Fall 1-5-2024

The Most Diverse Square Mile in America: Sociodemographic, Health Profiles, and Access to Healthcare among the Refugee, Immigrant, and Migrant Population in Clarkston, Georgia

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Recommended Citation

Thein, Win Min, "The Most Diverse Square Mile in America: Sociodemographic, Health Profiles, and Access to Healthcare among the Refugee, Immigrant, and Migrant Population in Clarkston, Georgia." , Georgia State University, 2024.
doi: https://doi.org/10.57709/36408461

The Most Diverse Square Mile in America: Sociodemographic, Health Profiles, and Access to Healthcare among the Refugee, Immigrant, and Migrant Population in Clarkston, Georgia

By

WIN MIN THEIN

7th December 2023

ABSTRACT

INTRODUCTION: Georgia State University's Prevention Research Center conducted a community needs assessment (CNA) survey in Clarkston, GA to gather data on residents' health, experiences with violence and discrimination, and access to resources such as food, childcare, safe housing, early learning programs, and healthcare.

AIM: This capstone project compared socio-demographic characteristics, health status, and access to healthcare among Clarkston residents using CNA data. It specifically focused on documenting disparities between U.S.-born and foreign-born populations, as well as comparing healthcare access based on English proficiency skills. The long-term goal of these analyses is to identify population needs and provide recommendations for targeted public health interventions and policies.

METHODS: The CNA recruited participants who were $\leq$ 18 years of age, lived in Clarkston (zip code 30021) and who spoke English, Swahili, Arabic, Dari, Burmese, Amharic, Somali, or Spanish with a target sample size of 250 participants. Recruitment was conducted via electronic flyers shared in the community and local businesses, alongside visual banners and yard signs at survey events and high-traffic areas. Data was collected via Qualtrics and paper surveys and analyzed using SPSS.

RESULTS: About two-thirds of survey respondents were young (18-34). The community is ethnically varied, and many speak languages other than English. Foreign-born residents earn less than $30,000. Although general health profiles are good, foreign-born residents have chronic health issues and substance use differs by nationality. The survey also found that linguistic and cost barriers prevent foreign-born residents from accessing healthcare.

DISCUSSION:
The socio-demographic, health profile, and health access data show that Clarkston's diverse community faces challenges and disparities, particularly foreign-born individuals and those with limited English proficiency. The findings call for policy-level interventions and advocate for a multidimensional and holistic approach that would address both the short-term and the long-term well-being and socio-economic advancement, to achieve the final goal, equity.

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by

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M.B, B.S, MPH (Health Management and Policy)

GEORGIA STATE UNIVERSITY

A Capstone Submitted to the Graduate Faculty of Georgia State University in Partial Fulfillment of the Requirements for the Degree

MASTER OF PUBLIC HEALTH

ATLANTA, GEORGIA, 30303

APPROVAL PAGE

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Acknowledgments

The author would like to express heartfelt gratitude to Dr. Ashli A. Owen Smith, chair of the capstone committee, and Dr. Mary Helen O'Connor, committee member, for committing their time, knowledge, and expertise to supporting and mentoring my capstone project. I would also like to express my appreciation to all of my professors at the School of Public Health, who helped and equipped me to become a better public health professional. I am also thankful to the faculty members and my fellow peer students who assisted me with this capstone project. I will always remember all of your support, guidance, and encouragement in my academic career. Finally, I would like to thank the Foreign Fulbright Scholarship for providing a full scholarship to pursue the MPH program at Georgia State University, allowing me to advance my career.

Author's Statement Page

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CHAPTER I: INTRODUCTION

1.1 Background

1.1.1 History of Refugees and the United States

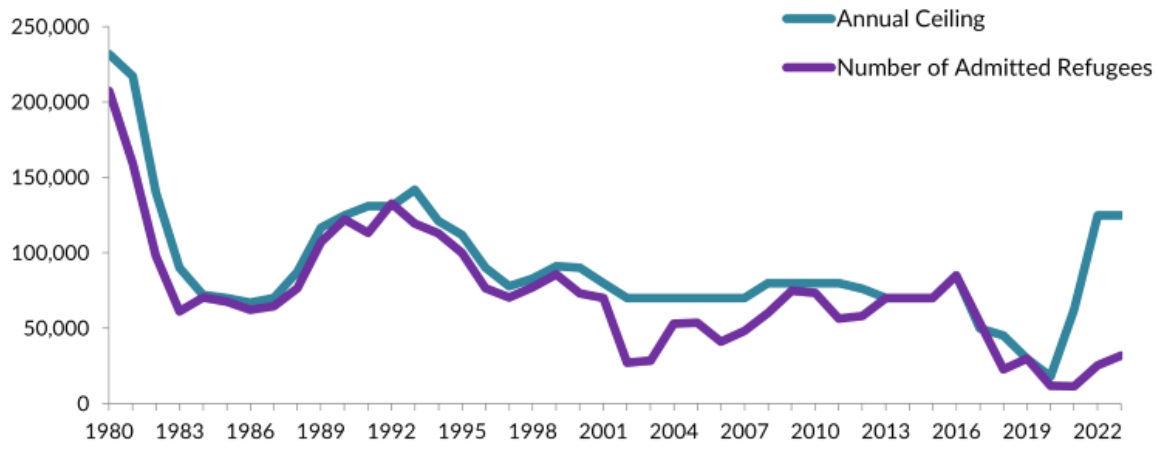
Since World War II, the world has been dealing with a plethora of refugee-related issues. According to the UNHCR's mid-2023 report, more than 110 million people are forcibly displaced worldwide as a result of persecution, conflict, violence, human rights violations, or events seriously disturbing public order, and this figure is expected to rise to 114 million by the end of September 2023. Among these 110 million people, 36.5 million are refugees, 62.5 million are internally displaced, 6.1 million are asylum seekers, and 5.3 million require international protection. Furthermore, millions of people are stateless as a result of being denied nationality, limiting their access to basic rights such as education, health care, employment, and freedom of movement (UNHCR, The UN Refugee Agency, n.d.).

The United States, along with about 26 other countries, is one of the most welcoming countries in the world for refugees. The United States has admitted over 3.1 million refugees since the Refugee Act was passed in 1980 (Refugee Admissions, United States Department of State, 2023). However, from 2017 to 2021, the Trump administration invoked executive orders to limit the number of refugees entering the United States. Under the Trump administration (January 20, 2017, to September 30, 2019), the United States admitted only 76,200 refugees over three years, compared to nearly 85,000 admitted in one fiscal year of 2016, the last year of the Obama administration (Pew Research Centre, 2020).

