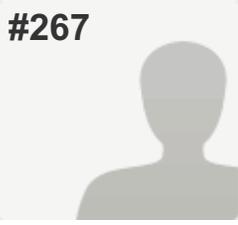


# Ending the Epidemic Task Force Recommendation Form

#267



**COMPLETE**

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**Q1: OPTIONAL: This recommendation was submitted by (please provide your first and last name, affiliation, and email address)**

First Name	Jennifer
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**Q2: Title of your recommendation**

A pragmatic meso-level approach to HIV  
vulnerability for Black MSM in New York:  
recommendations based on ethnographic research  
in Harlem

## Ending the Epidemic Task Force Recommendation Form

### Q3: Please provide a description of your proposed recommendation

Our recommendations, which draw on 10 months of ethnographic research with Black MSM in Harlem, draw on recent work articulating the notion of ‘meso-level.’ The term ‘meso’ “denotes institutions, ideologies, or social processes that are 1) neither at the micro, individual or interpersonal level (such as beliefs or characteristics of interactions) nor at the macro-social level (such as socially-structured inequalities of race, gender, sexuality); 2) characterized by a ‘sociologically-plausible’ or empirically-described causal relationship to a health-relevant practice, and 3) conceivably modifiable through sustained strategically-organized collective action” (Hirsch, 2014: 38). It is not news that Black MSM face multiple intersecting inequalities, which are expressed in elevated vulnerability to HIV as well as many other adverse health and social outcomes. Reflecting our findings in relation to the ways in which multiple aspects of context (law enforcement and criminal justice; housing police; educational contexts; health system climate and accessibility; spaces for leisure; religious organizations, and the funding availability for civil society organizations) shape that vulnerability, we recommend that the task force should:

Increase support through US health insurance reform (the Affordable Care Act) to community health centers in neighborhoods with highest concentration of HIV among black MSM to address disparities.

Mitigate mistrust in clinician-client relationships through city-wide (or state-wide) initiative for new and existing clinicians to increase cultural humility on race, sexuality, gender, and HIV.

Include law enforcement in addressing HIV vulnerability: condoms should not be admissible evidence for targeting sex work; police academy training should include discussion of bias crimes against gender nonconformity; there is a need for systematic monitoring of police practices to mitigate racial profiling.

Prioritize housing subsidies for at-risk populations, especially for LGBT youth; we should not wait until young people are homeless and HIV positive to help them.

Direct additional resources to implement policies to prevent school-based bullying and discrimination, particularly in neighborhoods with high rates of HIV, and improve monitoring and evaluation of those programs. (DASA as a law is great, but there's no funding available to do extra bullying prevention work in neighborhoods that have high rates of anti-lgbt violence).

Provide equitable funding for parks, libraries and “safe spaces” for LGBT youth, especially in neighborhoods with high incidence of HIV, violence and poverty. (The lack of safe spaces (can't socialize at home because that would out them to their parents, CBOs have limited funds to provide safe spaces, there have been cutbacks in library hours, parks and bars are fun to hang out in but may not facilitate safer sex practices or provide social support) means that Black MSM frequently end up seeking out social interaction in support in non-health-facilitating spaces).

Prioritize funding for CBOs and other key civil society stakeholders, including religious groups, who can mitigate stigma and ensure the sustainability of the multi-sectoral response.

Realized in a coordinated fashion, these policy interventions would present a powerful natural experiment to mitigate HIV vulnerability for Black MSM-- in New York City particularly, but also across the state. Could also randomize neighborhoods in New York to provide a control group.

NOTE: We presented this as a poster at the 2014 International AIDS meeting in Australia

**Q4: For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? (Select all that apply)**

Identifying persons with HIV who remain undiagnosed and linking them to health care

Other (please specify)

Community-level interventions

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**Q5: This recommendation should be considered by the following Ending the Epidemic Task Force Committee (Select all that apply)**

Prevention Committee: Develop recommendations for ensuring the effective implementation of biomedical advances in the prevention of HIV, (such as the use of Truvada as pre-exposure prophylaxis (PrEP)); for ensuring access for those most in need to keep them negative; and for expansion of syringe exchange, expanded partner services, and streamlined HIV testing by further implementing the universal offer of HIV testing in primary care, among others. The Committee will focus on continuing innovative and comprehensive prevention and harm reduction services targeted at key high risk populations, as well as grant-funded services that engage in both secondary and primary prevention.

Housing and Supportive Services Committee: Develop recommendations that strengthen proven interventions enabling optimal engagement and linkage and retention in care for those most in need. This Committee will recommend interventions that effectively address complex and intersecting health and social conditions and reduce health disparities, particularly among New York's low-income and most vulnerable and marginalized residents. These interventions will diminish barriers to care and enhance access to care and treatment leaving no subpopulation behind.

**Q6: Does this recommendation require a change to an existing policy or program, or the creation of a new policy or program?**

Change to existing program,

Other (please specify)

Both policy and program change (e.g., DASA exists but insufficient funding for Respect for All program in New York city); HASA is great for HIV+ people but we could do better with housing as prevention, etc.

**Q7: Would implementation of this recommendation be permitted under current laws or would a statutory change be required?**

Statutory change required,

Other (please specify)

A mix of permitted and statutory change required

**Q8: Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?**

Within the next three to six years

## Ending the Epidemic Task Force Recommendation Form

### **Q9: What are the perceived benefits of implementing this recommendation?**

It's not surprising that young Black MSM are the population for whom rates of infection continue to grow - they face multiple intersecting inequalities, and without working at the social level to address those inequalities it is unlikely that any program or intervention will be effective at slowing transmission rates. This policy agenda is deliberately formulated in a way that could be implemented at the city or municipal level, and some of these 'interventions' are already underway (e.g, DeBlasio administration's attempts to change the climate in relation to policing).

### **Q10: Are there any concerns with implementing this recommendation that should be considered?**

It requires substantial community engagement and multi-sectoral collaboration, as well as considering that social approaches may be a vital complement to biomedical approaches to prevention.

### **Q11: What is the estimated cost of implementing this recommendation and how was this estimate calculated?**

Unknown - but what is the cost of not implementing it?

### **Q12: What is the estimated return on investment (ROI) for this recommendation and how was the ROI calculated?**

Unknown

### **Q13: Who are the key individuals/stakeholders who would benefit from this recommendation?**

CBOs who have been working with Black MSM; units of the department of education who would have increased funding to implement their anti-bullying education; potential health care providers who serve Black MSM who might secure health insurance under the Affordable Care Act.

### **Q14: Are there suggested measures to accompany this recommendation that would assist in monitoring its impact?**

I would be possible to develop process measures in terms of policy change, and each policy change would have a specific impact (school retention for young Black MSM; creation of safe spaces and use of those spaces; enrollment in ACA and engagement with health care by previously disengaged HIV- BMSM; availability and uptake of housing units for vulnerable Black MSM, etc)

### **Q15: This recommendation was submitted by one of the following**

Other (please specify)  
NIH-funded university-based researcher