Arab-American Family Support Center

COMMUNITY HEALTH NEEDS ASSESSMENT

AAFSC RESEARCH INSTITUTE

SPRING 2022

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INTRODUCTION

The Arab-American Family Support Center (AAFSC) is a non-profit, non-sectarian organization that provides culturally and linguistically competent, trauma-informed social services to low-income immigrants and refugees in New York City and beyond. AAFSC initiatives operate across four priority areas – promote, prevent, get ready, and communicate – to strengthen families and communities. We promote mental and physical well-being, prevent gender-based violence and child abuse, provide the tools for learners of every age to succeed, and communicate community needs to partners and policymakers. While our doors are open to all, over 27 years, we have developed expertise serving low-income Arab, Middle Eastern, North African, Muslim, and South Asian (AMENAMSA) populations. Our staff speak 36 languages including Arabic, Bengali, Farsi, Hindi, Nepali, Punjabi, Urdu, and Wakhi.

To advance our mission of elevating the voices of immigrant and refugee communities, the AAFSC Research Institute centers the experiences and needs of NYC's AMENAMSA immigrant and refugee communities through culturally responsive and linguistically accessible research practices. Our efforts serve to expand our understanding of community needs and the impact of culturally appropriate intervention and bring important issues to the forefront of local and national conversation through data and research. We believe that community-driven research is essential to overcoming the barriers that commonly deter mainstream research entities from adequately reaching and representing underserved immigrant communities in their work, and we seek to codify and promote our culturally-adaptive data collection practices across sectors to promote a more equitable research landscape.

AAFSC's Community Health Needs Assessment models an industry-standard approach to understanding the quality of health and health care access among a local population and employs our culturally-responsive research practices to uncover and examine potential gaps and deficiencies in the level of health care access among AAFSC's service population. Through our 27 years as a trusted resource within immigrant and refugee communities, AAFSC has long understood and recognized the central role of health in family and community wellness, as well as the factors that undermine a family's physical and mental health. Our Community Health & Well-Being program – a core component of our 'Promote' Priority Area – advances health care access through direct benefit and insurance enrollment support and community outreach and education. These initiatives leverage our position of trust in underserved communities to support families in overcoming access hurdles and navigating taboo health topics through confidential one-on-one service interactions, community conversations, and education workshops.

Despite our extensive work in community health, AAFSC and our partners cannot rely on mainstream public health data to discern the needs of the Arab, Middle Eastern, North African, and South Asian communities we serve. Though exhaustive research on health and health care access has been conducted both locally and nationally, mainstream data collection efforts (including the US Census and many hospital-run Community Health Needs Assessments) do not adequately disaggregate racial/ethnic identity in a manner that appropriately represents Middle Eastern/North African communities and accounts for the diversity in experience of Asian-American Pacific Islander populations. As a result, our community members are rendered voiceless in conversations about health and health care access. As a data-driven learning organization, AAFSC is committed not only to understanding the needs and experiences of those we serve, but to documenting and sharing this information publicly to provide actionable information that can inform critical public health efforts in underserved immigrant communities. AAFSC's Community Health Needs Assessment endeavors to fill this gap by asking immigrant community members to vocalize their concerns, identify resource and service gaps, and propose the solutions that fit their needs. We hope this report serves to inform and bolster community-oriented and culturally-responsive efforts to improve health outcomes through robust collaboration between the healthcare system and community-based organizations such as AAFSC.

METHODS

This Community Health Needs Assessment survey was coordinated by the AAFSC Research Institute, a hub for research and evaluation that seeks to measure community needs and analyze the impact of culturally and linguistically-responsive interventions, alongside AAFSC's direct service programs. As with all work conducted by the Arab-American Family Support Center, we utilized a culturally-competent methodology to capture community perspectives accurately while overcoming hurdles that commonly deter mainstream research entities from adequately reaching and capturing the perspectives of immigrant communities. The study's design, methodology, and execution were informed and supported by members of our target community at every step of the process.

TARGET POPULATION

Our Community Health Needs Assessment survey sought to examine the experiences of our service population, who predominantly identify as members of Arab, Middle Eastern, North African, Muslim, and South Asian (AMENAMSA) immigrant and refugee communities in New York City and extends to all individuals across many communities who access our services.

DATA COLLECTION

Data from this report were collected between February and April of 2022 through four methodological components:

1. Long-form, semi-structured interviews with 6 community members representing a variety of communities within AAFSC's service population;
2. Long-form semi-structured interviews with 4 stakeholders representing professionals in healthcare and community-based settings with expertise working with both Arab and South Asian immigrant communities in NYC;
3. Focus group discussions held within AAFSC's program and outreach settings, ranging in size from 5-12 participants, and conducted with individuals representing a variety of communities within AAFSC's service population;
4. A survey conducted with 102 members of AAFSC's service population.

AAFSC staff recruited participants for this study through their daily interactions with community members across our suite of complementary programs. Trained in the principles of data collection and interviewing, our staff carry over the skills utilized in their direct service work to ensure that informed consent is obtained, and a safe, confidential research environment is secured. These conversations occur through a trauma- and resiliency-informed lens which enables our staff to navigate sensitive and taboo topics relating to health and capture the nuances of the participant's experience with a shared cultural understanding and language. Our study materials were extensively vetted by our internal community experts, ensuring our questions are accessible, relevant, appropriate for our target communities, and adequately anticipate potential health literacy barriers. For example, we equipped our survey interviewers with visual aids to support community members determine their insurance type based on their insurance card. We administered surveys, interviews, and focus group discussions verbally and in a variety of languages including Arabic, Bangla, Urdu, and Spanish, as well as English. Participation in the Community Health Needs Assessment was voluntary, and community interview subjects and focus group attendees were compensated for their time.