The number of immigrants allowed was reduced further from 30,000 in 2019 to 18,000 in 2020 to 15,000 in 2021, the lowest in US history since Jimmy Carter signed the Refugee Act in 1980 (Yang, 2020; Batalova, 2023b). This new policy exacerbated the global refugee crisis and

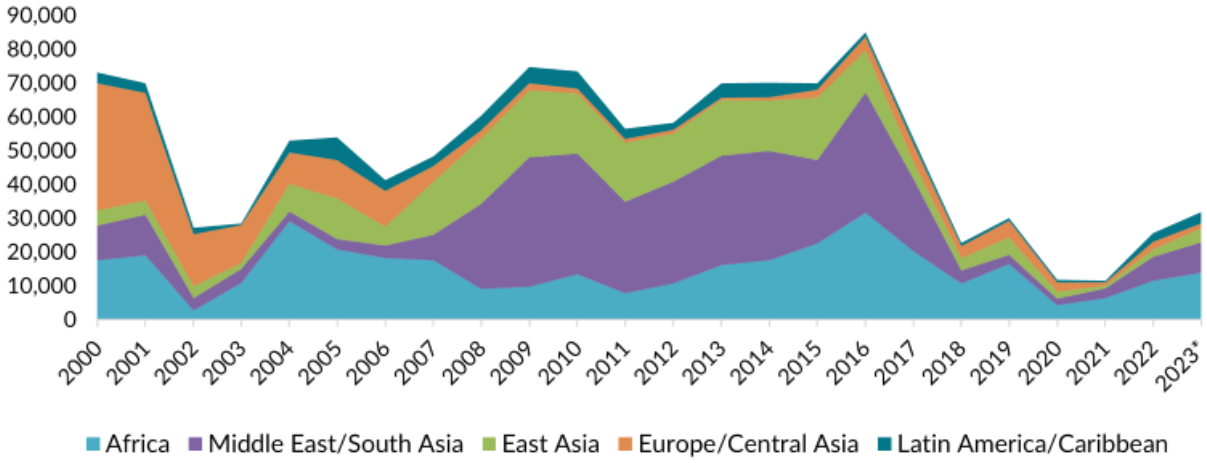
undermined America's long-standing reputation as a refugee-welcoming country, as well as its ongoing commitment to international human rights principles such as freedom of religion or belief and freedom of expression, and as a land of opportunity for all. In addition, refugees can bring significant human capital to the United States, which is valuable to U.S. foreign policy (Refugee Admissions, United States Department of State, 2023). Statistically, the consequences of strict immigration policy are as follows: in Georgia, which has long been known as a refugee-friendly state in the United States, the number of refugees resettled has dropped significantly, from 3,017 in 2016 to 385 in 2021 (Story, 2023).

Figure 1: **Annual Refugee Resettlement Ceiling and Number of Refugees Admitted to the United States, FY 1980-2023**



Source: MPI analysis of State Department WRAPS data.

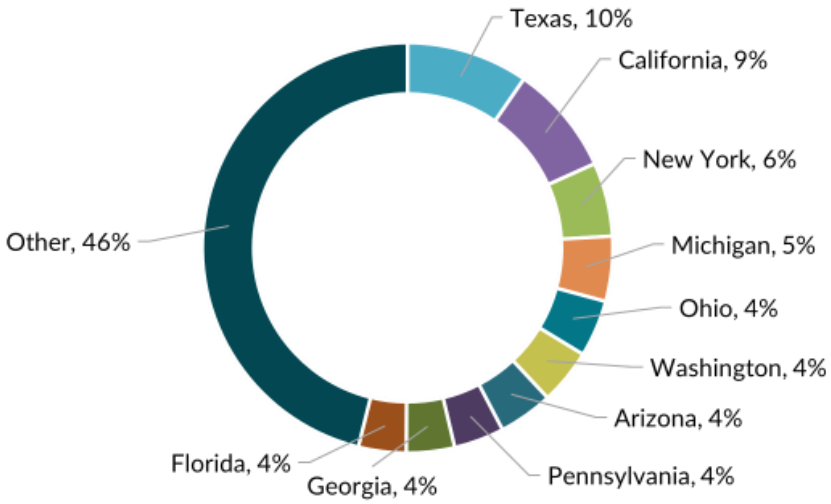
Figure 2: **Regions of Origin of U.S. Refugee Arrivals, FY 2000-23**



Source: MPI analysis of State Department WRAPS data.

Resettlement includes assistance with transitioning into the new country's social, economic, and political cultures and norms. Most refugees who arrive in the United States usually face barriers to immigrant policies as well as social and economic integration. Refugee resettlement policies are increasingly being debated across the country, and while small towns welcome refugees, certain states have become more anti-immigrant, with opposing points of view. Clarkston, Georgia, is one of the top ten refugee-receiving cities in the country (Batalova, 2023c).

Figure 3: **Refugee Arrivals by Initial U.S. State of Residence, FY 2012-22**



Source: MPI analysis of State Department WRAPS data.

Georgia imposes some restrictive laws on immigrant populations, making it difficult for immigrants to participate in civic, economic, and political life. Undocumented immigrants, in particular, face challenges in obtaining healthcare and other forms of social assistance (Kim & Bozarth, 2020; MuOz, 2023). On the other hand, the impact of the influx of immigrants extends beyond demographic changes, as refugees bring human capital and have a significant impact on the local economy and built environment, particularly in small cities and suburbs across the country. As a result, welcoming refugees is not only a humanitarian issue but also a revitalization tool for some cities experiencing economic downturns (Kim & Bozarth, 2020).

1.1.2 City of Clarkston, Georgia

Clarkston, Georgia (see Figure 4), a small, vibrant community in DeKalb County, has become a destination for international refugees. The community is also known as "the most diverse square mile in America," with over 60 spoken languages and people fleeing genocide or war in fear of being tortured or imprisoned for their beliefs or skin color. (How This Small Town Accommodated Thousands of Refugees—and Survived, 2018d). Clarkston, located about 15 miles from Atlanta, originated as a farmland populated primarily by white Americans. When the Georgia Railway was built in the late 1800s, it became a railway town, with the majority of residents being middle-class Caucasians. Following the relocation of many residents to the Metro Atlanta suburbs, African Americans and Hispanics became new residents of Clarkston (Yang, 2020). Then, following the passage of the Refugee Act in 1980, the first wave of refugees arrived in Atlanta, primarily from Southeast Asia, and refugee resettlement agencies identified Clarkston as a perfect location for newly arrived refugees, with existing affordable and vacant apartments and proximity to transit lines and agency services (Kim & Bozarth, 2020; Yang, 2020).

Immigrants arrived in Clarkston in various waves, depending on the level of conflict in their home countries. There has been an increase in the number of Burmese, Nepali, Congolese, Sudanese, Iraqi, and Syrian refugee communities since the early 2000s. While only 9% of the population was foreign-born in 1990, foreign-born residents became 49.4% of the total population in 2021 (Kim & Bozarth, 2020; Admin, 2021; United States Census Bureau QuickFacts, n.d.). Georgia has resettled approximately 37,000 refugees over the last 25 years, with an average of 2,500 to 3,500 per year. The government provides refugees with 8 months of assistance through resettlement programs (How This Small Town Has Welcomed Thousands of

Refugees—and Thrived, 2018d and Refugee and Entrant Assistance—State Administered Programs | Benefits.gov, n.d.). The number of refugees gradually increased, and the landscape of Clarkston changed dramatically. Because of its diversity, it is now known as the "Ellis Island of the South," with over 40 nationalities speaking 60 languages living in the 1.4-square-mile city. The small town has become a popular destination for refugees and immigrants from all over the world (Yang, 2020).

