STUDY PROTOCOL

REVISED Review of health research and data on/with racially minoritised groups: Implications for addressing racism and racial disparities in public health practice and policies in Europe: a study protocol [version 2; peer review: 2 approved]

Previously titled: Review of health research and data on racialised groups: Implications for addressing racism and racial disparities in public health practice and policies in Europe: a study protocol

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v2 **First published:** 13 Jan 2023, **12**:57
https://doi.org/10.12688/f1000research.128331.1
Latest published: 07 Dec 2023, **12**:57
https://doi.org/10.12688/f1000research.128331.2

Abstract

Historically, across Europe, data and research on/with racially minoritised groups have not been collected or carried out in a sufficient, adequate, or appropriate manner. Yet, to understand emerging and existing health disparities among such groups, researchers and policymakers must obtain and use data to build evidence that informs decision-making and action on key structural and social determinants of health. This systematic search and review aims to contribute to closing this gap and promote a race-conscious approach to health research, strengthening the utilisation and deployment of data and research on/with racially minoritised groups in Europe. Its ultimate goal is to improve equality and equity in health*.

Concretely, the study will do so by reviewing and critically analysing the usage of the concepts of race, ethnicity, and their related euphemisms and proxies in health-related research. It will examine the collection, use, and deployment of data and research on/with racially minoritised groups in this area. The study will focus on Belgium, France, and the Netherlands, three countries with graphical proximity and several similarities, one of which is the limited attention that is given to racism and racial inequalities in health in research and policy. This choice is also justified by practical knowledge of the context and languages. The results of the review will be used to

Open Peer Review

Approval Status ✓ ✓

	1	2
version 2 (revision) 07 Dec 2023	✓ view	✓ view
version 1 13 Jan 2023	? view	? view

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Any reports and responses or comments on the article can be found at the end of the article.

develop guidance on how to use and deploy data and research on/with racially minoritised groups.

The review is part of a larger project which aims to promote race-conscious research and data. The project does this by a three-pronged approach which: 1) highlights the need for a race-conscious approach when collecting and using data, carrying out research on/with racially minoritised groups; 2) builds expertise for their effective use and deployment, and; 3) creates a knowledge network and community of practice for public health researchers working in Europe.

Keywords

racism, racial health disparities, racialised minority groups, health data, health research

This article is included in the Sociology of Health gateway.

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Competing interests: No competing interests were disclosed.

Grant information: This study has been funded by the Flemish Government, Science and Innovation.
The funders had no role in study design, data collection and analysis, decision to publish, or preparation of the manuscript.

How to cite this article: Meudec M, Affun-Adegbulu C and Cosaert T. **Review of health research and data on/with racially minoritised groups: Implications for addressing racism and racial disparities in public health practice and policies in Europe: a study protocol [version 2; peer review: 2 approved]** F1000Research 2023, **12**:57 https://doi.org/10.12688/f1000research.128331.2

First published: 13 Jan 2023, **12**:57 https://doi.org/10.12688/f1000research.128331.1

REVISED **Amendments from Version 1**

Following the reports of the two reviewers, we have revised this review protocol.

For clarity, we mention now that we start from the assumption that there is often inappropriate, inadequate, or insufficient use and deployment of data and research on racially minoritised groups in health research in Belgium, France and the Netherlands. One of the aims of this review is to prove this hypothesis.

We agree that concepts are not inherently proxies or euphemisms, that this depends on the research question and that different variables may be useful for different purposes. We explain our understanding in a clearer and more nuanced way in a revised version of Key definition 3.

Following the comment on categorisations, we realised that we had fallen into the trap of binary categorisations and the centering of Whiteness, and we thank the reviewer for highlighting this pertinent issue. We have replaced the term 'racial minority groups' with 'racially minoritised groups', and 'minorities' with 'minoritised' throughout the document. We have revised the title, the abstract and the Key definitions n. 5.

We have also added some clarifications on the following terms: 'disparities', 'race', 'ethnicity', 'inequality/inequity', 'xenophobia'.

Throughout the text, we have replaced 'research on racially minoritised groups' with 'research on/with racially minoritised groups', and added a justification for this change in the title, the abstract and in note n. 4.

Following the comments from both reviewers on the potential bias, we have exapnded the Risk of bias section. With regards to the claim to a 'racially diverse team', we have decided to remove this claim in the review protocol, and to further elaborate on the positionality of all team members, and their respective contributions to the project, when we publish the article presenting the results of the study.

Any further responses from the reviewers can be found at the end of the article

Introduction and rationale

While health disparities*[1] linked to the socio-politically constructed concepts of race*[2] and ethnicity* have long been established, the COVID-19 pandemic has brought renewed attention to the issue. Although most people have been affected by the pandemic, an increasing body of international research[3] shows that racially minoritised groups* have been disproportionately affected in terms of disease exposure, susceptibility to the disease, the severity of the disease and mortality rates. In addition to this, the measures taken to contain or mitigate the pandemic have had a particularly negative impact on the determinants of health and access to care for people within such groups. This has, in many cases, had negative consequences for their health statuses and health outcomes, which has ultimately further increased already existing health disparities between racially minoritised and majoritised groups (Katikireddi *et al.,* 2021). Addressing this will require evidence-based decision-making and action on key structural and social determinants of health such as racism* and racial discrimination, which are mediated by race, ethnicity, and related concepts.

Yet, we start from the assumption that, in many countries across Europe, there is often inappropriate, inadequate, or insufficient use and deployment of data and research* on racially minoritised groups. The reasons for this assumption can be grouped into two main categories. One is the continuous emergence of biologically or genetically based race research which is often linked to scientific racism (Roberts, 2011a, 2011b; Saini, 2019). Cerdeña, Plaisime, and Tsai (2020), recognising this, introduced the race-conscious approach* which, in contrast to the race-based approach*, focuses on racism and racial health disparities*. This race-conscious approach forms the basis and the goal of this project. The other category, which this project focuses on, includes issues related to the poor use and deployment of data and research on/with[4] racially minoritised groups, in the monitoring and tackling of health disparities, and public health policymaking and social change (Farkas, 2017; Holtzman, Khoshkhoo, and Nsoesie, 2022).

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[1] All terms followed by an asterisk (*) are defined in the 'Key definitions' section of this protocol.

[2] The authors follow the widely accepted notion that race has no biological basis. Regardless, race exists as a social reality and thus has real consequences. See also: key definitions.

[3] For international literature, see for instance Aldridge *et al.* (2020), Baqui *et al.* (2020), Linos *et al.* (2022), Miconi *et al.* (2021), Mukumbang *et al.* (2020), OECD (2020), Poteat *et al.* (2020), Van Dorn *et al.* (2020), Wadhera *et al.* (2020), Williamson *et al.* (2020), Yaya *et al.* (2020). For Belgium, see Vanthomme *et al.* (2021), for France, see Carillon *et al.* (2020); and for the Netherlands, see Coyer *et al.* (2021).

[4] The term 'on/with' is used deliberately. On the one hand, we want to acknowledge that in reality, much research is not done 'with' the communities it focuses on. On the other hand, however, we do not wish to reify and normalise the formulation 'doing research on' and the associated academic culture throughout our text. In addition, we only have access to the data that researchers have chosen to publish, so we do not always know whether the research is actually done 'on' or done 'with' the community in question. For all these reasons, using the formulation 'on/with' seems to be the most nuanced and correct way.

Data and research on/with racially minoritised groups are often underutilised and under-deployed for three broad reasons. The first reason is related to data collection. In many countries, there is a lack of national data systems using race/ethnicity data, which means that there is limited statistical evidence on health disparities between racially minoritised and majoritised groups. This is partly due to national political models and philosophies around immigration and ethnic diversity management. Examples of this can be seen in the recent removal (law proposed in 2013 and accepted in 2018) of the word 'race' from the French Constitution (Gay, 2015), and more broadly, in the republican model which is practised in France. According to this model, a recognition of ethnic and/or racial diversity is seen as subversive, and consequently, the collection of ethnic statistics for official purposes is deemed to be unnecessary or even contrary to the ideals of the model (Rivenbark and Ichou, 2020). This can also be seen in Belgium where the Belgian Census does not include any questions on ethnicity, let alone racial identification (Lorant and Bhopal, 2011), or in the Netherlands, where the new population classification is based on the country of birth of the person, which implies a classification by origin and not by identification or experience of discrimination (Statistics Netherlands, 2022). According to advocacy groups like the European Network Against Racism (ENAR)[5], this lack of data on ethnic/racialised groups makes it difficult to combat racism and racial inequalities, and it also means that clear guidelines with workable definitions on the subject matter are limited. This lack of (collection of) data at the individual/population level is often exacerbated by the lack of recognition and undervaluing of data such as lived experiences, testimonies, and other similar forms of knowing[6]. Some of these problems could also be related to the lack of representation of racially minoritised groups at high levels of society. In addition to this, even in cases where data exists, and it is valued and recognised as such, it might still not be used for research to address racial health inequities, as many researchers do not have the opportunity and/or expertise to categorise, analyse data on racially minoritised groups, or to interpret and communicate the results in such a way as to promote racial health justice.