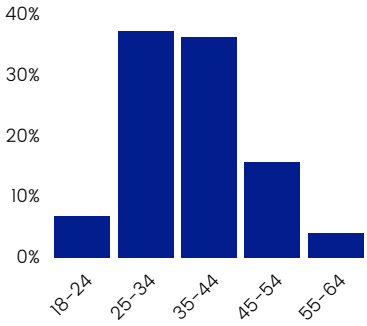
LIMITATIONS

Participants in the research project were recruited using a "purposive sample" approach and are not representative of the entire AMENAMSA community. Survey respondents and community interview participants were readily connected to and accessing services provided by AAFSC. As such, the data collected in this project may not capture the health outcomes and needs of more vulnerable community members who are not connected to services. Another consideration of our sample approach is that our participant population skewed female, in line with the gender breakdown of AAFSC's overall client base, the majority of whom are women. Therefore, our data may not be capturing the same degree of nuance and generalizability for the health outcomes and needs of those who identify as men.

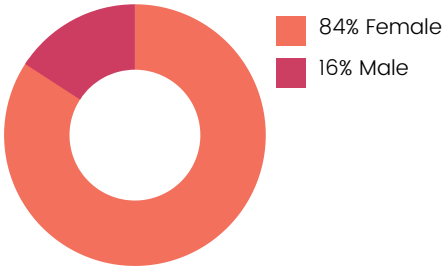
ABOUT THE SAMPLE

This study's survey sample is characteristic of the general make-up of the Arab-American Family Support Center's service population.
While our respondents reflect the diverse communities we serve....

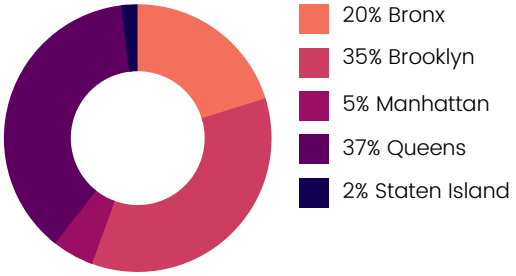
AGE



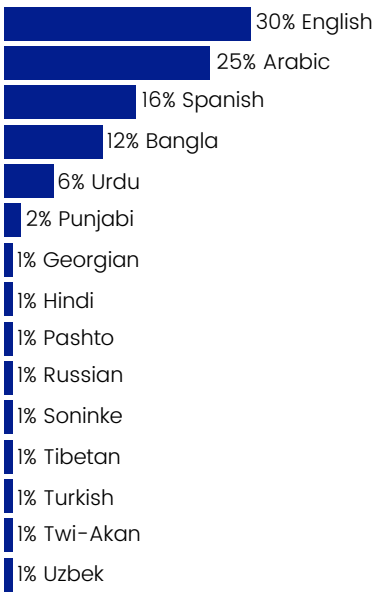
GENDER



BOROUGH OF RESIDENCE

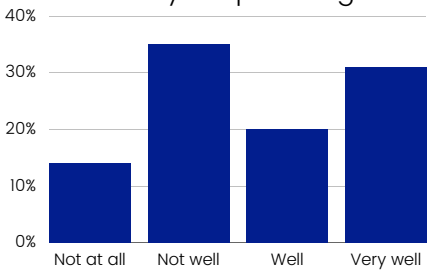


PRIMARY LANGUAGE

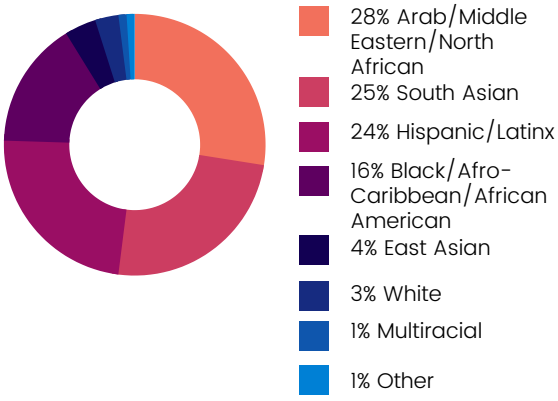


ENGLISH PROFICIENCY

How well do you speak English?

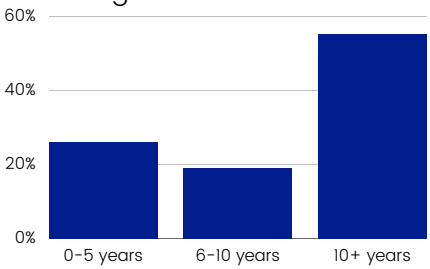


RACIAL/ETHNIC IDENTITY

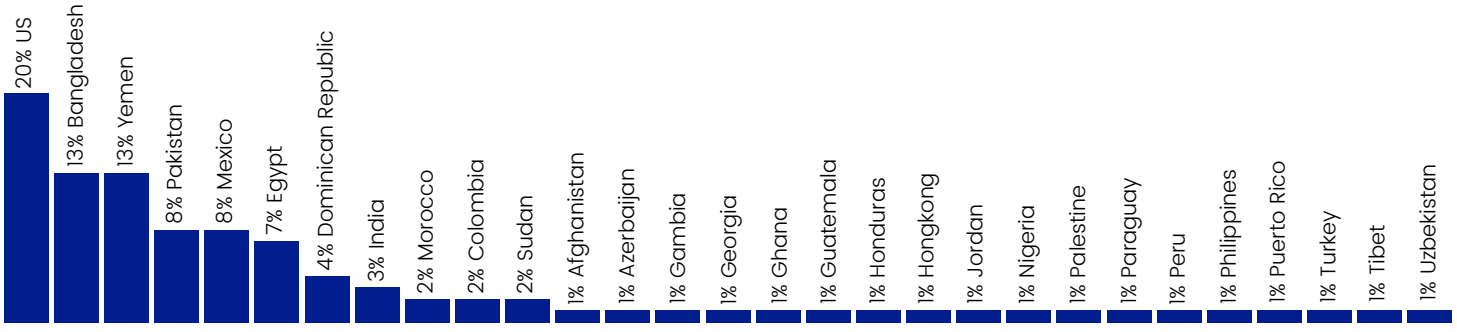


RECENCY OF ARRIVAL

How Long Have You Lived in NYC?