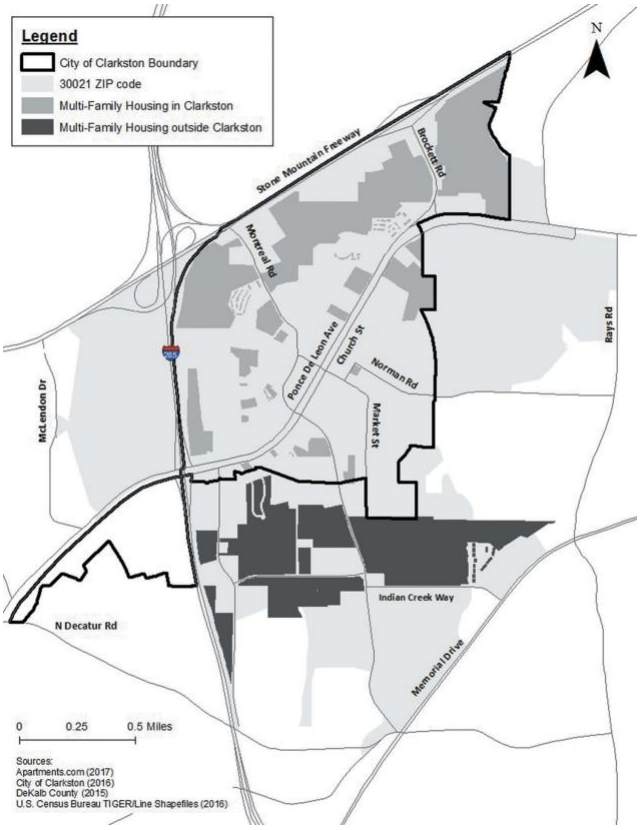


Figure 4: Map of the City of Clarkston (Kim & Bozarth, 2020)

As a result, resettlement agencies, non-governmental organizations (NGOs), and social enterprises choose Clarkston as their base of operations to serve and support the refugee community. Kitti Murray, the founder of Refugee Coffee, moved to Clarkston and now offers job training and opportunities to refugees. Ethne Health Community Clinic was founded by a group of young doctors to serve the community (Yang, 2020).

1.1.3 Barriers and Challenges faced by the Clarkston community,

Several organization representatives (resettlement agencies) residing in Clarkston, as well as Clarkston residents, stated that arriving refugees have numerous needs after living in terrible conditions in their home country and overcrowded camps (Refugees in Clarkston Get Help for Health Challenges, 2015). Refugees arriving in Clarkston, GA, face a variety of challenges, including language barriers, insufficient housing, economic hardship, cultural adjustment, access to health care, and mental health issues (Jirons, 2023). As a result, all refugee resettlement agencies assist refugees in finding housing and jobs that provide some health care benefits during their first year of arrival (Refugees in Clarkston Get Help for Health Challenges, 2015). Refugees are provided with Medicaid coverage upon arrival; however, it is only for eight months Refugees in Clarkston Get Help for Health Challenges, 2015).

Some of the most significant barriers to healthcare have been articulated by refugees who have been resettled in Clarkston. First and foremost, language barriers have been identified as a source of difficulty during medical interpretation. Furthermore, the difficulty in finding interpreters and the limited availability of languages offered by translation phone lines make communication difficult. Second, many refugees lack access to healthcare due to a lack of transportation. Finally, newcomers face difficulties in navigating and purchasing insurance because they do not have it in their home countries (Three Leaders' Thoughts on Healthcare Change for Clarkston, 2018). Language barriers, a lack of educational attainment, a lack of transportation, cultural difficulties, unaffordable housing, unemployment, mental health issues, and poor health outcomes were all mentioned by participants at the Georgia State University (Prevention Research Centre) summit in 2022 (Jirons, 2023).

1.1.4 Importance of Community Needs Assessment (CNA) and Community Health Needs Assessment (CHNA)

Communities are defined as people who live in a specific geographical area and share common interests or characteristics such as religion, race, or occupation. A community needs assessment (CNA) provides information to decision-makers about local community needs and challenges in order to change local policy, systems, and environments to have a positive and sustainable impact in their communities (CDC, Community Needs Assessment, n.d., 2013). The Affordable Care Act (ACA) requires all non-profit hospitals to conduct community health needs assessments (CHNA) every three years. The goal of CHNA is to improve the community's health and well-being by identifying health needs and existing gaps in services, prioritizing health needs, implementing evidence-based practices, and strengthening community relationships (Gruber et al., 2019). In their article, Brownson et al. (2009) discussed how CHNA is included as a step in the Evidence-Based Public Health Framework. CHNA's goals are to identify the needs of the targeted community, identify resources and assets, raise awareness of community concerns and problems, establish program priorities, goals, and objectives, and provide a baseline for evaluation and a foundation for organizational decisions made on actions (Community Health Assessment: What It Is and Why It's Important, n.d.).

The steps of CHNA are as follows: (1) profiling (gathering information to understand the population's current state of health and needs), (2) analyzing, identifying, and prioritizing the health issues to address, (3) developing programs and policies to address the prioritized health issues, and (4) implementing the planned activities and evaluating the health outcomes (Chavan et al., 2018). Based on the results of the CHNA, a community health improvement plan (CHIP)

is developed, which is a long-term, systematic effort to address public health problems. A CHIP is essential for developing health-promoting policies and actions (CDC, Assessment and Plans, Community Health Assessment, STLT Gateway, n.d.). Improved organizational and community collaboration, increased public health knowledge, strengthened partnerships within public health systems, identified strengths and weaknesses to address quality improvement, and preparation for accreditation and benchmarks for public health practice improvements are all benefits of developing CHNA and CHIP (CDC, Assessment and Plans, Community Health Assessment, STLT Gateway, n.d.).

1.2 The Rationale of the Clarkston Community Needs Assessment: Documenting the Needs and Assets of Residents in Clarkston, Georgia

The GSU Prevention Research Centre in the School of Public Health designed and implemented a community needs assessment (CNA) survey for Clarkston, GA, residents during the summer of 2023 in response to concerns raised by community organizations (and at the request of the City of Clarkston). People in Clarkston (area code 30021) who were at least 18 years old and spoke English, Swahili, Arabic, Dari, Burmese, Amharic, Somali, or Spanish were included in the target population. The data collection process was completed in August, and the data cleaning process was completed in September. The findings will be disseminated to community-based organizations, healthcare providers, and other stakeholders to provide them with a more nuanced understanding of both the needs and challenges faced by Clarkston residents, allowing them to develop appropriate strategies, policies, programs, or interventions to address these issues (CDC, Assessment and Plans, Community Health Assessment, STLT Gateway, n.d.).

1.2.1 The Purpose and Objectives of the Capstone Project:

The capstone project is intended to demonstrate skills and knowledge gained in MPH courses and to apply them to public health practices (School of Public Health, 2020; MPH thesis/capstone handbook, Georgia State University). Thus, the rationale for this capstone project was to analyze community needs assessment data, with a particular focus on the study population's sociodemographic characteristics, health profile, and healthcare access. My capstone project identified sociodemographic characteristics and how they are related to (1) the health profile of the population, and (2) access to healthcare for the residents living in Clarkston, GA.