The second reason is linked to the research itself. There is disinclination among certain researchers to carry out any research linked to race and/or ethnicity, as the use of such variables in research continues to be seen as contentious, to some degree. Some researchers see these variables as valuable tools for analysing health inequalities* and addressing health inequities as well as the impact of various forms of racism (institutionalised, systemic/structural, interpersonal, internalised racism) on racially minoritised groups. Others, on the contrary, disagree, on the grounds that the data and results of research that use these variables can be misused and instrumentalised against racially minoritised groups. They also contend that such data and research can be used in ways that are sometimes difficult to anticipate, for instance to fuel stigmatisation and racial stereotyping, quoted as a "problematic use" of data by Nancy Krieger (2021). Additionally, research on/with racially minoritised groups is often seen as too difficult to implement in practice, due to challenges of finding appropriate approaches and solutions to conceptualisation, operationalisation, data collection, data management, data analysis, interpretation, representativeness, transferability and generalisability. For instance, in cases where data is collected on/with racially minoritised groups, it might be done in a "non-standardised" way which, certain researchers may find difficult or impossible to use in research (Simon, 2005).

The third reason focuses on the results of research on/with racially minoritised groups. In many cases where data on racialised groups is available and it is being used for research, it does not necessarily lead to anti-racist interventions. Moreover, the results are frequently not used for advocacy, and/or the results and recommendations are not implemented or used to effect policy change and achieve real-life impact. This is amongst others because the results are deemed to be too specific, subjective, or politicised. Many researchers also consider transformative research, advocacy and activism to be beyond their mandate. Furthermore, similarly to broader society, within the field of health, there are strong tendencies to erase contributions from marginalised/racialised researchers or to erase race when analysing inequalities, as was for example the case with the concept of intersectionality* in feminist studies (Bilge, 2013). In contrast, when the results are used in research or policymaking, this is generally done either through (un)conscious racial biases in the framing of social problems, or without sufficient attention to unintended consequences which means that in some cases, results, instead of supporting efforts to address racial health disparities, actually (inadvertently) reinforce stereotypes about ethnic/racial groups (Kaplan and Bennet, 2003; Zuberi, 2003; Laveist, 1996).

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[5] See https://www.euractiv.com/section/non-discrimination/news/unbalanced-hate-lack-of-data-abets-geography-of-discrimination-in-europe/ (accessed August 26th, 2022).

[6] For an illustration, see this scoping review on empirical studies published in Scandinavian Journal of Public Health (Elstad *et al.*, 2022) or see the epistemological discussion made by Lisa Bowleg on the uses of qualitative methodologies in Critical Health Equity Research (Bowleg, 2017).

Table 1. **RECoRD project, the research steps.**

RECoRD project Race-Conscious Research and Data*		
Review of health research and data on/with racially minoritised groups	Systematic search	2022
	Critical analysis	2022-2023
Guidance on how to use and deploy data and research on/with racially minoritised groups	Proposed guidance	2023
	Participatory development of final guidance	2023-2024

*See key definitions section.

The consequence of all this for public health is the adoption and implementation of policies that are intended to be race-neutral but which in fact produce a colourblind paradigm that reproduces 'methodological whiteness'[7] and creates or exacerbates health inequities* and inequalities amongst racially minoritised groups. This criticism is reflected in the widespread calls to decolonise health research, improve equality and equity in health in an intersectional way, and ultimately, achieve social and racial justice. Decolonial approaches to global and public health* have been a growing field in recent years and offering many opportunities for collaboration with anti-racist public health and critical race theories (Meghji and Niang, 2022). These calls are being responded to at all levels of society. In 2018, for instance, there was a 65% increase in the number of English articles that were published on racism in healthcare at the global level (Hamed *et al.,* 2022). In the same year, the European Union (EU) High Level Group on Non-discrimination, Equality, and Diversity[8] adopted a set of non-binding guidelines on how to improve the collection and use of equality data, compiled practices implemented at national level related to the set of guidelines and developed a diagnostic tool/checklist with which to assess the availability and quality of equality data collected at national level[9].

This project likewise aims to contribute to improving equality and equity in health, by promoting a race-conscious approach to health research and strengthening the utilisation and deployment of data and research on/with racially minoritised groups. We do so by taking a three-pronged approach which highlights the need for a race-conscious approach while using data and research on/with racially minoritised groups; builds expertise for their effective utilisation and deployment; and creates a knowledge network and community of practice for public health researchers working in Europe.

Research steps

The project begins with a literature review which critically analyses the way race, ethnicity, and related terminology euphemisms and proxies* are conceptualised, operationalised, and used in public health research in three countries in continental Europe. It then goes on to critically examine, using literature from other countries or other research fields on this issue, how research on racialised minority groups is conducted. The results will then be used to develop guidance on how to utilise and deploy data and research on racialised minority groups. Finally, as a follow-up to the review, our findings will be stored in a knowledge repository that is accessible to health researchers (see the project's research steps in Table 1 below). The overarching goal is to contribute to addressing health disparities among racialised minority groups, across Europe.

Key definitions

1. Race: Refers to socially and politically constructed perceptions of differences among people based on phenotypic characteristics such as skin colour. Although the sciences have been (and still are) heavily involved in the production of race and racial categorisations, there is no scientifically supported biological basis for racial categorisation. However, various societal actors construct races as real, which has a variety of detrimental implications for economic, political, social, and cultural life (CIHI, 2022).

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[7] See Bhambra (2017a, 2017b). "'Methodological whiteness', I suggest, is a way of reflecting on the world that fails to acknowledge the role played by race in the very structuring of that world, and of the ways in which knowledge is constructed and legitimated within it. It fails to recognise the dominance of 'whiteness' as anything other than the standard state of affairs and treats a limited perspective – that deriving from white experience – as a universal perspective. At the same time, it treats other perspectives as forms of identity politics explicable within its own universal (but parochial and lesser than its own supposedly universal) understandings." (2017b).

[8] See https://ec.europa.eu/transparency/regexpert/index.cfm?do=groupDetail.groupDetail&groupID=3328

[9] See the Guidance note on the collection and use of equality data based on racial or ethnic origin, accessed online Aug. 26, 2022: https://ec.europa.eu/info/sites/default/files/guidance_note_on_the_collection_and_use_of_equality_data_based_on_racial_or_ethnic_origin.pdf

2. Ethnicity: A multi-dimensional social construct based on cultural distinctiveness and shared group cultural identity and characteristics. Examples of ethnic characteristics are, amongst others, language, and cultural norms, which are sometimes linked to religion and nationality. Different from, but often used as a euphemism or proxy for race (Song, 2018; CIHI, 2022).

3. Racial and ethnic euphemisms and proxies: A word or expression used inappropriately or inadequately to designate and describe racially minoritised groups. We understand concepts as racial and ethnic euphemisms and proxies when there is a clear mismatch between 1) the used concepts or variables and 2) the aim of the research or the interpretation of the results. This includes the use of terms which are related to concepts like migration, religion, language, origin, postcode (= place-based discrimination), citizenship, nationality, and culture. Note however that the concepts mentioned above are not inherently proxies or euphemisms for race and ethnicity,[10] and can be of adequate use depending on the topic of research.

4. Racialisation: A complex, contradictory and arbitrary process through which groups and individuals are assigned a particular 'race' and on that basis subjected to differential and/or unequal treatment. Put simply, racialisation is "the process of manufacturing and utilising the notion of race in any capacity" (Dalal, 2002, p. 27). While white people are also racialised, this process is often rendered invisible or normative to those designated as white. As a result, white people may not see themselves as part of a race but still maintain the authority to name and racialise 'others'. The individual and group identities of members of racialised groups shape both their relationships and interactions between each other, as well as with members of the out-group, and it influences social practice, and engagements with time, space, social structures and institutional systems. Racialisation thus has impacts on every aspect of life[11].

5. Racially (minoritised) groups: Refers to groups that are subject to racialisation and are also minoritised, marginalised or underrepresented based on various characteristics such as skin colour, migration status, citizenship, religion, culture, language or geographic location[12]. To emphasise the process of racialisation, some authors use either this wording (Milner and Jumbe, 2020; Rai *et al.*, 2022) or "marginalised racial groups" (Barber, 2020). This quote from Selvarajah *et al.* (2020: 2-3) is particularly interesting for a reflection on the term 'minoritised'[13]: "We recommend the term minoritised, which emphasises active processes, shifting beyond binary discussion of minority versus majority. We build on existing explanations to define minoritised, as 'individuals and populations, including numerical majorities, whose collective cultural, economic, political and social power has been eroded through the targeting of identity in active processes that sustain structures of hegemony.' Power is emphasised as central to racism and intersecting forms of discrimination. It highlights maintenance of structures which diminish minoritised people's capability to lead healthy lives. It neither singles out nor creates groups, and adds more nuance than words like marginalised by connecting back to terms such as ethnic minority, thus acknowledging existing literature while resisting its coupling with dubious assumptions about ethnicity. It is important to acknowledge the fact that racially minoritised groups are not homogenous groups, given the intersecting forms of oppression within minoritised groups. Although we clearly want to avoid any form of oversimplification, and we acknowledge the fact that health inequities cannot be reduced to race alone, we see a stark omission of research analysing racism in health in Europe; therefore, we see this one-dimensional study as a first essential step to enable the development of more complex research using intersectional lens in the future."

6. Racism: Organised systems within societies that cause avoidable and unfair inequalities in power, resources, capacities, and opportunities for racially minoritised groups (Paradies, Ben, Denson *et al.,* 2015). Racism can manifest through beliefs, stereotypes, prejudices, or discrimination. This encompasses everything from open threats and insults to phenomena deeply embedded in social systems and structures. Racism can occur at multiple levels, including internalised (the incorporation of racist attitudes, beliefs or ideologies into one's worldview), interpersonal (interactions between individuals) and systemic (for example, the racist control of and access to labour, material and symbolic resources within a society) (Paradies, Ben, Denson *et al.,* 2015: 2).