COUNTRY OF ORIGIN

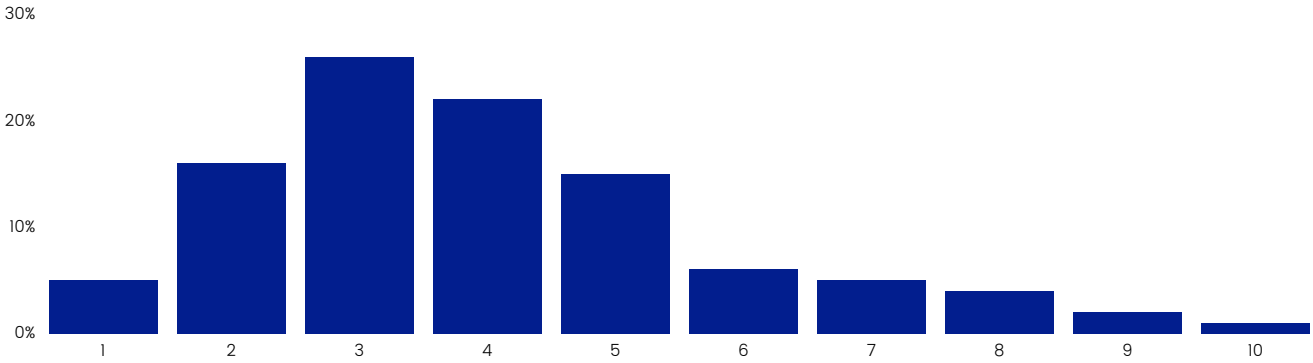


ABOUT THE SAMPLE, cont.

...they also exemplify the socio-economic distinction between the communities accessing AAFSC's services and the NYC population at large.

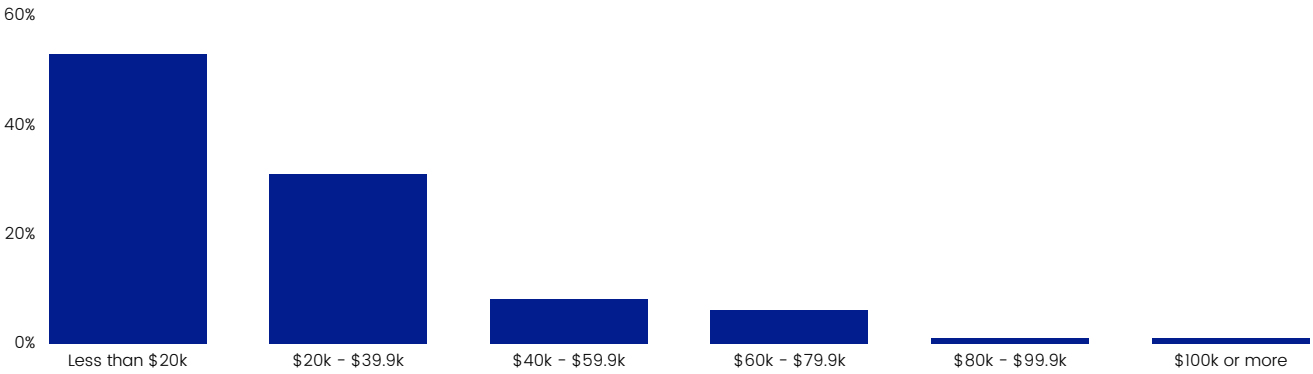
HOUSEHOLD SIZE

The average household size in our sample is 4, compared to NYC's average of 2.57 persons per household.[1]

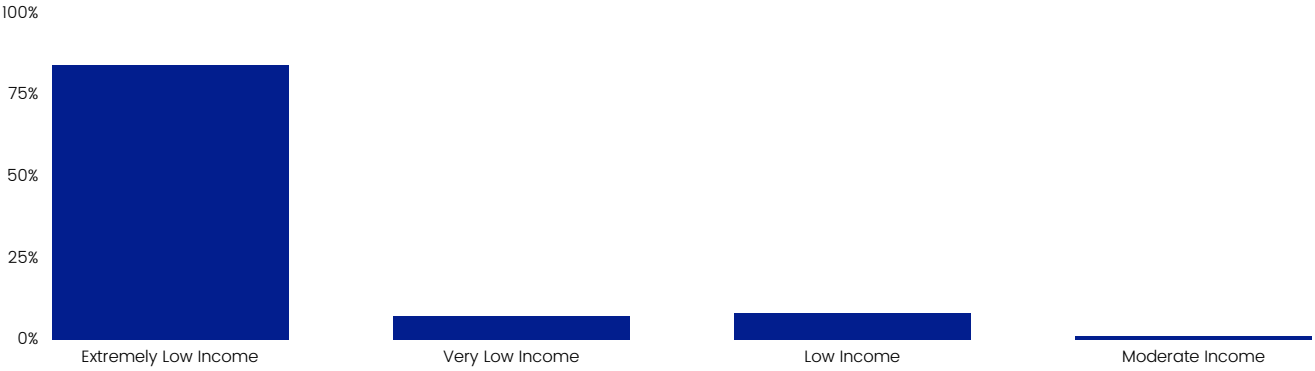


HOUSEHOLD INCOME

NYC's median household income is $67,046 per year.[2] Most of our respondents live in households earning far less. When accounting for larger household sizes, most families in our sample fall in the "Extremely Low Income" band, as determined by NYC's Area Median Income calculations.



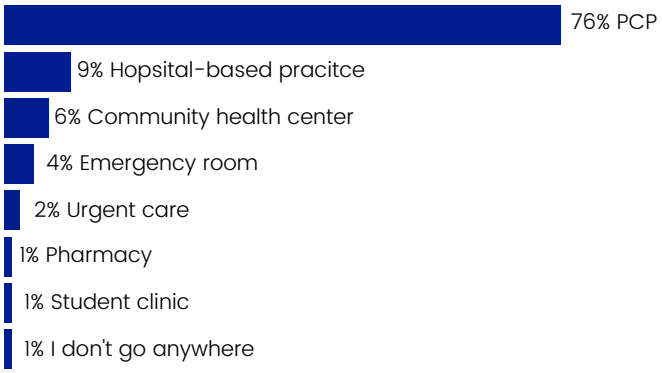
INCOME BANDS



GENERAL HEALTH CARE PRACTICES

Looking at some of the key factors indicating overall health and health care access in our sample, we see that respondents generally have a **basic level of access to care** through insurance (mostly Medicaid) and a connection to a primary source of health care. However, respondents report **slightly less favorable overall health outcomes** and **high levels of overall stress**.