The primary goal of this capstone project was to analyze data from the CNA in Clarkston, GA. This capstone report will first review the literature to gain a thorough understanding of the overall challenges faced by all refugees and immigrants, diverse populations, and socioeconomically disadvantaged populations, followed by a discussion of the specific challenges faced by refugee communities, such as food insecurity, housing, employment, education, physical and mental health, and access to healthcare. Then, I will discuss the significance of conducting CNA in these populations. Finally, I will present the results of my CNA data analysis, including the socio-demographic characteristics of the Clarkston community based on survey responses, and display results by age, gender, education level, race and ethnicity, income, primary language, and years lived in the United States. I will also present findings from a comparative data analysis of U.S.-born vs. foreign-born individuals for (1) general health profiles and (2) access to healthcare, as well as those with higher vs. lower English language proficiency skills for access to healthcare.

Therefore, in sum, the objectives of this capstone project were to:

1. Analyze socio-demographic characteristics and identify demographic variations.
2. Analyze the general health profile of the community and compare the general health profile with U.S.-born vs. foreign-born.
3. Compare access to healthcare services with U.S.-born vs. foreign-born
4. Compare access to healthcare services with English language proficiency

CHAPTER II: REVIEW OF LITERATURE

2.1. Definition of terms and overview of the global refugee crisis

A migrant, according to the International Organization for Migration (IOM), is "any person who is moving or has moved across an international border or within a state away from his or her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes of the movement are; or (4) what the length of stay is." (2018) (Abbas et al.). According to the United Nations High Commissioner for Refugees, an immigrant is anyone who has fled their home country due to conflicts, natural disasters, or fear of persecution because of their race, religion, nationality, political beliefs, or membership in a particular social group. The current global refugee crisis peaked between 2015 and 2017, with a significant increase in the number of refugees, asylum seekers, and internally displaced people (IDPs), primarily from Africa, the Middle East, and South Asia.

The passage of the Immigration and Nationality Act (INA) in 1965, as well as global changes in socioeconomic and political situations, resulted in an increase in the number of immigrants and refugees entering the United States. As a result, the number and diversity of immigrants in cities in the United States have increased in recent years, particularly in urban areas (Congressa, 2017). The share of the foreign-born population in the U.S. has increased from

35.7 million (12.4%) in 2005 to 46.2 million (13.9%) in 2022, according to the American Community Survey (2022). According to the survey, the number of immigrants from Latin America and Asia has increased in recent years (Rose, 2023).

According to United States Immigration law, refugee status may be granted to immigrants who fled their home countries due to fear of persecuted based on race, religion, nationality, or membership in a particular social or political group. Globally, approximately 983,000 people apply for asylum each year, with 1.6 million applying in the first six months of 2023 (Congressa, 2017; UNHCR, The UN Refugee Agency, n.d.). Most refugees seek asylum when they arrive in the United States, but immigration policies and practices in the United States are complex, and thus in 2021 alone, the United States admitted 17,692 asylum seekers, a 42.9% decrease from the previous year and a lowest year since 1994 (USA Facts, 2023). After arriving in the United States, immigrants can apply for additional permanent visas (to become lawful permanent residents) and, after residing in the country for 3-5 years, can apply for citizenship. Surprisingly, the majority of immigrants come from 146 different countries and are generally younger than the general population (Congressa, 2017).

According to the UNHCR, "a refugee is someone who has been forced to flee his or her country because of war, violence, or persecution for reasons of race, religion, nationality, political opinion, or membership in a particular social group" (What Is a Refugee? Definition and Meaning (USA for UNHCR, n.d.). Forced migration and displacement can occur for a variety of reasons, but the most common are armed conflict, civil unrest, extreme poverty, crime, fear of persecution, and governance failure. According to Article 25 of the Universal Declaration of Human Rights and Article 23 of the Refugee Convention, the populations are vulnerable and

require protection, security, rights, and access to healthcare. However, refugees' and migrants' basic needs and rights are not always met (Abbas et al., 2018).

2.2 Challenges faced by refugees, immigrants, and asylum seekers across the U.S.

If a person or family arrives in the United States with refugee status, the law requires a case worker to assist them for 90 days through resettlement agencies in looking for housing, finding a job, enrolling their children in school, and connecting them to other important resources such as English language training, health care, and social services (Malave, 2019). However, once in a new country, these refugees face several challenges, including adjusting to a new culture and environment, finding work, learning a new language, and dealing with the trauma they experienced before and during migration. Refugees, immigrants, and asylum seekers arriving in the United States faced numerous challenges before, during, and after their arrival (Abbas et al., 2018; Congressa, 2017; Schmitz et al., 2003).

2.2.1 Physical Health Challenges

The health of these populations frequently deteriorates during migration and in host countries due to poverty, poor living conditions, and limited access to healthcare. Women, children, and the elderly are at particular risk (Abbas et al., 2018). When immigrants arrive in their new host country, they frequently face a number of challenges, including housing, education, health, and access to healthcare. When immigrants first arrive in the United States, they are often healthier; however, their health deteriorates due to poverty, a lack of access to healthcare, dietary changes, and living in stressful environments. Undocumented immigrants are at an even higher risk of poor health due to a lack of access to healthcare as a result of their immigration status. Furthermore, many immigrants face prejudice and discrimination, which

causes significant psychological stress, particularly for those from the Middle East (Congressa, 2017).

Furthermore, language barriers, difficulty navigating and understanding the United States healthcare system, and a lack of insurance limit their ability to manage their health for non-communicable diseases such as hypertension and diabetes, as well as to prevent and treat infectious diseases (Reed & Barbosa, 2016). Although some medical assistance (Medicaid) is provided upon arrival for a certain period, some legal restrictions prevent these populations from accessing healthcare. Refugees and asylum seekers are typically only able to access emergency medical care, pregnancy and childbirth, and immunization services, all of which have a significant impact on the health of refugee populations (Malave, 2019).

2.2.2 Challenges Related to Social Determinants of Health

For refugees and immigrants, the social determinants of health present a complex web of challenges, such as education, employment, housing, and food security, affecting every aspect of their lives in a new country. Some refugees and immigrants came to the United States for their children's educational opportunities. In fact, many families struggle to meet their children's educational needs due to language barriers and unfamiliarity with the American educational system. Furthermore, employment opportunities are typically constrained by limited English proficiency skills and unrecognized qualifications, resulting in underemployment, jobs that do not provide health benefits, or jobs with poor or labor-intensive working conditions that have an impact on their health. Poverty, housing insecurity, and food insecurity exacerbate these issues, as many refugees and immigrants live in areas that lack safe and affordable housing and

nutritious food options. Their struggle to meet these basic needs of life frequently leads to neglect of their health, which can result in both short- and long-term poor health outcomes.

