led process informed through the lenses of:

- Addressing Poverty with Economic Justice
- Social and Health Equity
- Racial, Ethnic, and Language Justice and Equity

LEADERSHIP STRUCTURE

1. Steering Committee
2. Planning/Organizing Committee
3. Population-based Workgroup Committees

These committees came together to brainstorm and develop population-based recommendations and action steps.

HISPANIC/LATINX POPULATION-BASED WORKGROUP COMMITTEES:

1. Youth and Younger Adults
2. Older Adults
3. Immigrants
4. Latinas
5. LGBTQI+ Latinx
6. Individuals Incarcerated or Recently Released
7. Children and Families

Each population workgroup looked at a myriad of issues that included:

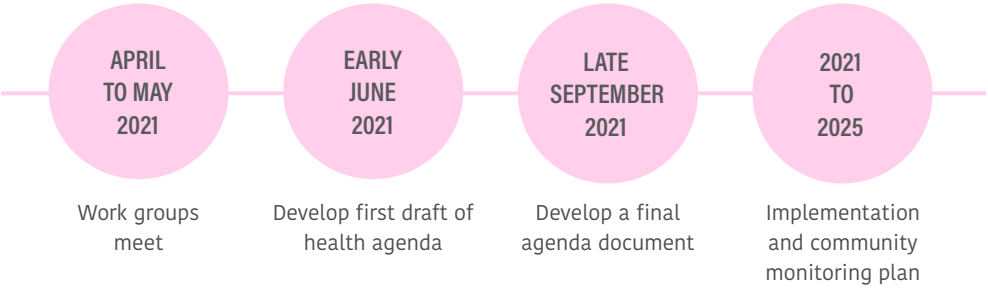
a. Poverty: Socio-economic impact on health
b. Prevention
    i. Chronic Diseases
    ii. Infectious Diseases
c. Access to Care (Policy and Health Care Delivery)
d. Mental Health
e. Substance Use
f. Research and Data
g. COVID-19
h. Environmental impacts on health

Each work group assessed the state of each issue to:

- Outline challenges, and
- Make recommendations (short, medium and long term)

TIMEFRAME:

The outcome of this process had two phases in the development and adoption of a health action agenda: conducting a community summit in June 2021 and finalizing a document in late September entitled: "Setting Our Agenda: NYC Hispanic/Latinx Health Action Agenda 2021-2025. The agenda and the implementation plan had short-term, mid-term, and long-term goals.



GETTING INVOLVED:

Setting Our Agenda is a unique opportunity to have a collective and proactive voice for the Hispanic/Latinx community in New York City. The final product is widely distributed with the intention of impacting the NYC elections in November 2021 and informing policymakers, key institutions, elected and appointed officials, media and others of our health needs, recommendations for solutions and the urgency on an agreed upon path to create wellness in our communities. Any questions please feel free to contact Rosy Mota at rmota@latinoaids.org,

VIII. ACKNOWLEDGMENTS

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- Gloria Zelaya, *El Puente*

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