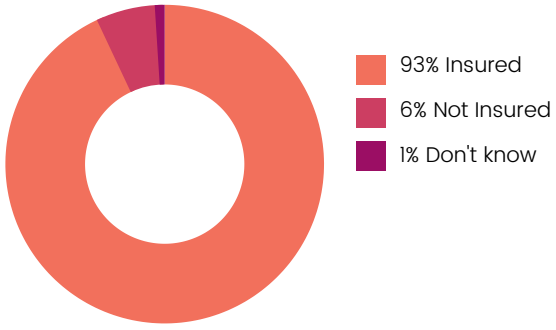
PRIMARY SOURCE OF HEALTH CARE



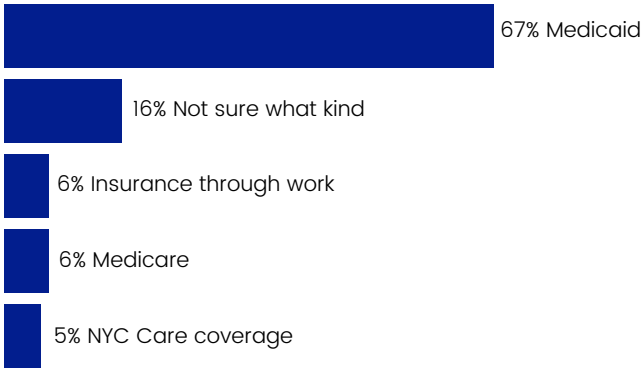
Most respondents are seeing a primary care physician as their primary source of care, while about 1 in 4 are accessing services not traditionally intended for primary care functionality in the American healthcare system. Nearly all respondents could identify a source of primary care, and most (97%) reported accessing their primary health care source within the past year.

INSURANCE STATUS

According to the US Census, 7.9% of NYC residents do not have insurance.[3] In our sample, which reflects a population actively connected to social services (including health insurance enrollment support), the share of uninsured individuals is 5.9%. We know that these numbers may skew in favor of health insurance enrollment as our clients access our health insurance enrollment program. As such, we are mindful of the immigrant population not yet utilizing our services and who do not have insurance.



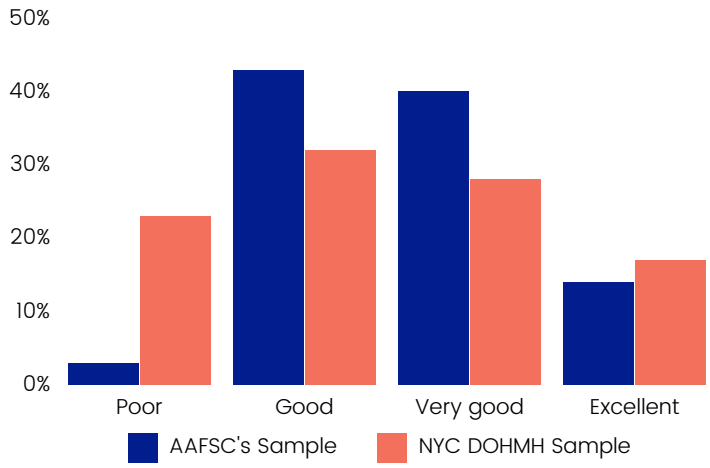
INSURANCE TYPE



According to the American Communities Survey (US Census), 43% of NYC residents utilize public health insurance[4], compared to 73% (Medicare, Medicaid) in our sample.

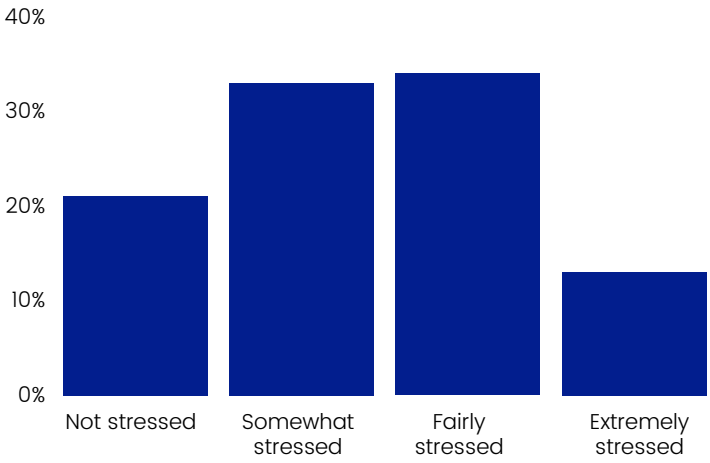
GENERAL HEALTH CARE PRACTICES, cont.

SELF-REPORTED HEALTH STATUS



When asked to characterize their overall health, respondents in our survey were less likely to report "excellent" health compared to those surveyed in a NYC Department of Health and Mental Hygiene (DOHMH) study assessing city-wide health in 2018.[5] They were also less likely to characterize their health as "poor" compared to the city-wide sample.