2.2.3 Mental Health Challenges

All of these circumstances have an impact on the psychological health of immigrants and refugees. Mental health issues among refugees and immigrants are complex, deep-rooted, and frequently linked to previous traumatic experiences and stressful times adapting in a new country. The psychological impact of fleeing conflict or persecution, combined with assimilation stressors such as language barriers, employment difficulties, and acculturation, can result in mental health issues. Children who have had their education interrupted or who have experienced trauma are especially vulnerable to mental health issues because they must navigate a new educational system while dealing with potential bullying and peer pressure. Such experiences can exacerbate conditions such as depression, anxiety, and post-traumatic stress disorder, and they can be worsened by a lack of culturally and linguistically sensitive mental health services (Schmitz et al., 2003). As a result, these populations typically face a triple disease burden: non-communicable diseases, infectious diseases, and mental health issues (Abbas et al., 2018).

2.2 Challenges faced by refugees, immigrants, and asylum seekers from Clarkston, GA

"Over the past two decades, Georgia has accepted and resettled 37,000 refugees, with an average of about 25,000 to 25,000 each year, statewide, with the majority of whom coming to Clarkston" (How This Small Town Has Welcomed Thousands of Refugees—and Thrived, 2018f). Clarkston, Georgia, the most diverse square mile in the United States and also known as "Ellis Island of the South," is now home to over 17,000 refugees who speak more than 60 languages. After the Refugee Act was passed in 1980, the United States began the formal process

of accepting refugees through resettlement agencies, and resettlement agencies identified Clarkston, GA, as an ideal location for refugees due to various housing units and already established public transportation (Feinberg et al., 2023). Due to conflicts and disasters, refugees flee to Congo, Burma, Afghanistan, Iraq, Somalia, and Nepal in search of new opportunities (Feinberg et al., 2021).

According to Feinberg et al.'s (2021) study on healthcare access and social determinants of health, the Clarkston community's average income was $15,476, which was below the poverty line. Only 41.2% of survey respondents had jobs, 29.4% had health insurance, and nearly 60% had English language proficiency issues. As a result, low income, unemployment, limited or no health insurance, and limited access to healthcare all have a significant impact on the health outcomes of these populations. Furthermore, when compared to the general population, these refugees have higher rates of mental health issues such as depression, post-traumatic stress disorder, and psychosis (Feinberg et al., 2021). As a result, resettlement agencies provide these refugees with short-term (6-month) assistance in the following areas: finding housing, finding jobs, English language training, social benefits (food stamps), and temporary Medicaid coverage (Feinberg et al., 2021).

However, because these benefits typically exhaust after 6-9 months, it is the individual's responsibility to reapply for them. After the expiration of resettlement assistance, most refugees start to face challenges as almost 70% of Clarkston residents are unable to navigate and maintain these social support benefits on their own due to limited English skills and a lack of transportation (Feinberg et al., 2023). As a result of high rates of poverty and unemployment, refugees in Clarkston continue to struggle with access to healthcare, resulting in high morbidity

and mortality and health disparities (Feinberg et al., 2021). Other social factors, such as English language proficiency, income, transportation, housing, and culture, frequently exacerbate their need for healthcare (Feinberg et al., 2020).

Another barrier to understanding healthcare information and using healthcare services for the refugee population is a lack of culturally and linguistically appropriate health promotion materials (Feinberg et al., 2021). Cultural and linguistic differences are frequently cited as barriers to accessing healthcare services for refugees. The most significant barrier to accessing healthcare is English language proficiency, and instructions are typically provided in English, which may include jargon. As a result, most refugees do not understand what healthcare providers say about their health without the assistance of interpreters, resulting in an exacerbation of their health conditions and poor health outcomes (Feinberg et al., 2020). Primary healthcare clinics are the first point of contact for refugees seeking medical attention; however, several barriers to care have been well documented. Language barriers, unfamiliarity with preventive healthcare approaches, different cultures and beliefs about health, and building trust between healthcare providers and refugee patients are the most common challenges. These obstacles keep them from navigating healthcare services and following medical advice to maintain or improve their health (Malave, 2019).

2.3 Importance of Community Health Needs Assessment (CHNA) in Clarkston

A community health assessment (CHA), also known as a community health needs assessment (CHNA), is an assessment that identifies the community's key health needs and issues through systematic, comprehensive data collection and analysis. The primary goal of the Community Health Needs Assessment (CHNA) is to develop appropriate strategies, policies, and

programs to address community health needs and issues (CDC, Assessment and Plans, Community Health Assessment, STLT Gateway, n.d.). The community need assessment is not a one-time event; rather, it is an ongoing process that identifies community problems and needs as well as assesses community resources, all of which are critical in promoting community health and well-being (Chavan et al., 2018).

The CHNA can also provide a snapshot of the effectiveness of local policies, programs, and practices. As a result, based on the findings of the CHNA, it can be used to effectively plan and prioritize resources, develop programs and policies, and deliver care to those in greatest need to achieve health equity (Chavan et al., 2018). Conducting a CHNA among Clarkston residents can provide stakeholders with the opportunity to better understand the socioeconomic and health challenges that Clarkston residents face, as well as to develop policies, programs, and practices that are tailored to the needs of the population to achieve health equity. Clarkston's most recent community needs assessment (CNA) was conducted in 2020 during the COVID-19 pandemic, so it was time to conduct another CNA to identify community needs relevant to the current socio-political context (Clarkston Community Needs Assessment - Prevention Research Centre, 2021).

CHAPTER III: Methods and Procedures

3.1 Methods

3.1.1 Survey Development

The survey instrument assessed several domains, including social cohesion, social capital, trust/discrimination, experience with violence, food insecurity, housing insecurity, physical health (including diabetes and chronic pain), mental health (including depression, anxiety, and substance use/abuse), and barriers to accessing childcare and healthcare.

Additionally, we asked a series of basic socio-demographic questions, including age, race/ethnicity, gender, country of origin, primary language spoken at home, English language fluency (defined for the current analysis as the extent to which respondents were able to speak English), refugee status, number of years spent in the U.S., total household income, and educational attainment.

The survey instrument was IRB-approved and programmed into Qualtrics in English. It was professionally translated into seven additional languages: Swahili, Arabic, Dari, Burmese, Amharic, Somali, and Spanish. The translated surveys were then distributed to native speakers of those 7 languages to solicit their feedback on the accuracy of the translation; edits to the programmed survey were made accordingly as needed.

3.1.2 Survey Recruitment

To recruit participants, the research team utilized several strategies. First, the team distributed electronic flyers about the events through community organization partners and on social media channels. Second, the research team distributed hard-copy flyers to local health centers, local community-based organizations, and other local businesses and apartment complexes in/around Clarkston. Finally, the research team attended pre-planned community events and was able to use the event hosts' advertising to maximize reach.

3.1.3 Survey Implementation

The research team conducted 10 community-based survey events on weekend days lasting approximately 3-5 hours each over the course of 3 months. Four of these events were community-wide events hosted by the City of Clarkston or local community-based organizations (e.g., the Clarkston Early Learning Fair, the Clarkston Juneteenth Festival, the Clarkston World

Refugee Day Festival, and a Clarkston Back to School event); three of these events took place at local health clinics; two of these events took place at Clarkston apartment complexes; and one took place at a local church.