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[10] It has to be noted here that the concept of ethnicity is itself sometimes used as a proxy to not talk about race (Song, 2018).

[11] Inspired by SOURCE: Alberta Civil Liberties Research Centre, "Racialization" (2018)/Calgary Anti-Racism Education, "CARED Glossary" (2020).

[12] See for instance a definition proposed by Souissi (2022) on the Canadian Encyclopedia. Access online, September 1st, 2022: https://www.thecanadianencyclopedia.ca/en/article/racialized-minorities

[13] We also refer readers to these writings by Gunaratnam (2013) for an important reflection on the term 'minoritised'.

7. Health equity: Refers to the absence of differences in health associated with social disadvantages that are modifiable, and considered unfair. This means everyone has a fair chance to reach their full health potential without being disadvantaged by social, economic and environmental conditions (CIHI, 2022; NCCDH, 2014).

8. Health disparities or health inequalities: Refers to a condition in which different social groups have different health outcomes. Generally, disadvantaged social groups such as the poor, racially/ethnic minoritised groups, women and other groups who have persistently experienced social disadvantage or discrimination systematically, experience worse health or greater health risks than more advantaged social groups (Braveman *et al.*, 2004; Braveman, 2007). When systemic barriers to good health are avoidable yet still remain, they are often referred to as 'health inequities'.[14]

9. Racial health disparities: Refers to health disparities that exist between racially minoritised groups and the racially majoritised group, as compared to the racial majority. It describes the increased presence and severity of certain diseases, poorer health outcomes, and greater difficulty in obtaining healthcare services. Usually, it is the racially minoritised groups who are at a disadvantage compared to the racially majoritised one.

10. Intersectionality: The complex, cumulative way in which the effects of multiple forms of discrimination (such as racism, sexism, classism, xenophobia, and religious discrimination) combine, overlap, or intersect especially in the experiences of marginalized individuals or groups (Crenshaw, 1989).

11. Race-based approach: Based on a biologically essentialist conception of race according to which all members of a racial category are believed to have defined shared physical or genetic characteristics, or a specific biological essence. This assumption allows the members of the group to be seen, both by themselves and by others, not as individuals with personal traits, but rather as prototypes of the collective with identical traits and characteristics, which leads to stereotyping, essentialization, fixity, homogenisation.

12. Race-conscious approach: Focuses on racial discrimination and racism as central issues, in contrast to the race-based approach. As a reference point, Cerdeña, Plaisime and Tsai (2020) introduce "race-conscious medicine as an alternative approach that emphasises racism, rather than race, as a key determinant of illness and health, encouraging providers to focus only on the most relevant data to mitigate health inequities".

13. Race-conscious research and data: Following the previous definition, we would like to define 'race-conscious research and data' as an area of research that aims to address racial inequities in health, combat racism in healthcare and promote racial justice in health.

14. Racial justice in health: Using the race-conscious approach to tackle racial health disparities and injustices and improve health among racially minoritised groups in an intersectional way, with the aim of advancing equality and equity in health and ultimately, achieving social and racial justice[15].

15. Decolonial approaches to Global and Public Health: This field is not homogeneous but decolonising global and public health implies re-politicising and re-historicising health at all levels: epistemic and theoretical (production and distribution of knowledge), ontological, educational, organisational, healthcare-related, etc. (Bhakuni and Abimbola, 2021; Affun-Adegbulu and Adegbulu, 2020; Büyüm *et al.,* 2020; Naidu, 2021).

16. Data: Any type of information that is collected to be examined, considered, and used for research as well as to support decision-making. This includes quantitative information, such as measurements and calculations, and qualitative information, such as lived experiences and blog posts[16].

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[14] What Is Health Inequity?, see https://www.vdh.virginia.gov/health-equity/unnatural-causes-is-inequality-making-us-sick/what-is-health-inequity/#:~:text=%E2%80%9CDifferences%20in%20health%20status%20among,living%20in%20various%20geographic%20localities.%E2%80%9D (site visited June 22, 2022).

[15] Inspired by Reference to the Praxis Project,: see health law as social justice, 2014.

[16] Inspired by https://dictionary.cambridge.org/dictionary/english/data

17. Research: “A detailed study of a subject, especially in order to discover (new) information or reach a (new) understanding[17]”, which involves “weaving together different strands of information, thought, and data[18]”, amongst others, to contextualise both the research and its findings. As social scientists and public health researchers, we see research as an activity that leads directly to practical applications and engagement/advocacy in the field of health.

18. Othering: Processes of distancing and differentiation in which certain individuals, groups or practices are defined and labelled as ‘Others’, thus not corresponding to the norms of a social group. It refers to a binary conception of ‘us/them’, usually involving stereotypes of ‘them’ and hierarchical power relations, including practices of inclusion and exclusion. See for instance Udah (2019).

19. Xenophobia: “Attitudes, prejudices and behaviour that reject, exclude and often vilify persons, based on the perception that they are outsiders or foreigners to the community, society or national identity.” (European Commission, Migration and Home Affairs) As such, xenophobia needs to be distinguished from racism, which concerns (systemic) acts of discrimination towards someone based on their perceived affiliation to a racially minoritised, regardless whether this person is seen as a foreigner or not (Suleman *et al.,* 2018: 2018). This distinction is important, as the mechanisms and outcomes of both forms of discrimination are different and can affect different groups.

Objectives

The objectives of the literature review are to:

1. Examine how data on racially minoritised groups is used (= conceived, collected, analysed, interpreted, reported) in health research

2. Examine the ways in which this data is used to address racial health inequities

3. Critically analyse the way race, ethnicity and related euphemisms and proxies are conceptualised, operationalised, and used in health research

4. Develop guidance on how to appropriately utilise and deploy data on/with racially minoritised groups, how to undertake race-conscious research and how to effectively use the results to address racial health disparities

Scope of the research

Thematic scope: The review will take race and ethnicity in health research as a focus of analysis. It will expand to include related euphemisms and proxies such as migration, citizenship, nationality, religion, culture, language, postcodes, etc. In the analysis, we will consider other characteristics which influence and shape health inequities, such as gender, sexuality, disability, age, socio-economic condition, and geographic location. This will ensure that we integrate relevant intersecting determinants of health inequalities and inequities in our analysis of health disparities among racialised groups (Smedley *et al.*, 2003). It will also allow us to draw attention to the complexities of vulnerabilisation, its different forms and its various causes as well as the interplay between them.

Geographical context: The review will focus on research on Belgium, France and the Netherlands (and their overseas territories), three countries in continental Europe which have been selected for their geographical proximity, as well as their linguistic and cultural similarities and differences. In addition to this, given the personal and professional background of the review team members, the team has an in-depth knowledge of these three countries. Three countries were chosen for the study, for practical reasons, as resources constraints mean that we do not currently have the ability to conduct a Europe-wide study. We however hope to be able to both deepen this work and extend it to other European countries in a second phase.

Timespan: The review will cover the period between 2018 and 2022 which will allow us to take into account data and research on/with racially minoritised groups from before and during the COVID-19 pandemic (two years before, two years during). This is because, as argued above, the COVID-19 pandemic has led to an increased focus and attention on the issue of health disparities between racially minoritised and majoritised groups.

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[17] See https://dictionary.cambridge.org/dictionary/english/research
[18] See https://blog.scienceopen.com/2016/05/why-context-is-important-for-research/

Methods

A systematic search and review approach will be taken to this review, as this combines strengths of a critical review with those of an exhaustive search process. This approach is especially suited for our review because by facilitating the comprehensive exploration of what is known about the topic, it supports the synthesis of best evidence and the generation of recommendations for practice (Grant and Booth, 2009).

Review questions

The questions which will guide the review are as follows:

1. What terminology is used for health research on/with racially minoritised groups, and how are they operationalised?
2. What type of data on race, ethnicity and related euphemisms and proxies is used, and why?
3. How is research on/with racially minoritised groups carried out?
4. What evidence is available on the use of racially minoritised groups data to promote racial equity in health?
5. What are best practices on research and the use of data on/with racially minoritised groups, and why?

Data collection

Databases

The databases listed below will be used in this review. They were chosen for their large collections of both peer-reviewed and grey literature, which will ensure that we can capture the variety of published information on the subject matter.

- PubMed: https://pubmed.ncbi.nlm.nih.gov/
- Scopus: https://www.scopus.com/home.uri
- Web of Science: www.webofscience.com
- Cochrane Library: https://www.cochranelibrary.com/central/about-central

Search strategy

The search strategy was developed by creating a list of search terms that are relevant to the research questions and combining them as follows:

(race OR racial* OR ethnic* OR cultur* OR language OR linguistic OR religio* OR migra* OR immigrant OR foreign* OR “third country national” OR allochthonous OR residen* OR undocumented OR illegal OR irregular OR refugee OR asylum OR nationality OR citizen OR “non-citizen” OR minorit* OR gyps* OR roma OR traveller OR ancestry OR “family background” OR heritage OR origin OR neighborhood OR neigbourhood OR “postal code” OR postcode OR marginalised OR marginalized OR vulnerable OR precarious OR communit* OR “population group”)

AND

(“health”)

AND

(Belgium OR “Netherlands” OR France)

Search strings will be created from these terms and adapted to the requirements of each database. Given that the search strategy and this protocol was developed in the very early stages of the review process, we see the above as a nonexhaustive list. In addition to conducting explorative searches to refine the strategy, therefore, we will also take an inductive approach, in which we allow concepts that emerge from the review to further inform the search strategy.