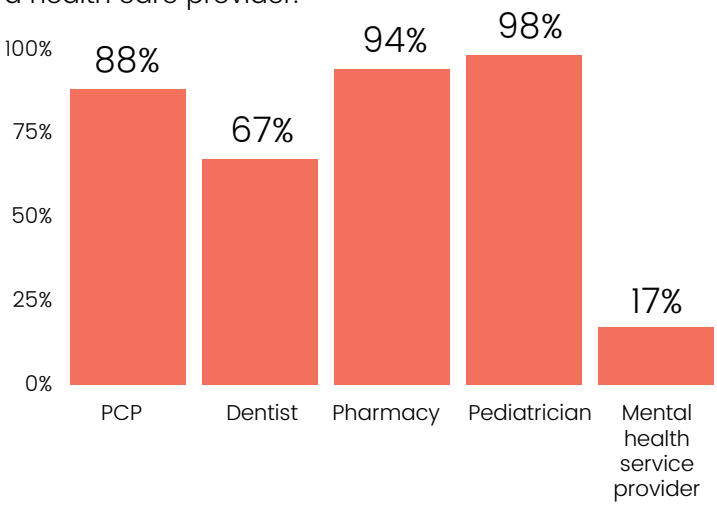
SELF-REPORTED STRESS

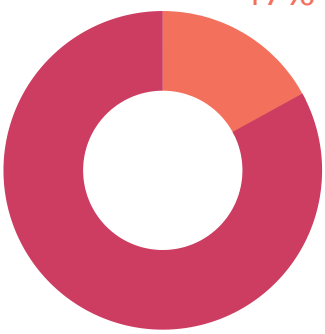


Nearly 4 in 5 respondents report being at least somewhat stressed. Several studies have shown that chronic stress can adversely affect long-term health outcomes. According to a study by NYC's DOHMH, COVID-19 related stressors, which disproportionately impacted people of color and low-income New Yorkers (a demographic that includes those in our sample), are associated with higher rates of behavioral health problems including anxiety and depression.[6]

HEALTH CARE PROVIDER ACCESS

Percentage of respondents who are currently accessing a health care provider.





17% of respondents said that in the past 12 months, they needed health care or health services but did not get the care they needed.

KEY THEMES
MAJOR HEALTH CONCERNS

Diabetes, heart disease, cancer, and mental health/distress have emerged as the major health concerns for our clients, ranked consistently in that order, according to our survey data.

Not only did diabetes rank as the number one most pressing health concern facing the community according to our surveyed clients, roughly 13% reported having difficulty accessing care for diabetes. More than two thirds of the adult population (over the age of 45) in all of New York City have been diagnosed with diabetes according to the 2019 NYC Health + Hospitals CHNA (Community Health Needs Assessment) report.[7] However, MD Taher, project coordinator for the NYU Center for the Study of Asian American Health states that this might be a specific concern for the South Asian community as "the number one health issue is diabetes and then high blood pressure, high cholesterol. These three are highly prevalent in the South Asian community and I have been seeing this issue for a very long time." He adds that perhaps what compounds this issue for this subset of the AMENAMSA community is that "people are getting diabetes at a younger and younger age." As diabetes and heart disease are highly related, it is no surprise that, along with our survey data, many of the focus group participants categorized their concerns for diabetes with concerns around heart disease, heart attack and hypertension. They identified lack of exercise as a result of both the set of circumstances brought on by the COVID-19 pandemic and the unavailability of safe, accessible, and cost effective locations to exercise (particularly for women) as exacerbating these health concerns.

TOP REPORTED HEALTH CONCERNS

DIABETES
HEART DISEASE
CANCER
MENTAL HEALTH

Cancer was also identified as a top health concern in the survey data, and this was corroborated in the findings from the client and community stakeholder interviews. Respondents consistently rated cancer in their top 3 concerns, significant given that the wider-NYC population ranks cancer in 6th place (as reported by the 2019 NYC Health + Hospitals population data, ranked below drug/opioid use and asthma).[8] Dr. Perla Chebli, Postdoctoral Fellow at the Department of Population Health at the NYU Grossman School of Medicine, whose work has primarily focused on cancer disparities, intervention development, and implementation science for Arab American communities in NYC, notes that "cancer is a big problem in the Arab community, partly because of delayed screening behaviors, but there might also be some genetic or biological risk factors for some types of cancers." The low utilization of preventive screenings seems to be significant in shaping the issue of cancer prevalence according to both our qualitative data and quantitative data. The survey data indicate that only 54% of surveyed clients had received the routine cancer screenings relevant to their age and gender groups. This is 20-50% lower than the cancer screening rates for the larger population of NYC residents. In a later section, this report will discuss interviews with clients and community stakeholders that point to AMENAMSA community perceptions of cancer screenings, diagnosis, and preventive medicine overall that may be related the prevalence of cancer.

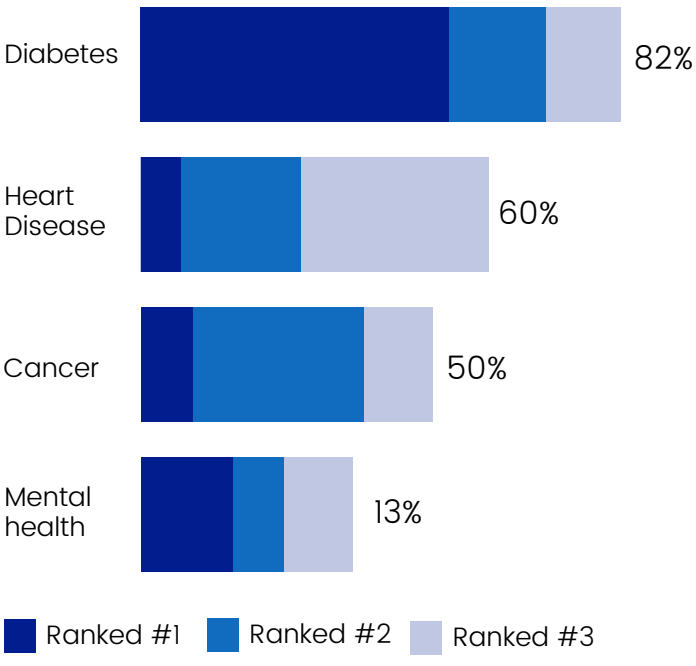
KEY THEMES

MAJOR HEALTH CONCERNS

Finally, respondents highlighted concerns around mental health in both the quantitative and qualitative data. Mental health ranked as the fourth most pressing health concern in the community according to clients. Of all the clients that reported difficulty accessing specific health care services, 20% reported being unable to access mental health care and almost 80% of participants indicated being "somewhat stressed" to "extremely stressed." AAFSC's own mental health counseling has a waitlist of 190 individuals. Like concerns around cancer, perceptions around mental health and social stigmas may be related to limited availability of resources, insufficient public awareness, and barriers to utilization. In one of the focus groups, participants mention that "mental health therapy services aren't accessed since they are stigmatized and there is a constant fear of 'what will others say?' People like to show that they are physically and mentally strong while they may be needing the help." This presents a dichotomy in which community members seem to recognize the prevalence of mental health concerns in the community while simultaneously recognizing and perhaps upholding its stigmatization.