Individuals were eligible to take the survey if they lived in zip code 30021 (Clarkston, GA), could read one of the languages in which the survey was provided, were 18 years of age or older, and were able to provide consent. Participants were asked to indicate their preferred language and then were asked to read the consent form and complete the survey on laptops provided in that language; hard copies of consent forms and surveys were also available if needed. In some cases, translators were also available on-site in case there were issues or questions. Participants were compensated $20 in cash at the end of the survey. Data collection was done via electronic (Qualtrics) and paper surveys, and subsequent data analysis was conducted by SPSS software.

3.2 Results

3.2.1 Table 1: Sociodemographic Characteristics of the Study Population Total and by Nationality Status

Table 1 represents the sociodemographic characteristics of the study population, both in total and by nationality status. The age distribution shows that 51.3% are between the ages of 18 and 34, which is more prominent among respondents who were U.S.-born (61.5%) than foreign-born (48.6%; $p<.012$). Gender distribution leans towards females, who represent 62.8% of survey participants, with a fair representation of U.S.-born (64%) and foreign-born (62.5%) groups. Clarkston is known for its racial and ethnic diversity, with significant representation in all groups. The largest group is black or African American (33.8%), then white (12.2%), and

Asian or Asian American (15.5%). While 54.2% of the U.S.-born (over half of the respondents) identified as Black or African American, the foreign-born population also predominantly identifies as the same group (27.9%).

There were also substantial differences in the major languages spoken, showing Clarkston's multicultural diversity. Swahili/Kiswahili (17.6%), Arabic (12.6%), and English (28.4%) are the three most frequently used languages among participants. Arabic (16.3%), Dari (14.5%), and Swahili/Kiswahili (22.1%) are the three languages that most foreign-born respondents speak. Income levels of participants are predominantly below $30,000 per year, more prominent among foreign-born (69.7%) than U.S.-born respondents (28.6%, $p<.001$). Participants' educational backgrounds varied, with a university or graduate degree being the highest level (28%), then a high school diploma or GED (21.3%). However, there is a notable difference in educational levels between U.S.-born and foreign-born respondents ($p<.001$). The length of residence figures show the different trends among immigrant populations, with the largest proportion of the foreign-born respondents residing in the U.S. for 4–10 years.

3.2.2 Table 2: Health of the Study Population, Total and By Nationality Status

Table 2 summarizes the study's population's health status. The majority (56.3%) reported their general health as excellent or very good, with no significant difference between respondents born in the United States and those born elsewhere. Diabetes affects 17.1% of the population, with foreign-born people reporting a greater rate (19.1%) than respondents who were U.S.-born (10.4%), though this difference is not statistically significant ($p =.0159$). Among those reporting that they have received a diabetes diagnosis, there were no significant differences based on nationality status in receiving treatment, whether pills or insulin.

Most participants report no interruption from chronic pain that interferes with general activity or enjoyment. Mental health indicators also reveal that the majority do not feel down, depressed, or hopeless, with only a few reports of negative experiences. The majority of respondents reported abstaining from tobacco (85.6%), excessive alcohol use (85.2%), illegal drug use (88.3%), and prescription drug misuse (89.7%). Interestingly, substance use issues were more prevalent among U.S.-born respondents: tobacco use: U.S.-born (18.8%) vs. foreign-born (13.2%), excessive alcohol consumption: U.S.-born (27.1%) vs. foreign-born (11.3%), and any illicit drug use: U.S.-born (14.9%) vs. foreign-born (10.8%).

3.2.3 Table 3: Healthcare (HC) Access Among the Study Population, Total and By Nationality Status

In terms of HC access indicators, 65.3% of the population received regular checks or well visits, with U.S.-borns receiving a much higher percentage (82.6%, $p<.005$). Finding an HC provider is challenging for 25.6% of respondents, with foreign-born individuals having higher difficulty (28.4%). 28.6% of respondents experienced transportation difficulties, with foreign-born respondents reporting greater rates (34.1%) than U.S.-born respondents (8.7%). The difficulty in understanding HC providers and the requirement for a translator are significant, especially for foreign-born individuals, who had 43.6% and 39%, respectively, compared to U.S.-born individuals (only 9.1% and 2.2%).

The issue of cost as a barrier to HC is noteworthy, with 28.6% of respondents reporting that they did not receive care due to cost, but there is no distinction between U.S.-born and foreign-born respondents in this regard. Furthermore, 39.8% of the study's population needed medical care but waited or did not receive it for various reasons, indicating concern for delaying

receiving medical care. Regarding childcare, it indicates a concern, with 17.8% of the study population reporting that their children have missed, delayed, or skipped well-child visits or routine vaccinations. The difference between U.S.-born and foreign-born individuals is statistically significant (p =.003), with children of U.S.-born respondents being more likely to miss well-child visits or routine vaccinations (29.5%) compared to those of foreign-born individuals (14.6%).

3.2.4 Table 4: Healthcare Access Among the Study Population, Total and By English Proficiency

Table 4 compares healthcare access based on English proficiency. 66.3% of the sample population reported having regular checkups. Notably, individuals who speak English "very well" or "well" were more likely (72.9%) to have regular checkups or well visits than those who speak English "not at all" or "not well" (52.3%) (p<.004). Finding an HC provider was challenging for 26.3% of survey respondents, with those with insufficient English-speaking skills having more difficulty (34.4%) than those with greater proficiency (22.3%). Transportation was a difficulty for 29.4% of participants, with a substantial difference between those who did not speak English well (49.3%) and those who did (19.7%). 35.4% of individuals reported difficulty paying for healthcare services, with those with lesser English proficiency experiencing the most difficulty (42%). 28.9% of the study group reported not receiving care due to cost, with those with poorer English proficiency suffering the most (31.8%).

Over a third of respondents (37.1%) had difficulty understanding healthcare providers, with a considerably larger proportion (50.7%) among those with weak English-speaking skills compared to those with higher ability (30.2%). Furthermore, 31.8% of the survey population expressed a need for a translator, with half of those with weak English-speaking skills indicating

this need, compared to 22.7% of their counterparts. A considerable 40% of individuals need medical care but have waited or did not receive it for any reason; however, there is little difference between the two groups. 17.6% of respondents stated that their children had missed, delayed, or skipped any well-child visit or routine immunizations, and this is more prevalent among children whose parents or caretakers had weak English-speaking skills (20.3%) than their counterparts (16.2%).

CHAPTER IV: Discussion

4.1 Discussion

Based on the data, the sociodemographic profile of Clarkston, Georgia, indicates a diverse population with significant racial, ethnic, linguistic, educational, and economic opportunities. According to the findings, Clarkston's racial and ethnic diversity is one of its most distinguishing features, with a significant representation of various racial and ethnic groups, highlighting the need for culturally appropriate service provisions and interventions to address their unique needs, increase service uptake, and improve outcomes. The linguistic diversity in a multilingual population calls for the development of multilingual resources, translators, and language-appropriate public health interventions to ensure vital information reaches everyone through effective communication, resulting in access to critical health and social services to improve health and other social outcomes.