The results of the search strategy will be refined by language and date to include only publications that were written in English, French, and Dutch and which were published from January 1st, 2018 until July 8th, 2022.

The database searches will be supplemented by reference mining of the selected publications to ensure that relevant documents or articles that might have been missed, are identified and included. In addition, purposive manual searching of websites of key actors and organisations will be carried out to identify relevant grey literature we might have missed in the database searches.

The details of the search process, as well as the results of the searches conducted will be documented as meticulously as possible, in order to maximise recall and ensure that the process can be reported and reproduced accurately.

Selection process

The citations produced by the search strategy will be screened for relevance and for inclusion in the study. To be eligible, the article or report must have both health AND race, ethnicity, or related concepts as its subject matter.

The research will be done by a core team of three researchers, who will be supported periodically by three master students with relevant experience and knowledge.

In the first instance, two researchers, in consultation with the third researcher, will search the selected databases for relevant citations, using the developed search string. The results of this search procedure will then be uploaded into Covidence, a systematic review management software which supports some of the steps of the review process.

Next, Covidence will be used to identify and automatically remove duplicates, a process that will be verified by one researcher. Given that Covidence is limited in its ability to recognise duplicates, the selected references will be exported to Zotero by one researcher, who will then do an additional duplicate check.

After this, the title and abstract screening of the documents in Covidence will be done by three students, who are supported and supervised by one researcher. From this stage onwards, weekly discussions will be held to streamline and systematise the selection process as much as possible. Following this initial selection, the full texts of the selected documents will be obtained and checked meticulously against the review's inclusion and exclusion criteria. This full text screening will be done in Covidence by the three researchers and three students, with every document being checked at least twice to minimise bias and error. The process will be set and carried out in such a way as to ensure that each full text is screened by at least one of the three researchers from the core team. Conflicts will be discussed and resolved as a group, during the weekly meetings, and potential deviations from the review protocol will be documented and reported.

The types of documents to be included are peer-reviewed primary studies and reviews; preprints; commentaries; editorials, published in a scientific journal and of which a full-text version is available. In addition to this, we will also include published grey literature where the full text is available online.

Data extraction

Once the screening process is finished, the data on the study characteristics and other relevant variables will be extracted by the three researchers and one student from the final collection of retained documents, in a systematic way. This will be done in Covidence and the extracted data will be stored in Excel. In order to minimise error, the team will use a standardised extraction sheet that has been designed collaboratively by the three researchers and the three students, with some input from the extended project group (Meudec *et al.,* 2022c).

Approximately 30 variables will be extracted from the publications that are included in the review. This will include information on the:

1. Study characteristics
    a. Publication (title, year of publication, author(s) and their affiliation, journal, type of document)

2. Variables of interest
    a. Concepts that are used for health research on/with racially minoritised groups and how they are operationalised
    b. Research methodology and methods used
    c. The data used, and how this is collected, and applied

A full overview of the variables to be extracted can be found in the Data Extraction sheet (see Data availability).

Data management

Citations generated from the search strategy will be reviewed using the Covidence software which will be used to identify publications for inclusion in the review. These will then be uploaded and stored in a Zotero library. The data extraction of selected publications will be done using Covidence.

Data analysis

First, a descriptive analysis will be done to provide an overview of the data that is extracted from the included publications, using quantitative and qualitative methods.

Following this, a critical analysis will be undertaken to identify the:

1. Concepts that are used for health research on/with racially minoritised groups
2. Types of data on race, ethnicity and related euphemisms and proxies that are used, and arguments put forward to justify their use
3. Methodology and methods that are used for research on/with racially minoritised groups, with a particular focus on recommendations, research gaps, innovative approaches, and methods

The results of the critical analysis will then be used to inform the development of proposed guidelines for best practices in the use and deployment of data and research in racialised minority groups, with the aim of addressing health disparities.

Reporting and registration

The first and final drafts of the review protocol are stored on a community platform on Zenodo (Meudec *et al.,* 2022a, 2022b). This protocol has been completed in line with the PRISMA-P reporting guidelines (Meudec *et al.,* 2022d).

The finalised review protocol will be registered and peer-reviewed on the Open Research Platform F1000Research.

Review team

Core team: Marie Meudec, Clara Affun-Adegbulu, Theo Cosaert

Review team: Marie Meudec, Clara Affun-Adegbulu, Theo Cosaert, Eskedar Getie Mekonnen, Lidvine Ngonseu Harpi, Enata Mushimiyimana

Extended project group: Soledad Colombe, Charles Ddungu, Sarah Demart, Cleo Maerivoet, Lazare Manirankunda, Joris Michielsen, Claudia Nieto, Christiana Nöstlinger, Jef Vanhamel, Ella Van Landeghem, Tine Verdonck

Following ITM guidelines on authorship (Institute of Tropical Medicine, 2017), the core team has carried out the following tasks: 1) conception of the work; 2) design of the study and drafting of the review protocol; 3) execution of the study; 4) data analysis; 5) data interpretation; 6) writing of the review. The review team will participate in tasks 2, 3, 4, 5, 6. The extended group has been, and will be involved in steps 2, 5, and 6.

Positionality

Marie Meudec is a white researcher who has no personal experience of racism. From personal and professional experience - a) research on health inequalities and discrimination based on gender, sexuality, migratory status, different forms of spatial marginalisation, police racism, etc, b) providing expert court testimony on police racial profiling in Canada and asylum cases in the UK; and c) organising and facilitating anti-racism workshops on whiteness and white supremacy in Canada, Marie has developed a sensitivity to issues of racism and racial justice in the countries where she has lived and worked (France, Canada, UK, Haiti, Belgium).

Clara Affun-Adegbulu is a Black woman with a lived and personal experience of anti-Black racism and misogynoir, amongst others. During her nursing studies and throughout her career as a district and psychiatric nurse in Belgium, France and the UK, Clara also gained direct professional experience of anti-Black racism, race- and ethnicity-based discrimination more generally, as well as the intersections of the two with other forms of discrimination. Her understanding of, and sensitivity to these issues has further developed, as a result of her work as a public health researcher studying health equity, including among migrants and displaced populations from fragile and conflict-affected settings.

Theo Cosaert is a white male junior researcher with no personal experiences of racism. He grew up and was trained in a West-European context (Belgium and the UK) and his academic practice is shaped by these schools of thought. He was trained in sociology and in medical anthropology, and all of his previous work focused on experiences of and barriers to the healthcare system. He tries to centralise perspectives of minoritised groups in his research by listening and by creating space where and when he can do so.

Data availability

The list of references used in the review will be stored on Zotero, while the project documents will be stored on Zenodo, as well as the Data Science Hub/ITM website. Both the review references and project documents will be open access and freely accessible to the public (Meudec *et al.,* 2022a, 2022b, 2022c, 2022d).

Dissemination

The finalised review protocol will be shared online on the F1000research website. An overview of the output of the RECoRD project can be found here https://linktr.ee/record_itm. The review results have been and will be shared and discussed during conferences (AfroEuropeans Conference Sept 2022; European Public Health Conference Nov 2022; Be-Cause health conference 2023; ECTMIH 2023) and seminars at the Institute of Tropical Medicine (Belgium). The review results will also be submitted to an open access scientific journal after finalisation.

Outcomes and prioritisation

The primary outcome will be a list of concepts (related to race, ethnicity and their related euphemisms and proxies) that are used in health research on/with racially minoritised groups. This list will also include – if provided – the definitions and justifications for such a use, and the ways these concepts are operationalised in research.

A secondary outcome will focus on the use of such concepts (context, research questions, research methodologies, results).

A third outcome will examine the recommendations, research gaps, and innovative approaches.

A fourth outcome will consist in the development of proposed guidelines for best practices in the use and deployment of data and research on/with racially minoritised groups, with the aim of addressing health disparities.

The results of this review will be developed in a manuscript submitted to a scientific journal for publication.

Risk of bias

In addition to asserting our respective positionalities, we also identify several biases and limitations in our work. Firstly, our core team is small and represents only a margin of the diverse intersections of social identities that are present in society. Specifically, the core team is mostly trained in North American and European higher education, which implies that our own frames of reference are primarily Western. The categories and concepts we employ are therefore partial and limited, and inevitably bias our questions, methods and the interpretation and analysis of data both consciously and unconsciously. We are trying to mitigate this bias continually, for example by drawing from the field of Critical Race Theory, by gathering feedback from a larger and more diverse team of researchers, and by holding meetings with a range of stakeholders during future stages of the research (analysis, writing, and guideline development).

Second, this research project focuses on ethnic and racial disparities in health, and thus centralises/emphasises race and racism. This may be a bias in that, by focusing on racial disparities, we temporarily sideline other criteria present within intersecting systems of oppression. We see this research as a first step in demonstrating the lack of a racial lens in health research, and we know that future research will need to take an intersectional lens as its starting point.

A further bias may arise from the fact that we only have access to published results, and we do not have access to all the internal discussions or specific issues related to the use of specific terms or concepts over other options. As this analysis is something of a retrospective study, our analysis is based solely on the information that the authors decided to incorporate in their published manuscripts. This constitutes a bias in the sense that we may risk attributing certain intentions to the authors even though we cannot confirm this in this review. We regret the fact that, in general, authors of scientific articles in this field are not more explicit in justifying their use of a particular terminology.

