Lack of Arab or Middle Eastern and North African Health Data Undermines Assessment of Health Disparities

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Collection of race and ethnicity data has been controversial in the United States, and the identification of legally recognized race and ethnic categories has shifted over time as a result of changes in the sociopolitical climate. For example, the shift from using the Asian (Mongol) to the White classification for Arab or Middle Eastern and North African (MENA) populations came after contentious court battles at the beginning of the 20th century, when being White was a prerequisite for US citizenship.[1]

Furthermore, the accuracy of racial and ethnic categories has been questioned.[2–4] A case in point is that the Hispanic/Latino group did not emerge as a recognized ethnic group until the 1980 US census count,[5] and there was little consensus as to whether this category should be considered a race or an ethnicity.[6] The categories adopted in the US census tend to result from both research and political lobbying. The political motivations underlying the collection of race and ethnicity data range from remedying inequalities to advancing White supremacist values.[4,7,8] Accurate and robust collection of ethnicity and race data is the first critical step in identifying and addressing disparities in health.[9,10]

One ethnic minority group that is often omitted from medical and health-related data collection altogether is the Arab/MENA population in the United States. Race and ethnicity disparity statistics often exclude the Arab/MENA population because either data are not being collected on this population or the group is not being disaggregated from the White race category. A growing body of research shows that Arab/MENA Americans have both health and social patterns distinct from those of Whites. Findings suggest that, relative to non-Hispanic Whites, Arab/MENA Americans have a higher prevalence of metabolic disorders and cardiovascular disease,[11–13] as well as low birth weight[14,15] and depressive symptoms.[16,17] Furthermore, this group is bifurcated in terms of socioeconomic status, reporting both higher and lower educational levels than Whites.[18,19]

It appears that the experiences of Arab/MENA Americans place them at elevated risk of developing a myriad of health problems, perhaps owing to discrimination and social stress.[10,20] We argue that disaggregating the Arab/MENA population in race and ethnic group data collection by including an Arab/MENA ethnic category will advance the science of health disparities.

ADVANCING KNOWLEDGE ON HEALTH DISPARITIES

Data on the Arab/MENA population should be disaggregated from data on White samples to advance the science of health disparities. In particular, such data will address issues pertaining to external validity (the extent to which scientific findings are generalizable across people, settings, and times[21]). Sampling schemes that do not include Arab/MENA individuals compromise scientific inquiry by inaccurately attributing trends to Whites, making invisible the unique challenges faced by Arab/MENA populations and further obscuring disparities between White and minority individuals and groups. Such threats to external validity result in bad science. Because systematic comparisons cannot be made regarding the health outcomes of Arab/MENA Americans across contexts and communities, the strongest scientific statements are often generalizations that do not advance research on health disparities. The external validity of studies aiming to describe health disparities is thereby limited by incomplete and inaccurate descriptions of the racial and ethnic landscape in the United States.

We argue that studying Arab/MENA Americans is necessary to establish an accurate and comprehensive account of health disparities in the United States and offers unique opportunities for clarifying and revealing life course mechanisms that create and sustain these disparities. Accumulating research underscores the importance of distinguishing Arab/MENA Americans from Whites (often considered as a monolithic "control" group) to reveal hidden patterns of vulnerabilities among both Arab/MENA and other minority populations.[22] Because Arab/MENA Americans experience ethnic discrimination and "othering,"[10] placing them in the White category masks the disparities between Whites and other ethnic minorities (e.g., Blacks and Latinos).

For example, identification of Arab/MENA individuals separately from White individuals allows for an understanding of how patterns of social relations and health in the Arab/MENA population differ from those in the White population and, in so doing, makes the severity of disparities between Black and White groups more apparent.[16] Thus, a commitment to external validity in the scientific enterprise makes it imperative that the Arab/MENA population be disaggregated from the White category to adequately identify disparities between Whites and all racial and ethnic minority groups.

RECOGNIZING ARAB/ MENA POPULATIONS

The Office of Management and Budget (OMB) determines the minimal reporting criteria for race and ethnicity data in the United States for federal agencies. Agencies such as the US Census Bureau apply these guidelines in their data collection and dissemination practices. As the largest purveyors of statistical insight into the condition of the US populace, federal agencies provide the de facto standards for how race and ethnicity data are collected on demographic forms across numerous sectors, including health care. Many organizations, including hospitals and health care organizations, use US census race and ethnicity questions to inform the demographic data they collect. These standard demographic forms do not include a separate category for Arab/MENA populations.

As evidence that the White racial category was an inadequate option for people of Arab/MENA descent, results from the 2010 decennial census indicated that more than 1 million individuals of Arab/MENA descent chose the "some other race" classification.[23] These same data showed that the number of Arab/MENA Americans was more than twice that of the recognized Pacific Islander racial group.[24] Evidence that the White racial category was an inadequate option for people of Arab/MENA descent prompted the Census Bureau to examine more appropriate options for categorizing Arab/MENA populations.