The income disparities, particularly affecting the foreign-born population, highlight the need for economic development programs and employment opportunities. Initiatives that can assist local businesses and foster the creation of jobs, as well as financial literacy training programs, can enhance the economic prospects of these foreign-born people. Furthermore, many

foreign-born residents living below the poverty line suggest a need for social service assistance such as housing and food security. The observed educational discrepancies, with foreign-born individuals having lower education status, highlight the need for targeted educational programs, as well as language classes and skill-based training programs, to compete in labor markets and thrive in the local economy. To close the educational gap and support these populations' long-term socioeconomic development, it is also possible to do this by forming partnerships with educational institutions that will fund scholarships and tuition for them.

The overall general health profile of the survey data suggests that the respondents generally viewed their health positively. However, there were still some health challenges that needed to be addressed to improve the health outcomes of the residents. The incidence of chronic diseases such as diabetes is notably higher among the foreign-born population, and this disparity highlights the need for health education programs and chronic disease management interventions that are culturally and linguistically appropriate. While mental health generally seems to be stable, reports of some negative experiences cannot be ignored. This calls for the development or expansion of current mental healthcare services, including counseling and support programs, to reach these populations, which should be accessible and culturally competent. Surprisingly, substance use—tobacco use, illicit drug use, and excessive alcohol consumption—is higher among U.S.-borns, possibly reflecting broader social issues that require targeted interventions. However, due to the sensitive nature of these questions, careful interpretation will be required, and some respondents, particularly foreign-born respondents, may be reluctant to disclose such behaviors.

The analysis of healthcare access highlights an important issue and demonstrates major differences, as nationality status and English language proficiency influence the ability to

navigate and utilize healthcare services. Foreign-born residents continue to experience challenges in accessing healthcare, finding healthcare providers, navigating transportation to health facilities, and communicating and interacting with healthcare providers. These hurdles not only hinder immediate access to healthcare, but they also have implications for adverse health outcomes. Another barrier to healthcare access for both U.S.-born and foreign-born residents is cost, emphasizing the need for policy-level interventions that address structural barriers while ensuring accessibility, affordability, and equity for all. Finally, the pattern of missed, delayed, or skipped well-child visits or routine vaccinations for children raises concerns for both U.S.-born children and those with limited English proficiency skills. It emphasizes the pressing need for home health services to eliminate the barriers of transportation, offering services on weekends to accommodate families who have difficulty accessing care during the weekdays, health education campaigns, and potential outreach programs to raise awareness and improve well-child visits and vaccination rates in the Clarkston community.

4.2 Strengths and Limitations

4.2.1 Strengths

The study has some notable strengths. First, a professional translator double-checked the survey's quality to make sure the language used was accurate and culturally appropriate for collecting accurate responses from survey participants. Second, the data was collected in a variety of locations to reach more people and capture a greater range of experiences and responses, which contributed to the data's depth and diversity. Finally, using translators during data collection increases the participation of non-native English speakers. It enhanced participation while also improving the quality and accuracy of the data collected from survey participants.

4.2.2 Limitations

While the study provides useful information about socio-demographics, general health profiles, and healthcare access, it does have some limitations that we must address. First, while the sample size of the study is larger than that of many Community Needs Assessments (CNAs), it remains relatively small. As a result, it has an impact on the statistical power of the study as well as the reliability of the findings. Second, we used a convenience sampling method rather than a random selection method, which limits the results' generalizability to the broader Clarkston population. Lastly, there was a potential selection bias because the survey participants were not necessarily representative of the entire population. Those who are healthier or more engaged with the community, or who attend events or clinics at the time of data collection, may have been more likely to participate in the survey. There might be some respondents who reported feeling down or not feeling well who may not have answered all questions, or certain individuals who were anxious or depressed could have been less likely to attend these activities. These biases could contribute to an overestimation or underestimation of the general health profile, as well as an overestimation or underrepresentation of the challenges faced by the community. Hence, each of these must be carefully considered when interpreting the study's findings.

4.3 Conclusion

In conclusion, the socio-demographic, health profile, and health access data demonstrate barriers and disparities faced by the diverse community in Clarkston, particularly among foreign-born residents and those with limited English proficiency skills. The findings call for policy-level interventions and advocate for a multifaceted approach to not just improving healthcare access,

affordability, and equity but also enhancing educational attainment, English proficiency skills, and economic stability for Clarkston residents, using culturally and linguistically appropriate approaches. This multidimensional and holistic approach would address both the short-term and long-term well-being and socio-economic advancement of this diverse population to achieve the final goal of equity.

Appendices: List of Tables

Table 1: Sociodemographic Characteristics of the Study Population, Total and By Nationality Status

Characteristic	**Total N* (%)**	**By Nationality Status⁺**		**Test Statistic (df)**	**p-value**
		US-Born	Foreign-Born		
Age*				χ^2=8.88 (2)	**.012**
18-34	96(51.3%)	61.5%	48.6%		
35-54	73 (39)	20.5%	43.9%		
> 55	18 (9.6)	17.9%	7.4%		
Gender				χ^2=0.37 (2)	**.847**
Male	81 (37.2)	36%	37.5%		
Female	137 (62.8)	64%	62.5%		
Race/ethnicity				χ^2=38.37 (8)	**<.001**
Asian or Asian American	33 (15.5)	10.4%	17.0%		
Southeast Asian	17 (8)	2.1%	9.7%		
Hispanic Latino, Latina, LatinX	9 (4.2)	-	5.5%		
Middle Eastern	14 (6.6)	-	8.5%		
White	26 (12.2)	27.1%	7.9%		
Black or African American	72 (33.8)	54.2%	27.9%		
African	29 (13.6)	-	17.6%		
Other	7 (3.3)	2.1%	3.6%		
Two or more races	6 (2.8)	4.2%	2.4%		
Primary language				χ^2=133.21 (19)	**<.001**
Amharic	14 (6.3)	-	8.1%		
Arabic	28 (12.6)	-	16.3%		
Burmese	11 (5.0)	-	6.4%		
Dari	25 (11.3)	-	14.5%		
English	63 (28.4)	88.0%	11.0%		
Farsi	7 (3.2)	-	4.1%		
French/French Creole	-	-	-		
Hindi	-	-	-		
Karen	-	-	-		
Swahili/Kiswahili	39 (17.6)	-	22.1%		
Pashto	-	-	-		
Spanish	7 (3.2)	-	4.1%		
Tagalog (Filipino)	-	-	-		
Urdu	-	-	-		
Vietnamese	-	-	-		
Other	6 (2.7)	-	3.5%		
Income				χ^2=23.25 (3)	**<.001**
Less than $30,000 per year	88 (58.3)	28.6%	69.7%		
$30,000 - $60,000	41 (27.2)	45.2%	20.2%		
$60,001 - $100,000	11 (7.3)	9.5%	6.4%		
Greater than $100,000	11 (7.3)	16.7%	3.7%		
Education				χ^2=36 (4)	**<.001**

No schooling	45 (21.7)	2.1%	27.5%		
Some primary	24 (11.6)	4.3%	13.8%		
HS diploma or GED	44 (21.3)	10.6%	24.4%		
Some technical or university	36 (17.4%)	34.0%	12.5%		
University or graduate degree	58 (28)	48.9%	21.9%		
Years in the US^					
Less than 1 year	25 (11.3)	-	14.5%		**N/A**
1-3 years	44 (19.8)	-	25.6%		
4-10 years	62 (27.9)	-	36.0%		
>10 years	41 (18.5)	-	23.8%		