Another bias could stem from our personal and professional involvement with systemic racism in health. Given our respective positionalities and lived experiences, and given that we do not ultimately aim to achieve objectivity or neutrality in this research, we would like to acknowledge that our judgment in analysing research papers can sometimes be harsh, especially after analysing several documents containing racial/ethnic proxies and euphemisms in the course of a single day. We try to mitigate this by holding weekly meetings with the core team, during which we share our emotions and discuss elements that emerge in the course of the research.

Finally, this research project focuses on systemic racism in a European context. As such, health disparities are conceptualised in such a way that the white racial majority is seen as the benchmark of good health from which racially minoritised groups diverge. While we recognise that this is a simplified and binary way of analysing disparities, we also want to acknowledge that in doing so we are using whiteness as the default. We are aware of the need to decenter whiteness in research, and we urge the reader to be aware of this bias. Here are a few suggestions of intellectual traditions centering the voices of racialised groups that you can get inspiration from: Black Feminist Thought, Black Intellectual Tradition, Critical Race Theory, Indigenous methodologies, etc.

Data availability

Underlying data

No data are associated with this article.

Extended data

Zenodo: Review protocol - First draft - Review of health research and data on racialised minorities: Implications for addressing racism and and racial disparities in public health practice and policies in Europe. https://doi.org/10.5281/zenodo.7155891. (Meudec *et al.*, 2022a).

This project contains the following extended data:

- First draft of the review protocol, October 7, 2022.

Data are available under the terms of the Creative Commons Zero "No rights reserved" data waiver (CC0 1.0 Public domain dedication).

Zenodo: Review protocol - Final version - Review of health research and data on racialised minorities: Implications for addressing racism and and racial disparities in public health practice and policies in Europe. https://doi.org/10.5281/zenodo.7298547. (Meudec *et al.*, 2022b).

This project contains the following extended data:

- RECoRD Review protocol_final version.pdf. (Final version of the review protocol, November 7, 2022).

Data are available under the terms of the Creative Commons Zero "No rights reserved" data waiver (CC0 1.0 Public domain dedication).

Zenodo: Data Extraction Sheet for the Review - 2. https://doi.org/10.5281/zenodo.7473314. (Meudec *et al.*, 2022c).

This project contains the following extended data:

- Data extraction sheet.pdf (Data extraction sheet using approximately 30 variables - study characteristics and various variables of interest).

Data are available under the terms of the Creative Commons Zero "No rights reserved" data waiver (CC0 1.0 Public domain dedication).

Reporting guidelines

Zenodo: PRISMA-P checklist for ‘Review of health research and data on racialised groups: Implications for addressing racism and racial disparities in public health practice and policies in Europe - Study protocol’. https://doi.org/10.5281/zenodo.7458371. (Meudec*et al.,* 2022d).

Data are available under the terms of the Creative Commons Zero “No rights reserved” data waiver (CC0 1.0 Public domain dedication).

References

Affun-Adegbulu C, Adegbulu O: **Decolonising Global (Public) Health: from Western universalism to Global pluriversalities.** *BMJ Glob. Health.* 2020; **5**(8): e002947.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Aldridge RW, Lewer D, Katikireddi SV, *et al.*: **Black, Asian and Minority Ethnic groups in England are at increased risk of death from COVID-19: indirect standardisation of NHS mortality data [version 1; peer review: 3 approved with reservations].** *Wellcome Open Res.* 2020; **5**: 88.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Baqui P, Bica I, Marra V, *et al.*: **Ethnic and regional variations in hospital mortality from COVID-19 in Brazil: a cross-sectional observational study.** *Lancet Glob. Health.* 2020; **8**(8): e1018–e1026.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Barber S: **Death by racism.** *Lancet Infect. Dis.* 2020; **20**(8): 903.
Publisher Full Text

Bhakuni H, Abimbola S: **Epistemic injustice in academic global health.** *Lancet Glob. Health.* 2021; **9**(10): e1465–e1470.
PubMed Abstract | **Publisher Full Text**

Bhambra GK: **Brexit, Trump and ‘methodological whiteness’: on the recognition of race and class.** *Br. J. Sociol.* 2017a; **68**(S1): S214–S232.
PubMed Abstract | **Publisher Full Text**

Bhambra GK: **‘Why are the white working classes still being held responsible for Brexit and Trump?’ LSE Brexit Blog.** 2017b.
Reference Source

Bilge S: **Intersectionality Undone: Saving Intersectionality from Feminist Intersectionality Studies.** *Du Bois Rev.* 2013; **10**(2): 405–424.
Publisher Full Text

Bowleg L: **Towards a Critical Health Equity Research Stance: Why Epistemology and Methodology Matter More Than Qualitative Methods.** *Health Educ. Behav.* 2017; **44**(5): 677–684.
PubMed Abstract | **Publisher Full Text**

Braveman P: **International Perspectives on Health Disparities and Social Justice.** *Ethn. Dis.* 2007; **17**.

Braveman P, *et al.*: **An Approach to Studying Social Disparities in Health and Health Care.** *Am. J. Public Health.* 2004; **94**: 2139–2148.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Büyüm AM, Kenney C, Koris A, *et al.*: **Decolonising global health: if not now, when?** *BMJ Glob. Health.* 2020; **5**(8): e003394.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Carillon S, Gosselin A, Coulibaly K, *et al.*: **Immigrants facing Covid 19 containment in France: An ordinary hardship of disaffiliation.** *J Migr Health.* 2020; **1-2**: 100032.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Canadian Institute for Health Information: **Guidance on the Use of Standards for Race-Based and Indigenous Identity Data Collection and Health Reporting in Canada.** 2022.
Reference Source

Cerdeña JP, Plaisime MV, Tsai J: **From race-based to race-conscious medicine: how anti-racist uprisings call us to act.** *Lancet.* 2020; **396**(10257): 1125–1128.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Coyer L, Wynberg E, Buster M, *et al.*: **Hospitalisation rates differed by city district and ethnicity during the first wave of COVID-19 in Amsterdam, The Netherlands.** *BMC Public Health.* 2021; **21**(1): 1721–1729.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Crenshaw K: **Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics.** Univ. Chic. Leg. Forum, vol. 1989, no. 1. 1989. Accessed: Nov. 15, 2021.
Reference Source

Dalal F: *Race, Colour and the Process of Racialization: New Perspectives From Group Analysis, Psychoanalysis, and Sociology, P.27.* Brunner-Routledge; 2002.

Dalsania AK, Fastiggi MJ, Kahlam A, *et al.*: **The Relationship Between Social Determinants of Health and Racial Disparities in COVID-19 Mortality.** *J. Racial Ethn. Health Disparities.* 2022; **9**: 288–295.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Elstad JI, Heggebø K, Dahl E: **Nordic research on health inequalities: A scoping review of empirical studies published in Scandinavian Journal of Public Health 2000–2021.** *Scand. J. Public Health.* 2022; **50**: 843–851.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

European Commission: **Migration and Home Affairs. Xenophobia.** *EMN Asylum and Migration Glossary.* (page consulted on the 3rd of November, 2023).
Reference Source

Farkas L: *Analysis and comparative review of equality data collection practices in the European Union: Data collection in the field of ethnicity. Directorate-General for Justice and Consumers.* Publications Office of the European Union; 2017.
Reference Source

Gay A: **Deny and Punish: A French History of Concealed Violence.** *Occasion.* 2015; **9**.
Reference Source

Grant MJ, Booth A: **A typology of reviews: an analysis of 14 review types and associated methodologies.** *Health Inf. Libr. J.* 2009; **26**: 91–108.
PubMed Abstract | **Publisher Full Text**

Gunaratnam Y: **Race GPS: No right turn ahead [Online].** 2013.
Reference Source

Hamed S, Bradby H, Ahlberg BM, *et al.*: **Racism in healthcare: a scoping review.** *BMC Public Health.* 2022; **22**: 988.
Publisher Full Text

Holtzman G, Khoshkhoo NA, Nsoesie E: **The Racial Data Gap: Lack of Racial Data as a Barrier to Overcoming Structural Racism.** *Am. J. Bioeth.* 2022; **22**(3): 39–42.
PubMed Abstract | **Publisher Full Text**

Institute of Tropical Medicine: **ITM Guidelines regarding authorship in scientific publications.** 2017. Accessed online December 19th, 2022.
Reference Source

Kaplan JB, Bennett T: **Use of Race and Ethnicity in Biomedical Publication.** *JAMA.* 2003; **289**(20): 2709–2716.
Publisher Full Text

Katikireddi S, Lal S, Carrol E, *et al.*: **Unequal impact of the COVID-19 crisis on minority ethnic groups: a framework for understanding and addressing inequalities.** *J. Epidemiol. Community Health.* 2021; **75**(10): 970–974.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Krieger N: **Structural Racism, Health Inequities, and the Two-Edged Sword of Data: Structural Problems Require Structural Solutions.** *Front. Public Health.* 2021; **9**(April).
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Laveist TA: **Why we should continue to study race ... but do a better job: An essay on race, racism and health.** *Ethn. Dis.* 1996; **6**(1–2): 21–29.