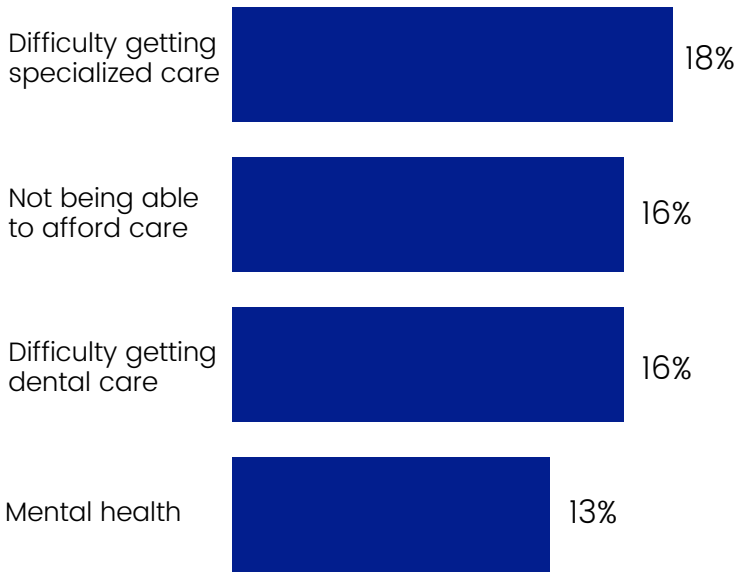
TOP HEALTH CONCERNS FACING COMMUNITIES

What are the top three most important health issues facing your community?



TOP HEALTH CONCERNS FACING FAMILIES

Which challenges does your family experience accessing and receiving healthcare?



KEY THEMES
COVERAGE

The rates of insurance coverage were relatively high in our surveyed client population, at 93%, comparable to the city-wide rate of insurance coverage status. However, roughly 70% of our clients are insured via Medicaid and 5% via NYC Care, compared to the 26% covered by Medicaid statewide (there are no accurate data available to estimate the percentage of population enrolled in NYC care).[9] While these rates may be impressive in terms of the progress that has been made towards bridging gaps in insurance enrollment across the city, 27% of respondents cited "not being able to afford health care" as a challenge for their family. Further, 50% of those who reported not accessing necessary health care cited affordability as the critical barrier to utilization. Both findings raise concerns about affordability of care, even with insurance subscription. There also remain concerns about the sufficiency of both Medicaid coverage and NYC Care coverage. Maha Attieh, Lead Health Program Navigator at AAFSC whose work involves supporting clients through the public health insurance enrollment process, finds NYC Care to be a concerningly insufficient program for the needs of her clients. She reports that, while this option is an improvement for the undocumented population previously excluded from any health care options, it is not a replacement for the comprehensive care that health insurance can facilitate; "we need coverage - medical, dental, and vision - for our community. Something that works for everybody."

Gaps in coverage for our client base are also readily apparent. Many cited the inability to find affordable dental care as a major concern. While 67% of our surveyed clients stated that they have a dentist, dental care was among the most frequently mentioned services that participants were unable receive, and 27% of respondents reported that their family experienced "difficulty getting dental care." Unavailability and costliness associated with dental care were major points of discussion during an Arabic language focus group run as part of this project, and there was consensus that "dental care is way too expensive, so many people don't pursue it." One client detailed how, when they were subscribed to MetroPlus, they were "experiencing serious dental pain and needed an extraction. However, there were barely any dentists that accepted this plan and if they did, it was a long waitlist to see a dentist. The health insurance plan also didn't cover extractions for some reason so we were notified we would be billed." To avoid the difficulties of securing affordable care, many of our clients or members of their community have considered or have traveled abroad to countries like Turkey in pursuit of dental care. This raises concerns about the safety and quality of dental care being received and the coordination of necessary follow-up care that might have long-term detrimental consequences.

1 in 3 respondents do not have a dentist

Why not? (Top reasons)

- **50%** Say they don't need one
- **13%** Say they don't have insurance
- **13%** Say it's too expsensive
- **13%** Say they don't know how to find one

Further, although a majority of our clients are insured, access is often limited by insurance literacy. One client observed that many members of their community "do not know how their insurance works so they do not go to see a PCP." Dr. Chebli added that many members of the community require assistance navigating the healthcare system and that "they have coverage, but they don't know what is covered and what is not...So that's another layer of stress and that could deter them further down the line from accessing services that they might need."