*Total N smaller than the full sample
^Among foreign-born respondents only
+Reflects column percents rather than total percents

Table 2: Health of the Study Population, Total and By Nationality Status

Health Indicator	**Total N (%)**	**By Nationality Status**		**Test Statistic (df)**	**p-value**
		US-Born	Foreign-Born		
General Health				χ^2=2.87 (2)	**.238**
Excellent or Very Good	121 (56.3)	54.2%	56.9%		
Good/Fair	86 (40.0)	45.8%	38.3%		
Poor	8 (3.7)	-	4.8%		
Diabetes – Has a provider ever told you that you have pre-diabetes, diabetes, or "a problem with sugar"?				χ^2=1.98 (1)	**.159**
Yes	36 (17.1)	10.4%	19.1%		
No	174 (82.9)	89.6%	80.9%		
Diabetes – Receiving ANY tx (pills or insulin to lower blood pressure)				χ^2=0.003 (1)	**.954**
Yes	14 (41.2)	40.0%	41.4%		
No	20 (58.8)	60.0%	58.6%		
Chronic Pain – Pain interference (interference with general activity)				χ^2=0.011 (1)	**.917**
None	127 (64.5)	63.8%	64.7%		
A lot or some	70 (35.5)	36.2%	35.3%		
Chronic Pain – Pain interference (interference with enjoyment)				χ^2=0.43 (1)	**.512**
None	130 (67)	63%	68.2%		
A lot or some	64 (33)	37%	31.8%		
Mental Health - Little interest or pleasure in doing things				χ^2=3.33 (2)	**.190**
All or most of the time	51 (24.3)	14.6%	27.2%		
Some or a little of the time	58 (27.6)	29.2%	27.2%		
None of the time	101 (48.1)	56.3%	45.7%		
MH - Feeling down, depressed, or hopeless				χ^2=4.48 (2)	**.107**
All or most of the time	34 (16.3)	12.5%	17.5%		
Some or a little of the time	63 (30.3)	20.8%	33.1%		
None of the time	111 (53.4)	66.7%	49.4%		
MH – Feeling nervous, anxious, or on edge				χ^2= 0.44 (2)	**.804**
All or most of the time	33 (16.1)	19.1%	15.2%		
Some or a little of the time	74 (36.1)	34%	36.7%		
None of the time	98 (47.8)	46.8%	48.1%		
MH – Not being able to stop or control worrying				χ^2=0.24 (2)	**.887**
All or most of the time	35 (17.1)	16.7%	17.2%		
Some or a little of the time	65 (31.7)	29.2%	32.5%		
None of the time	105 (51.2)	54.2%	50.3%		

MH – Feeling lonely or alone				χ^2= 0.90 (2)	**.638**
All or most of the time	43 (21)	16.7%	22.3%		
Some or a little of the time	49 (23.9)	22.9%	24.2%		
None of the time	113 (55.1)	60.4%	53.5%		
Substance use – Used any tobacco product?				χ^2=0.94 (1)	**.332**
Everyday/weekly/monthly	31 (14.4)	18.8%	13.2%		
Never	184 (85.6)	81.3%	86.8%		
Substance use – Had 4 or more alcohol drinks one day?				χ^2= 7.36 (1)	**.007**
Everyday or weekly or monthly	32 (14.8)	27.1%	11.3%		
Never	184 (85.2)	72.9%	88.7%		
Substance use – Used any illicit drugs (Marijuana, cocaine, heroin, meth, ecstasy)?				χ^2= 0.60 (1)	**.438**
Everyday or weekly or monthly	25 (11.7)	14.9%	10.8%		
Never	189 (88.3)	85.1%	89.2%		
Substance use – Used any prescriptions more than prescribed or were not prescribed for you?				χ^2= 2.37 (1)	**.124**
Everyday or weekly or monthly	22 (10.3)	4.3%	12%		
Never	192 (89.7)	95.7%	88%		

Table 3: Healthcare Access Among the Study Population, Total and By Nationality Status

Healthcare Access Indicator	**Total N (%)** [#]	**By Nationality Status**		**Test Statistic (df)**	**p-value**
		US-Born	Foreign-Born		
Has received regular checkup/Well visits (adult)	132 (65.3)	82.6%	60.3%	χ^2= 7.84 (1)	**.005**
Has had "Troubles" with accessing care: Finding a healthcare provider	53 (25.6)	15.6%	28.4%	χ^2= 3.048 (1)	**.081**
Has had "Troubles" with accessing care: Transportation difficulties	60 (28.6)	8.7%	34.1%	χ^2= 11.40 (1)	**<.001**
"Troubles" with accessing care: Paying for HC services	72 (34.8)	24.4%	37.7%	χ^2= 2.71 (1)	**.100**
"Troubles" with accessing care: Difficulty in understanding what HC provider said	76 (36.4)	9.1%	43.6%	χ^2= 17.91 (1)	**<.001**
"Troubles" with accessing care: Need a translator to understand what HC provider said	65 (31.1)	2.2%	39%	χ^2= 22.32 (1)	**<.001**
Not receiving care due to cost	57 (28.6)	30.4%	28.1%	χ^2= 0.09 (1)	**.759**
Needed medical care but waited or did not get it for any reason	80 (39.8)	42.2%	39.1%	χ^2= 0.14 (1)	**.706**
Children have missed, delayed or skipped any well-child visits or routine vaccinations	36 (17.8)	29.5%	14.6%	χ^2= 11.84 (2)	**.003**

[#]Total N for these comparisons (excluding missing values)

Table 4: Healthcare Access Among the Study Population, Total and By English Proficiency*

Healthcare Access Indicator	Total N (%)	By English Proficiency		Test Statistic (df)	p-value
		Not at all (or) not well	Very well (or) well		
Regular checkups/Well visits (adult)	136 (66.3)	52.3%	72.9%	χ^2= 8.40 (1)	**.004**
"Troubles" with accessing care: Finding a healthcare provider	55 (26.3)	34.4%	22.3%	χ^2= 3.45 (1)	**.063**
"Troubles" with accessing care: Transportation difficulties	62 (29.4)	49.3%	19.7%	χ^2= 19.55 (1)	**<.001**
"Troubles" with accessing care: Paying for HC services	74 (35.4)	42%	32.1%	χ^2= 1.98 (1)	**.160**
"Troubles" with accessing care: Difficulty in understanding what the HC provider said	78 (37.1)	50.7%	30.2%	χ^2= 8.45 (1)	**.004**
"Troubles" with accessing care: Need a translator to understand what the HC provider said	67 (31.8)	50%	22.7%	χ^2= 16.09 (1)	**<.001**
Not receiving care due to cost	58 (28.9)	31.8%	27.4%	χ^2= 0.42 (1)	**.517**
Needed medical care but waited or did not get it for any reason	82 (40)	41.8%	39.1%	χ^2= 0.13 (1)	**.715**
Children have missed, delayed or skipped any well-child visits or routine vaccinations	36 (17.6)	20.3%	16.2%	χ^2= 3.69 (2)	**.158**

*As measured by question, "How well do you speak English?"

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