Linos N, Bassett MT, Salemi A, *et al.*: **Opportunities to tackle structural racism and ethnicity-based discrimination in recovering and rebuilding from the COVID-19 pandemic.** *Nat. Commun.* 2022; **13**: 3277.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Meghji A, Niang SM: **Between Post-Racial Ideology and Provincial Universalisms: Critical Race Theory, Decolonial Thought and COVID-19 in Britain.** *Sociology.* 2022; **56**(1): 131–147.
Publisher Full Text

Meudec M, Affun-Adegbulu C, Cosaert T:**Review protocol - First draft - Review of health research and data on racialised minorities: Implications for addressing racism and and racial disparities in public health practice and policies in Europe (first draft)**. Dataset. *Zenodo.* 2022a.
Publisher Full Text

Meudec M, Affun-Adegbulu C, Cosaert T, *et al.*: **Review protocol - Final version - Review of health research and data on racialised minorities: Implications for addressing racism and and racial disparities in public health practice and policies in Europe**. Dataset. *Zenodo.* 2022b.
Publisher Full Text

Meudec M, Affun-Adegbulu C, Cosaert T, *et al.*:**Data Extraction Sheet for the Review - 2**. [Data set]. *Zenodo.* 2022c.
Publisher Full Text

Meudec M, Affun-Adegbulu C, Cosaert T: **PRISMA-P-checklist for RECoRD_final version (final)**. Dataset. *Zenodo.* 2022d.
Publisher Full Text

Miconi D, Li Z, Frounfelker R, *et al.*: **Ethno-cultural disparities in mental health during the COVID-19 pandemic: A cross-sectional study on the impact of exposure to the virus and COVID-19-related discrimination and stigma on mental health across ethno-cultural groups in Quebec (Canada).** *BJPsych Open.* 2021; **7**(1): E14.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Milner A, Jumbe S: **Using the right words to address racial disparities in COVID-19.** *Lancet.* 2020; **5**(August): e419–e420.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Mukumbang FC, Ambe AN, Adebiyi BO: **Unspoken inequality: How COVID-19 has exacerbated existing vulnerabilities of asylum-seekers, refugees, and undocumented migrants in South Africa.** *Int. J. Equity Health.* 2020; **19**(1): 1–7.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Naidu T: **Says who? Northern ventriloquism, or epistemic disobedience in global health scholarship.** *Lancet Glob. Health.* 2021; **9**(9): e1332–e1335.
PubMed Abstract | **Publisher Full Text**

National Collaborating Centre for Determinants of Health: *Glossary of essential health equity terms.* Antigonish, NS: National Collaborating Centre for Determinants of Health, St. Francis Xavier University; 2014.
Reference Source

OECD: **What is the impact of the COVID-19 pandemic on immigrants and their children? (Issue October).** 2020. Accessed online Aug. 25, 2022.
Reference Source

Paradies Y, Ben J, Denson N, *et al.*: **Racism as a determinant of health: A systematic review and meta-analysis.** *PLoS One.* 2015; **10**(9): e0138511.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Poteat T, Millett GA, Nelson LE, *et al.*: **Understanding COVID-19 risks and vulnerabilities among black communities in America: the lethal force of syndemics.** *Ann. Epidemiol.* 2020; **47**: 1–3.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Rai T, Hinton L, McManus RJ, *et al.*: **What would it take to meaningfully attend to ethnicity and race in health research? Learning from a trial intervention development study.** *Sociol. Health Illn.* 2022; **00**: 1–16.
Publisher Full Text

Rivenbark JG, Ichou M: **Discrimination in healthcare as a barrier to care: Experiences of socially disadvantaged populations in France from a nationally representative survey.** *BMC Public Health.* 2020; **20**(1): 1–10.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Roberts DE: **What's Wrong with Race-Based Medicine?** *Genes, Drugs, and Health Disparities.* 2011a; **2049**(2004): 1–21.
Reference Source

Roberts DE: **Fatal invention: how science, politics, and big business re-create race in the twenty-first century.** *In Choice Reviews Online.* 2011b; **49**(04): 49-2029.
Publisher Full Text

Saini A: **Superior: the return of race science. 4th Estate London.** 2019.

Selvarajah S, Deivanayagam TA, Lasco G, *et al.*: **Categorisation and minoritisation.** *BMJ Global Health.* 2020; **5**: e004508.
Publisher Full Text

Simon P: **The measurement of racial discrimination: The policy use of statistics.** *Int. Soc. Sci. J.* 2005; **57**(183): 9–25.
Publisher Full Text

Souissi T: **Racialized Minorities.** In *The Canadian Encyclopedia.* 2022.
Reference Source

Statistics Netherlands: **New classification of population by origin, Replacing classification based on migration background and the concepts western/non-western.** 2022. Accessed online December 19th, 2022.
Reference Source

Smedley BD, Stith AY, Nelson AR: *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academy Press; 2003.

Song M: **Why we still need to talk about race.** *Ethn. Racial Stud.* 2018; **41**(6): 1131–1145.
Publisher Full Text

Suleman S, Garber KD, Rutkow L: **Xenophobia as a determinant of health: an integrative review.** *J. Public Health Policy.* 2018; **39**: 407–423.
Publisher Full Text

Udah H: **Searching for a Place to Belong in a Time of Othering.** *Soc. Sci.* 2019; **8**(11): 297.
Publisher Full Text

Van Dorn A, Cooney RE, Sabin ML: **COVID-19 exacerbating inequalities in the US.** *Lancet (London, England).* 2020; **395**(10232): 1243–1244.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Vanthomme K, Gadeyne S, Lusyne P, *et al.*: **A population-based study on mortality among Belgian immigrants during the first COVID-19 wave in Belgium. Can demographic and socioeconomic indicators explain differential mortality?** *SSM - Popul Heal.* 2021; **14**: 100797.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Wadhera RK, Wadhera P, Gaba P, *et al.*: **Variation in COVID-19 hospitalizations and deaths across New York City boroughs.** *JAMA.* 2020; **323**(21): 2192–2195.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

White C, Nafilyan V: **Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 15 May 2020.** *Office for National Statistics.* 2020.
Reference Source

Williamson EJ, Walker AJ, Bhaskaran K, *et al.*: **Factors associated with COVID-19-related death using OpenSAFELY.** *Nature.* 2020; **584**(7821): 430–436.
PubMed Abstract | **Publisher Full Text** | **Free Full Text**

Yaya S, Yeboah H, Charles CH, *et al.*: **Ethnic and racial disparities in COVID-19-related deaths: counting the trees, hiding the forest.** *BMJ Glob. Health.* 2020; **5**: e002913.
Publisher Full Text

Zuberi T: *Thicker than Blood, How Racial Statistics Lie.* University of Minnesota Press; 2003.

Open Peer Review

Current Peer Review Status: ✓ ✓

Version 2

Reviewer Report 15 February 2024

https://doi.org/10.5256/f1000research.159496.r228518

✓ **Elie Azria**

INSERM, Université de Paris, Paris, France

Although I do not fully agree with some of the authors' responses, and the fact that the project has not been registered on the PROSPERO platform is a limitation of the project (which may also limit access to high-impact journals for publication), I consider the revisions to be appropriate and wish the project team all the best.

Competing Interests: No competing interests were disclosed.

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Reviewer Report 09 February 2024

https://doi.org/10.5256/f1000research.159496.r228519

✓ **Chinelo L. Njaka**

Goldsmiths University of London, London, England, UK

Race, Health, and Inequality in Europe: A Study Protocol Review of "Review of Health Research and Data on Racialised Groups: Implications for Addressing Racism and Racial Disparities in Public Health Practice and Policies in Europe," Version Two.

Introduction:
As overviewed in my previous review of "Review of Health Research and Data on Racialised

Groups: Implications for Addressing Racism and Racial Disparities in Public Health Practice and Policies in Europe," a broad range of actors from non-governmental organisations, academic institutions, and elsewhere have been advocating for the disaggregation of race data—particularly in the European context. The lack of doing so obfuscates key factors in health and other disparities, and by collecting data on race, these disparities can be illuminated and combatted through informed and evidence-based policy making (UN OHCHR 2018; see also previous review for more details).

The current version of the paper shows strengthened improvement and refinement from the previous version, offering an important contribution to existing scholarship around race and racialisation in the European Union, the socio-political reasons behind the lack of disaggregated race data collection, and an important challenge to that status quo through the systematic review of current literature that reveals the real challenges in health—and more broadly—that exist and persist through 'race neutral' policies.

Study Protocol Assessment:
The significance of this study protocol remains in its potential to inform and shape 'race-conscious' approaches to future public health policies that are able to acknowledge and address racialised disparities in The Netherlands, Belgium, and France specifically, as well as Europe more broadly. See my previous review for further detailed assessment, which all remains relevant to the current version of the protocol.

Areas for improvement and Recommendations:
The protocol has been greatly improved in the current version, though there remain a few minor areas of note that could be addressed to strengthen the protocol further.

The use of the word 'assumption' to describe the starting point for the authors does a disservice to the premise of the study. I understand that this was a change in response to the comments of another reviewer, but I do not think mere 'assumption' is accurate. There has been much documented challenge and scholarly enquiry around race (dis)aggregation in data collection over decades, so adding references to the protocol will support the authors' starting position as more than 'assumption' and better contextualise the current situation and issues with it, especially for those who are unaware or have otherwise not identified any issues with 'race-neutral' policies.