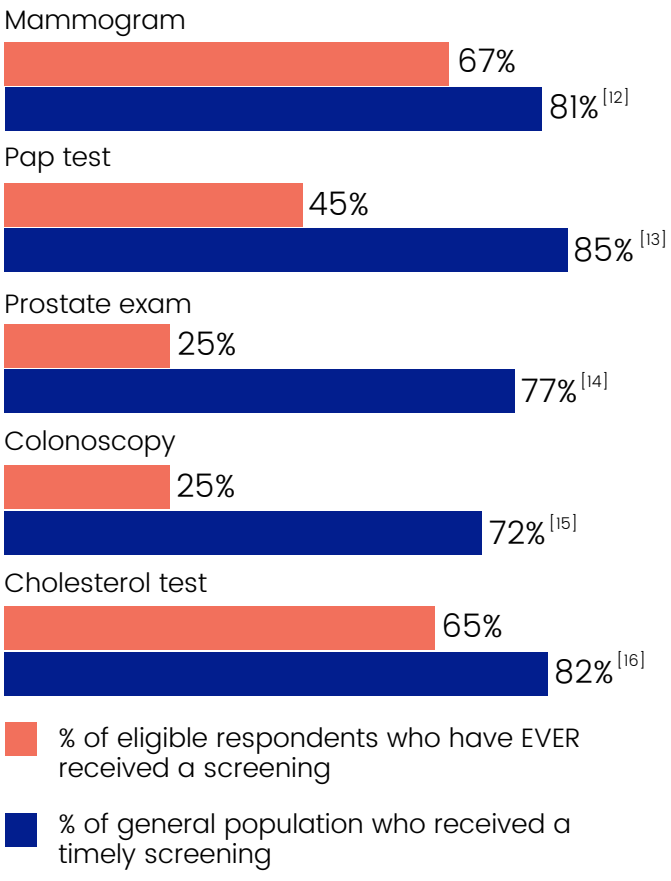
KEY THEMES
PREVENTIVE CARE

Related to the issues of insurance literacy, or more broadly to health care practice literacy, qualitative data that were corroborated in the quantitative analysis show that many of our clients are not readily accessing and/or utilizing preventive health care services. Many clients reported only going to see their primary care provider when they do not feel well, or something is bothering them. "I don't go if I feel healthy." Attieh readily observes this in her work; "some of them, they have insurance for the whole year. They never use it. Not even for annual checkups…the community, they think, 'God will heal us. God will make us feel better.' When [they] get sick, then [they] go to the doctor." This a consequence of differing beliefs and practices in utilization of health care cross-culturally. All the community stakeholders interviewed reported that AMENAMSA community members have different expectations and experiences around the use of standard health care practices and what they look like based on their experiences in their home countries. Many of the healthcare systems in Arab countries (which constitute the top countries of origin among AAFSC's client base) often adopt a curative medicine model as opposed to a preventive model, with limited preventive care programs and public education. [10] Research has also suggested that these communities also rely on media, family, and friends as sources of health information and visit a physician only if health problems and symptoms are acute.[11]

This dynamic may also partially explain the lack of sufficient cancer screening among our clients. Compounded by the unfamiliarity and resulting de-prioritization of preventive medicine, interviews with our community stakeholders point to issues related to fatalism around cancer and even cancer prevention care. They mentioned that many of their clients and community members feared the stigma associated with cancer and cancer diagnosis. Attieh described that she had a client that was so concerned about her cancer diagnosis that she refused seeking continued treatment because she was worried that "people would find out and then nobody would want to marry her daughter."

There is evidence to suggest that the curative medicine orientation observed in AMENAMSA communities may have implications for medication compliance. As one client stated; "People don't take the medication daily, for example if I feel fine today, I won't take my medication because I feel fine, if I don't feel good, I will take my medication." Also core to the issue of medication non-compliance is skepticism of the healthcare system - our interviews revealed a mistrust of American/Western medical systems and the perception that "[medical professionals] overprescribe." Ghadeer Ady, Social Worker, Public Health Educator, and Deputy Director of Programs & Implementation at AAFSC reports that medication non-compliance is sometimes a result of "mistrust in this system …and could also be mistrust in the physician… unless they really feel like the physician understands their needs."

RATES OF PREVENTIVE SCREENING ACCESS



KEY THEMES
LANGUAGE/CULTURAL ACCESS

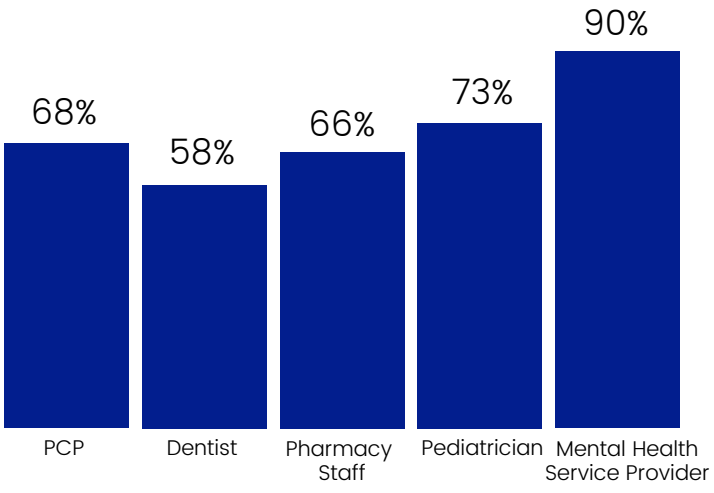
Ady's observation may show how de-prioritization of preventive care, social stigmas associated with cancer screening, and medication non-compliance represent gaps in communication and education between community members and healthcare workers. These gaps can potentially be bridged when healthcare workers are more fully aware of and able to adapt to the social and cultural background of their clients. During both client interviews and community focus groups, there was major consensus around the reality that patients felt more comfortable with and willing to seek continued care from practitioners who spoke their native language; "I feel more comfortable when the doctor/provider is of the same background because it makes me more familiar and comfortable with them" stated one client. This is one way to curb the feelings of discomfort and even prejudice some have reported experiencing when they wear "hijab" or "salwar kameez" or other traditional clothing in healthcare settings. Speaking with a provider directly in their native language is also greatly preferred over the more commonplace practice of using interpretation services such as phone translation. In fact, many clients have complaints surrounding interpretation services; "it's not very conducive to a natural flow of organic conversation with the provider and there are often issues with different dialects and errors in translation. [Patients] can tell that the translator wasn't really saying what they want them to say or the other way around," Dr. Chebli explains.

Along with additional comfort, Taher explained that more linguistically and culturally competent health care providers might be more readily able to identify specific concerns that might be otherwise overlooked. Taher pointed to the fact that endemic use of "jorda" and "gul" (forms of chewing tobacco) in the Bangladeshi community is often overlooked because healthcare providers are not aware of its usage and practice. This issue has resulted in nationwide underestimations of smoked and smokeless use of tobacco in the South Asian community that culminate in insufficient screening for preventable behaviors that cause serious health issues including various cancers, cardiovascular problems, tooth decay and asthma.[17]

In terms of women's health and linguistically and culturally specific care, a client stated that they liked going to their clinic because it "is close to home and the doctor is a woman." This is also reflected in many female clients' preference for female health care providers, who are in short supply for those seeking linguistically-accessible care. The Arab Medical Center, cited as a popular clinic in Bay Ridge, Brooklyn, employs a group of Arabic-speaking doctors, but all the providers are male. Perla explained that in her work as a health care navigator she "knows that there could be more cultural barriers for women. Especially when thinking about breast cancer screening, cervical cancer screening, there's a lot of barriers." Though Muslims vary in their interpretations and practices, modesty is the "overarching Islamic value" when it comes to gender interaction. Depending on who else is there, the "awrah," or areas of the body that are not to be revealed, change. Many observant Muslim women cover certain areas of their bodies when in the presence of males not related by blood or marriage, rendering procedures and screenings which require exposure of specific body parts a difficult and uncomfortable prospect. As many Muslim clients refuse to be seen by male doctors, Attieh explained that she has found success in overcoming this barrier to help promote breast care screenings among her clients by referring them exclusively to female providers.

