Best Practices for Using Race in Public Health Research

University of Illinois at Chicago School of Public Health
Collaboratory for Health Justice

Why talk about how we use race?

There are a number of concerns with using race, so we should do so intentionally.[1-8]

- Race is a social construct that was created to differentiate people based on physical features like skin color and was used to justify racism, eugenics, experimentation, and other societal horrors.[5]
- Race does not have a biological basis,[5-8] so it is conceptually questionable to utilize race alongside biological outcomes.
- Race is not a clear construct and lacks consensus definitions or has changing definitions.[4,7,8]
- Using race results in imprecise measurement.[4,7,8]
- Race is confounded by social class, socioeconomic status, nationality, ethnicity-affecting its overall validity for even being a proxy for racism.[3,5,7-10]

Even if your research aligns with health equity principles, research that focuses on structural inequities generally has race as a demographic factor used to identify groups that have experienced historical disadvantage and continue to experience discrimination and systemic racism. The National Institutes of Health continue to require researchers to report and analyze race as a demographic characteristic of the sample.[3,11] We must push to change such policies and remain reflexive and intentional in our use of race in health research.[2,5]

If we want our research to address health equity, racism should be named as as a structural determinant of health inequity and there should be recognition of how one's race intersects with other determinants of health such as, such as socioeconomic status, resource accessibility, and place.[2,7,10,12,13] We must consider if and how we use race as a proxy for other constructs such as racism, skin color, discrimination, disadvantage, etc. Lastly, we must engage in antiracism praxis, where the knowledge gained from theory, research, personal experience, and practice inform one another.[14]

Best Practices to Address Concerns with Using "Race"

Show that you have thoughtfully considered race, ethnicity, and inequities in your study design and interpretation.[2,5]

- If you are using race as study variable, specify the reason why, along with the limitations of using race as a demographic variable.[2-7,9,14]
- Indicate how race is measured in your data and its limitations as a valid measure. When doing original data collection, consider asking participants to self identify.[8,9]
- Note the limitations with the typical Office of Management and Budget (OMB) and Census categories (listed on page 2 for reference).[5-7,9,14,15]

Treat racism as a fundamental cause of health inequalities when choosing methods and interpreting results.[7,10]

- Consider using critical approaches that consider history and systems of oppression14 such as critical feminist theory,[19,20] decolonial theory,[21] or critical Whiteness studies,[22,23] or critical race theory, which elucidated contemporary racial phenomena, expands the vocabulary with which to discuss complex racial concepts, and challenges racial hierarchies.[17–19]
- Include measures related to racism and the social and structural determinants of health as relevant to your research (i.e. housing age and density, housing quality, distance to grocery stores, percentage of population criminal justice system involved, etc.).[3] Much of the time, including race and socioeconomic status such as education and income are rudimentary and do not address the complex factors linked with racism.[9]
- Utilize research approaches that allow for sharing experiences of marginalized people.
- In discussions that focus on differences between racial groups, emphasize that that race itself is not a risk factor; racism is.[3,8]
- Define populations by the presence and impacts of structural racism rather than ethnically or racially. Draw attention to the larger social, historical, and environmental context of groups.[15,16]

Let hypotheses drive the use of race.[5,9]

- Do not assume race is relevant to your hypotheses.[5] Do not use race and ethnicity when there is no biological, scientific, or sociological reason for doing so.[9]
- Consider if you are using race as a proxy for ethnicity, culture, skin color, discrimination, a genetic marker, or racism, for which there are more valid measures.[3,4,7–9,15,16] Include these measures in your study.
- Consider the implications of "controlling" for race in statistical analyses.8

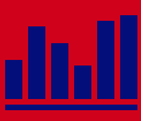
Avoid pathologizing or medicalizing race[2,7,24] **and supporting a narrative of race-based medicine, that there is a biological difference between racial groups.**[2,25,26]

- Do not default to using white as a reference group. This replicates the notion that non-white groups are "other",24
- Consider the implications of excluding data from a specific subset of the sample.8
- Do not use race as an explanatory variable.9

Acknowledge intersectional identities.[19]

- Describe the heterogeneity of groups[8,15,16,24] and examine data by at multiple intersections of social identity, such as race, gender, socioeconomic class, sexual orientation, and citizenship status.
- Examine models within racial groups.[8]

Statement on Contextualizing the Use of Race



"We are presenting these data by 'race.' We are using 'race' here as a proxy for racism. While 'race' is socially constructed and has no genetic basis, racism has real biological, physiological, political, and economic consequences. These consequences are rooted in state-sanctioned historical and contemporary racial oppression. We acknowledge that racism is complex. We challenge you to critically engage with this material and question the use of 'race' without the context of racism. Public health and other health professionals have a responsibility to contextualize measures of inequity along the lines of 'race' with a discussion of the negative impacts of racism on health."[27]

This statement was developed by the 2016 Curricular Praxis Workgroup of Radical Public Health, a group of students, faculty, practitioners, and alumni connected to the University of Illinois at Chicago School of Public Health. It is intended for members of our school community to use when presenting data by race. Similar to the way that a map is expected to include a legend, compass rose, and scale for it to be usable, the authors contend that charts, graphs, maps, and text that describes inequities along "racial" categories cannot be accurately understood without the context of racism.[27]

"If we acknowledge and name racism in our work, writing, research, and interactions with [students] and colleagues, we can advance understanding of the distinction between racial categorization and racism and clear the way for efforts to combat the latter." -Rachel Hardeman[28]

OMB and US Census Race & Ethnicity Categories (for reference)

Asian. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American. A person having origins in any of the Black racial groups of Africa.

American Indian or Alaska Native. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

White. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Native Hawaiian or Other Pacific Islander. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

Hispanic or Latino. A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

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