I agree that moving towards research that works *with* racially minoritised individuals and groups, rather than only *on* them is an important way forward in collecting data and improving research efficacy in general. However, as the authors noted, that is not yet happening frequently, and they are unsure if this has happened (and to what extent) in the research being analysed. Thus, the use of 'on/with' as aspirational, rather than as an accurate description is insufficient and potentially problematic because it can be misleading. Perhaps think through an alternative way to convey this current tension, as it is an important one with which to grapple and I commend the authors for this consideration.

The working definition for 'race' is not detailed sufficiently. The concept of race—and therefore the process of racialisation—is not limited to skin colour, so currently the definition reads more as one for 'colourism.' Providing additional examples of phenotypic characteristics (and/or others outside of phenotype) that can contribute to conceptions of race would improve this greatly.

For ‘ethnicity,’ the working definition could also be improved upon, as currently it reads as being synonymous to ‘culture.’ Editing to make clear that ‘ethnicity’ is distinct from ‘culture’ will not only increase the clarity for the readers, but also may help clarify what the researchers will be looking for during their literature review. If ‘culture’ will also be salient, which it likely will be, the authors might want to consider adding a separate definition for ‘culture’ to the protocol, as well.

The term ‘health inequities’ is introduced twice on page 4 before an asterisk on page 5 is used to signal that there is a definition below. However, there is not a definition given for this particular term. Previously, I suggested defining terms in the positive (e.g., ‘equity’) versus negative (e.g., ‘inequity’) for clarity, and I see that this recommendation was partially implemented. In light of the revisions made and definitions given, how is ‘equity’ distinct from ‘equality’? The definition given for ‘equity’ reads as definition for ‘equality.’ It would strengthen the protocol greatly to provide specific definitions for each concept in a clear and specific way that reflects how they are being operationalised (distinctively) in the research. At present, the definitions given leave unclear what ‘(health) equality’ is (and how it is distinct from ‘[health] equity’) and what ‘(health) inequity’ is (and how it is distinct from ‘[health inequality’).

Lastly and minorly, there are miscellaneous typos and a few missing words, as well as some subject/verb disagreement throughout the text—particularly when using the word, ‘data.’

Approval Status:
Based on the above assessment of the “Review of Health Research and Data on Racialised Groups: Implications for Addressing Racism and Racial Disparities in Public Health Practice and Policies in Europe” study protocol, the approval status given is: approved.

Whilst there are still a few areas that could use improvement for clarity—particularly around operationalised definitions—overall the study protocol has been sufficiently revised to demonstrate its merits, relevance, timeliness, and importance to contribute to current scholarly dialogue around race and health disparities in the European context. The current recommendations are minor in scope, and do not require an additional review for approval.

My best wishes to the authors and research team as they undertake this important research project.

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: race, racialisation, racism(s), public health, health inequalities/inequities, human rights, cross-national comparison

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard.

Version 1

Reviewer Report 06 June 2023

https://doi.org/10.5256/f1000research.140910.r172212

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Introduction
Researchers, advocacy groups, and institutions have long advocated for the collection of disaggregated race data, emphasising its crucial role in promoting equality, combating discrimination, and informing evidence-based decision-making (UN OHCHR 2018). Within the European context, some nations, influenced by various socio-historical factors, have been reluctant to gather demographic data that would highlight such disparities and provide insights into the experiences of different racialised and ethnic groups. This hesitance has led to 'race-neutral' policies, which have limited the availability of comprehensive and nuanced data on racialised inequalities, hindering efforts to understand fully the multiple factors that contribute to disparities and design targeted policies and interventions to move toward parity.

"Review of Health Research and Data on Racialised Groups: Implications for Addressing Racism and Racial Disparities in Public Health Practice and Policies in Europe" offers a timely and exciting study protocol that focuses on assessing the available health data and research in France, the Netherlands, and Belgium, where limited attention has been given to racism and racialised inequalities in research and policy in comparable ways. The aim of the protocol is to highlight the importance of recognising racialisation and racism in public health practice and policies, and to emphasise the challenges in fully capturing and understanding racialised health disparities without consistent and explicit ways of identifying racialised groups within Europe. By systematically examining existing research, this protocol aims to uncover key insights that can inform efforts to address racism and mitigate racialised disparities in healthcare.

Study Protocol Assessment
The significance and strength of this study protocol, as part of a larger project, lies in its potential to inform and shape future public health interventions and policies that aim to address racialised inequalities and inequities through advocating for a 'race-conscious' approach to European public health research. By critically examining the usage of race, ethnicity, and related terms in health-related research and analysing the collection and utilisation of data on racialised minority groups, the protocol provides valuable insights that can contribute to the future development of evidence-based guidance on the effective use of data and research with racialised groups, and promoting health equity across all racialised groups in Europe.

The rationale for the protocol is adequately described, highlighting the need to address racism and racial disparities explicitly in public health practice and policies in Europe. The protocol acknowledges the significant health inequities experienced by racialised groups and aims to review existing health research and data to gain a comprehensive understanding of these disparities. The protocol also allows for the examination of the ways that researchers are conceptualising and operationalising racialised terminologies in order to identify disparities along racialised divisions in the first instance. The objectives of the study protocol are well-defined and aligned with the research rationale, focusing on conducting a systematic review of existing research and assessing the quality and accessibility of data on racialised groups. These objectives are relevant and essential for addressing the research scope and informing evidence-based interventions and policies.

The study design appears appropriate for addressing the research objectives of reviewing health research and data on racialised groups in Europe. As outlined in the study protocol, a systematic review approach will be used to synthesise and analyse the available research and data using specific search parameters. This design allows for a comprehensive assessment of the determinants and consequences of racial disparities in public health outcomes. A particular strength of note is that, though this article is written in English, the scope of the protocol will analyse research additionally in Dutch and French, which reflects the languages used in the nations studied.

The study protocol provides sufficient details of the methods employed in conducting the systematic review. The inclusion and exclusion criteria for selecting relevant studies are clearly described, which helps ensure the broad reproducibility of the review process. Additionally, the study protocol outlines the steps for data extraction, synthesis, and analysis, contributing to the replicability of the study. Due to the nature of the methods used, however, exact reproducibility to achieve the precise research and data identified is essentially impossible, due to the continuous addition of published research, search algorithms, and other factors outside of researchers' control. This in no way reflects a deficit in the methods of the protocol.

Areas for Improvement and Recommendations
Whilst the study protocol displays the commendable strengths outlined above, several areas could be enhanced to improve its effectiveness and impact.

The main critique for the study protocol is the omission of bias consideration for the purposes of this research. It is imperative to acknowledge and address the biases that may arise during the research process. Providing statements of positionality seems to acknowledge this point, which is why it is surprising that there is no further elaboration on potential biases within the study protocol. Although the study is a critical review, the process still generates data and is critically assessed, so bias must be explicitly considered.

Further to this point, there are some issues of potential bias present in the protocol that should be addressed. The protocol and broader research need to address the implicit use of Whiteness as the default and move away from binary categorisations of racial(ised) 'majority' and 'minority'. An intersectional lens should be applied to acknowledge the complexities of race and other intersecting social identities that affect the specific disparities seen among particular racialised groups, rather than amalgamating all racialised minorities implicitly into one disparate group. This approach will help highlight the diverse experiences and perspectives among racialised groups and avoid essentialisation or oversimplification. Additionally, 'disparity' is often used in the protocol to imply 'worse', which is not always the case. Disparity only refers to the difference or inequality between groups, which means that groups racialised as White are also part of the 'disparity equation'.

The phrasing of data and research 'on' racialised groups can imply objectification, detachment, or othering of the communities of focus. Consider revising this language used throughout the protocol when discussing racialised and other minoritised or marginalised groups. The use of 'with' - also used in the protocol - better conveys the inclusivity advocated for throughout the protocol and wider research, and acknowledges the collaboration and partnership between researchers and the communities of focus.

With acknowledgement that only the positionalities of the authors are explicitly described, the claim of a 'racially diverse' team may need to be re-evaluated to ensure that it accurately reflects meaningful diversity and avoids tokenism. If the positionality of the authors is reflective of the entire team, then what has been demonstrated is not racialised 'diversity'. Perhaps expand on what is meant by **'**racially diverse**'** to acknowledge the range of racialised and ethnic backgrounds represented in the research team, which would also strengthen the robustness of the methods that are informed by the positionalities of all of the team members involved.

The research would benefit from a clearer distinction between the definitions of 'race' and 'ethnicity'. As written, it is unclear how some of the characteristics used to define race are meaningfully distinct from the 'cultural' aspects used in the definition for ethnicity. The authors may also need to evaluate critically whether the non-phenotypic characteristics offered, such as clothing and speech, should be considered as aspects of race, as this can perpetuate reification and stereotypes of racialised groups (as warned against in CIHI 2022, cited in the protocol). If they do wish to retain these non-phenotypic characteristics as components of race their operational definition, the authors need to strengthen their argument by providing explicit rationale for the purposes of this protocol.

The definitions offered for 'inequality' and 'inequity' in the protocol should be clearly referenced to establish the basis for these particular conceptualisations in this research and context. Depending on the field, area, or sector, these words have varying operational definitions, so the definitions offered are not necessarily universally accepted. Moreover, the definition of 'inequity' reads confusingly, and uses 'equitable' - a term not defined in the protocol - to explain it. The definitions could be revised to offer more straightforward explanations of the concepts; possibly by alternatively providing definitions in positive terms (i.e., 'equality' and 'equity') rather than (only) in negation.