PREVALENCE OF LINGUISTICALLY-COMPETENT PROVIDERS

% reporting their provider speaks their preferred language
(of those whose preferred language is not English)



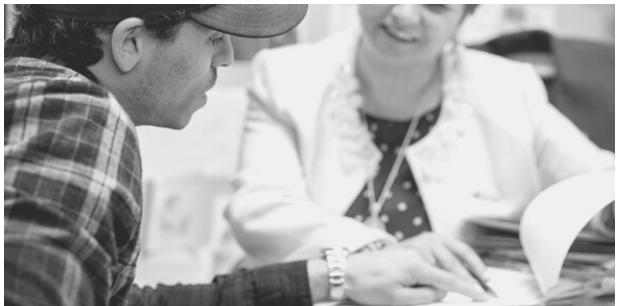
CONCLUSION

FUTURE RECOMMENDATIONS & RESEARCH ACTIVITIES

RECOMMENDATIONS

1. **Bridge gaps in health care access through the use of linguistically and culturally competent navigators.**
2. **Support community-based and linguistically-accessible health centers and the organizations and networks that promote access and trust within AMENAMSA immigrant communities.**
3. **Support public education initiatives in community-based settings to promote positive health care practices and address misconceptions.**

Our findings have highlighted the need for linguistically and culturally competent care to bridge gaps in access. Culturally and linguistically specific navigators can not only facilitate improved health care access and quality for underserved populations through advocacy and care coordination, but they can also address deep-rooted issues related to distrust in providers and the health system that often leads to the types of avoidant and non-compliant health care practices observed in AMENAMSA communities. By addressing many of the disparities associated with language and cultural differences and barriers, particularly in the preventive health and screening behaviors identified in this study, patient navigators can foster trust and empowerment within the communities they serve. Furthermore, through connections within immigrant neighborhoods and partnerships with trusted community institutions (such as community-based organizations like AAFSC), navigators can strengthen the linkages between community settings and the healthcare system.



Our findings also indicate that there is great demand for culturally and linguistically specific health centers and clinics in which providers and staff speak Arabic, Bangla, and/or Urdu. As most respondents noted that they found their provider(s) "in the neighborhood," "through family," or "through friends," local community connections are a powerful information network for accessing care, and it is critical for health care centers to be integrated within the community to facilitate rapport and trust. Additional support and expansion of such facilities, like Arabic Medical Center in Bayridge, Brooklyn (a hub for the Arab immigrant community in New York City) mentioned by many of the clients, may help meet the overwhelming demand. Community members are often faced with the difficult choice of either accessing comprehensive medical care (at a hospital, for example) where they might not have access to cultural or linguistically competent care, or accessing a more local or community clinic where the provider speaks their native language and understands their cultural frame, but is either lacking in specialized services and treatments and/or is overloaded with a long waitlist for appointments. As such, additional support for community clinics with cultural and linguistic expertise is imperative to increase the capacity and scope of practice of accessible health care.

To complement system-wide enhancements to the accessibility and availability of linguistically and culturally-responsive health services, community-based organizations, including the Arab-American Family Support Center, can be leveraged to advance public education and knowledge within underserved immigrant communities. Through workshops and education initiatives, trusted community institutions can provide a safe harbor to promote positive health care practices that address the foremost challenges highlighted in this report, including gaps in preventive care practices, misconceptions around illness, and insurance and healthcare system literacy. Though AAFSC and our partner organizations have a track record of success executing these and similar public education initiatives alongside our direct services, additional support is needed to expand the availability of facilities and community-embedded centers that can serve as a venue for these activities.

CONCLUSION

FUTURE RECOMMENDATIONS & RESEARCH ACTIVITIES, cont.

RECOMMENDATIONS

4 **Prioritize further clinical research and data disaggregation to better understand the medical and social needs of the AMENAMSA population.**

5 **Enhance the quality and availability of health services covered by public insurance to support comprehensive health care access in low-income immigrant communities.**

Despite widespread insurance coverage in AAFSC's service population, many of our clients, particularly those covered by public insurance, struggle to find and access health care that is high quality and comprehensively addresses their health needs, particularly for dental and specialized care. New York City is home to 504 Federally Qualified Health Centers (FQHCs), healthcare sites designed and funded to serve low income, uninsured, immigrant, and housing-insecure communities, and AAFSC's GIS analysis has found that the mere availability and proximity of these centers is not a concern. According to our story map, "Affordable Health Services in NYC's Immigrant Communities," nearly all geographic areas populated heavily by Arab, Middle Eastern, North African, and South Asian immigrant communities have access to a nearby FQHC that is required to accept Medicaid. The issue is therefore not one of availability, but accessibility and scope of practice. Our data therefore suggest that an expansion of the quality and cultural responsiveness of services covered under public health insurance is needed to ensure vulnerable communities are receiving an adequate level of care, from basic primary care to dental care and specialized services.

More research, particularly clinical research, is needed to better understand the medical and social needs of AMENAMSA populations, as noted by Dr. Chebli. Public health and medical researchers can improve their understanding of the health needs of the communities we serve through the identification and active recruitment of AMENAMSA patients, with a focus on vulnerable sub-populations and via disaggregation of health data for more inclusive and representative racial and ethnic identity categories. Understanding AMENAMSA health needs in the context of the existing racial and minority health landscape in the United States will be important to better understanding larger issues of immigrant and refugee health in the United States.

AAFSC stands ready to leverage these insights in our Community Health & Well-Being work alongside our community and healthcare system partners to work towards eliminating health disparities, promoting community well-being, and advancing equity citywide.

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