In its 2015 National Content Test, the US Census Bureau used updated forms including the MENA category as a standalone racial/ethnic category for respondents who traced their ancestry to Arabic-speaking countries and non-Arab countries in the Middle East and North Africa. The results from the test indicated that a separate MENA response category was optimal for collecting data from this population and that inclusion of a MENA category helps respondents more accurately report their identities.[9] When the Census Bureau recommendations regarding such a category were forwarded to the OMB, the office failed to make a decision by the decennial census operational deadline; no specific reason was given for failure to accept the recommendations.[25]

Population-representative health data for Arab/MENA individuals at the national level are limited to secondary data sets with inadequate specificity and generalizability. For example, the National Health Interview Survey allows for examination of the health of only first-generation immigrant Arab/MENA individuals. In addition, the US census allows for identification of Arab/MENA individuals through the ancestry question on the American Community Survey but includes only disability health measures. Similar to information for other ethnic minority groups, the data are usually pooled at the national level over multiple years to ensure that comparisons of health outcomes are well powered.

The majority of research on health outcomes relies on conveniently sampled surveys conducted in locations with large Arab/MENA populations.[26] One unique data set is the Behavioral Risk Factor Surveillance System, established in 1984 by the Centers for Disease Control and Prevention.[27] This ongoing state-based system of random-digit-dial, telephone-administered population-based health surveys collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury among adults aged 18 years or older. In 2007, the state of Michigan added the question "Are you of Arab or Chaldean origin?" Although this question allows for initial examination of health issues at the state level,[28] it has yet to spur the inclusion of an Arab/MENA category in other health systems or large, nationally representative health studies despite evidence of disparities between Arab/MENA and White populations.

IDENTIFYING ARAB/MENA POPULATIONS

As a means of advancing good science toward the elimination of health disparities, we capitalize on the results of the Census Bureau's National Content Test to present three options for researchers, private organizations, or government institutions seeking to collect data on the Arab/MENA population.

Option 1: Streamlined/Combined Question

This option is informed by the US census question combining race and ethnicity, assessed in the 2015 National Content Test and found to result in more accurate data.[9] This flexible option allows the responder to indicate both an ethnicity and a race (or either an ethnicity or a race). In addition, this approach allows researchers to compare outcomes across ethnicity and race categories. According to the US census, the six examples included in this tool were assessed in the 2015 National Content Test and were meant to show the broad geographic diversity of the Arab/MENA population. The census used the three largest Middle Eastern nationalities (Lebanese, Iranian, and Syrian) and the three largest North African nationalities (Moroccan, Egyptian, and Algerian) to test the MENA category.

Researchers should tailor examples included in the parentheses after the MENA option to their particular populations of interest. To determine which ancestry or ethnicity choices to include, researchers can consult the American Community Survey for top MENA ancestries selected in that survey by particular US region (2014 American Community Survey five-year estimates). Using the filters available in the US census's Web-based data tool, interested parties could also filter top Arab or MENA ancestry choices for a particular geographic location (Figure A, available as a supplement to the online version of this article at http://www.ajph.org, option 1).

Option 2: Separation of Ethnicity and Race

This option is adapted from the current US census question format, in which two separate questions are used to collect race and ethnicity data. For this option, an Arab/MENA ethnicity question is added that mirrors the Hispanic ethnicity question used in most major surveys. The standard OMB race categories remain the same. This option allows for independent examinations of ethnicity and race. This may be reasonable and necessary for certain research questions and for institutions interested in differences by race and ethnicity. MENA ethnicities should be removed from the White category examples to prevent confusion. It is assumed that Arab/MENA individuals who do not identify as White will choose another box as they see fit (Figure A, option 2).

Option 3: Adding a MENA Category

This option entails adding a MENA box to an existing data collection instrument (Figure A, option 3). The MENA box will be structured according to the format of the existing instrument. An example of an institution that uses option 3 is the Michigan Behavioral Risk Factor Surveillance System,[25] which in 2020 asked demographic questions largely according to OMB guidelines. In that survey, however, an additional question asking "Are you of Arab or Chaldean origin?" was included. Although not as broad as a MENA category, the intent was the same.

CONCLUSION

Omission of the Arab/MENA population from research on health disparities undermines rigorous scientific inquiry. The politics surrounding race and ethnic categories must be challenged directly to preserve and advance scientific inquiry. Not only are the experiences and health disparities of the Arab/MENA group being ignored,[29] but keeping this minority population in the White category masks disparities between Whites and other ethnic minority groups. Although institutions refer to the US census to determine how to adequately measure race and ethnicity, the OMB ignored $7.25 million in research by not implementing census recommendations for adding a separate Arab/MENA category.[9]

Given that the reason for the lack of an Arab/MENA category is likely associated with politics as opposed to science, it is imperative that researchers and practitioners take the initiative to include this group in data collection. If health professionals, scientists, policymakers, and program directors are to successfully identify inequities and develop interventions to remedy health disparities, data on the Arab/MENA population must be collected. AJPH

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CONTRIBUTORS

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CONFLICTS OF INTEREST

The authors report no conflicts of interest.

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