The protocol would also benefit from clarification and/or additional citations when referencing the definition for 'xenophobia'. The protocol is mindful against conflation, however the definition given for xenophobia appears to conflate race and ethnicity. The use of terms such as 'native' and 'host-country' have been used uncritically, as though those who are racialised as minorities are necessarily 'non-native' and those who are not are necessarily 'native' and 'hosts'. These terms can be problematised as reinforcing stereotypes or assumptions about individuals based on their racialised or ethnic backgrounds - as not all Europeans are part of a racialised majority, not all who are racialised as minorities are migrants, and especially with free movement within the European Union, not all who are racialised as part of a majority are from the location where they are living.

Approval Status
Based on the above assessment of the "Review of Health Research and Data on Racialised Groups: Implications for Addressing Racism and Racial Disparities in Public Health Practice and Policies in Europe" study protocol, the approval status given is: 'approved with reservations'.

Whilst the study protocol demonstrates several strengths and merits, there are areas that require improvement or clarification to enhance its effectiveness and impact. The strengths of the study protocol, including the clear rationale and objectives and appropriate study design, contribute to its overall value and support the 'approval with reservations' status. However, certain areas need attention to address reservations and ensure the quality and relevance of the protocol for this part of the research, as well as the wider research project. Recommendations have been provided regarding the need to consider and address potential biases and refine some of the language and key definitions used in the protocol. By implementing these recommendations, the study protocol can strengthen its potential for making a meaningful contribution to addressing racism and racialised disparities in public health practice and policies across Europe.

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?

Yes

Are sufficient details of the methods provided to allow replication by others?

Partly

Are the datasets clearly presented in a useable and accessible format?

Not applicable

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: race, racialisation, racism(s), public health, health inequalities/inequities, human rights, cross-national comparison

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 30 Nov 2023

Marie Meudec

APPROVED WITH RESERVATIONS

Introduction

Researchers, advocacy groups, and institutions have long advocated for the collection of disaggregated race data, emphasising its crucial role in promoting equality, combating discrimination, and informing evidence-based decision-making (UN OHCHR 2018). Within the European context, some nations, influenced by various socio-historical factors, have been reluctant to gather demographic data that would highlight such disparities and provide insights into the experiences of different racialised and ethnic groups. This hesitance has led to 'race-neutral' policies, which have limited the availability of comprehensive and nuanced data on racialised inequalities, hindering efforts to understand fully the multiple factors that contribute to disparities and design targeted policies and interventions to move toward parity.

“Review of Health Research and Data on Racialised Groups: Implications for Addressing Racism and Racial Disparities in Public Health Practice and Policies in Europe” offers a timely and exciting study protocol that focuses on assessing the available health data and research in France, the Netherlands, and Belgium, where limited attention has been given to racism and racialised inequalities in research and policy in comparable ways. The aim of the protocol is to highlight the importance of recognising racialisation and racism in public health practice and policies, and to emphasise the challenges in fully capturing and understanding racialised health disparities without consistent and explicit ways of identifying racialised groups within Europe. By systematically examining existing research, this protocol aims to uncover key insights that can inform efforts to address racism and mitigate racialised disparities in healthcare.

Response: Summary by reviewer
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Study Protocol Assessment
The significance and strength of this study protocol, as part of a larger project, lies in its potential to inform and shape future public health interventions and policies that aim to address racialised inequalities and inequities through advocating for a ‘race-conscious’ approach to European public health research. By critically examining the usage of race, ethnicity, and related terms in health-related research and analysing the collection and utilisation of data on racialised minority groups, the protocol provides valuable insights that can contribute to the future development of evidence-based guidance on the effective use of data and research with racialised groups, and promoting health equity across all racialised groups in Europe.
The rationale for the protocol is adequately described, highlighting the need to address racism and racial disparities explicitly in public health practice and policies in Europe. The protocol acknowledges the significant health inequities experienced by racialised groups and aims to review existing health research and data to gain a comprehensive understanding of these disparities. The protocol also allows for the examination of the ways that researchers are conceptualising and operationalising racialised terminologies in order to identify disparities along racialised divisions in the first instance. The objectives of the study protocol are well-defined and aligned with the research rationale, focusing on conducting a systematic review of existing research and assessing the quality and accessibility of data on racialised groups. These objectives are relevant and essential for addressing the research scope and informing evidence-based interventions and policies.
The study design appears appropriate for addressing the research objectives of reviewing health research and data on racialised groups in Europe. As outlined in the study protocol, a systematic review approach will be used to synthesise and analyse the available research and data using specific search parameters. This design allows for a comprehensive assessment of the determinants and consequences of racial disparities in public health outcomes. A particular strength of note is that, though this article is written in English, the scope of the protocol will analyse research additionally in Dutch and French, which reflects the languages used in the nations studied.
The study protocol provides sufficient details of the methods employed in conducting the systematic review. The inclusion and exclusion criteria for selecting relevant studies are clearly described, which helps ensure the broad reproducibility of the review process. Additionally, the study protocol outlines the steps for data extraction, synthesis, and

analysis, contributing to the replicability of the study. Due to the nature of the methods used, however, exact reproducibility to achieve the precise research and data identified is essentially impossible, due to the continuous addition of published research, search algorithms, and other factors outside of researchers' control. This in no way reflects a deficit in the methods of the protocol.

Response: We thank the reviewer for their interest and positive remarks.
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Areas for Improvement and Recommendations
Whilst the study protocol displays the commendable strengths outlined above, several areas could be enhanced to improve its effectiveness and impact.
The main critique for the study protocol is the omission of bias consideration for the purposes of this research. It is imperative to acknowledge and address the biases that may arise during the research process. Providing statements of positionality seems to acknowledge this point, which is why it is surprising that there is no further elaboration on potential biases within the study protocol. Although the study is a critical review, the process still generates data and is critically assessed, so bias must be explicitly considered.

Response: We thank the reviewer for their comment. We acknowledge the importance of a thorough reflection on potential biases that may arise during the research.

We added the following paragraph in the 'Risk of Bias'-section :
p.15: In addition to asserting our respective positionalities, we also identify several biases and limitations in our work. Firstly, our core team is small and represents only a margin of the diverse intersections of social identities that are present in society. Specifically, the core team is mostly trained in North American and European higher education, which implies that our own frames of reference are primarily Western. The categories and concepts we employ are therefore partial and limited, and inevitably bias our questions, methods and the interpretation and analysis of data both consciously and unconsciously. We are trying to mitigate this bias continually, for example by drawing from the field of Critical Race Theory, by gathering feedback from a larger and more diverse team of researchers, and by holding meetings with a range of stakeholders during future stages of the research (analysis, writing, and guideline development).

Second, this research project focuses on ethnic and racial disparities in health, and thus centralises/emphasises race and racism. This may be a bias in that, by focusing on racial disparities, we temporarily sideline other criteria present within intersecting systems of oppression. We see this research as a first step in demonstrating the lack of a racial lens in health research, and we know that future research will need to take an intersectional lens as its starting point.

A further bias may arise from the fact that we only have access to published results, and we do not have access to all the internal discussions or specific issues related to the use of specific terms or concepts over other options. As this analysis is something of a retrospective study, our analysis is based solely on the information that the authors decided to incorporate in their published manuscripts. This constitutes a bias in the sense that we may risk attributing certain intentions to the authors even though we cannot confirm this in this review. We regret the fact that, in general, authors of scientific articles in this field are not more explicit in justifying their use of a particular terminology.

Another bias could stem from our personal and professional involvement with systemic racism in health. Given our respective positionalities and lived experiences, and given that we do not ultimately aim to achieve objectivity or neutrality in this research, we would like to acknowledge that our judgment in analysing research papers can sometimes be harsh, especially after analysing several documents containing racial/ethnic proxies and euphemisms in the course of a single day. We try to mitigate this by holding weekly meetings with the core team, during which we share our emotions and feelings and discuss elements that emerge in the course of the research.

Finally, this research project focuses on systemic racism in a European context. As such, health disparities are conceptualised in such a way that the white racial majority is seen as the benchmark of good health from which racially minoritised groups diverge. While we recognise that this is a simplified and binary way of analysing disparities, we also want to acknowledge that in doing so we are using whiteness as the default. We are aware of the need to decenter whiteness in research, and we urge the reader to be aware of this bias. Here are a few suggestions of intellectual traditions centering the voices of racialised groups that you can get inspiration from: Black Feminist Thought, Black Intellectual Tradition, Critical Race Theory, Indigenous methodologies, etc.
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Further to this point, there are some issues of potential bias present in the protocol that should be addressed. The protocol and broader research need to address the implicit use of Whiteness as the default and move away from binary categorisations of racial(ised) 'majority' and 'minority'. An intersectional lens should be applied to acknowledge the complexities of race and other intersecting social identities that affect the specific disparities seen among particular racialised groups, rather than amalgamating all racialised minorities implicitly into one disparate group. This approach will help highlight the diverse experiences and perspectives among racialised groups and avoid essentialisation or oversimplification.

Response:
We have fallen into the trap of binary categorisations and the centering of Whiteness, and we thank the reviewer for pointing out this pertinent issue.

Based on your comments, we have changed the term ‘racial minority groups’ for ‘racially minoritised groups’, and ‘minorities’ for ‘minoritised’ as suggested in the literature by Gunaratman (2013), Selvarajah et al. (2020), and Rai et al. (2022). We have added these references in the review protocol as well.

We have changed Key definition 5 as follow:
p6-7: 5. Racially minoritised groups : Refers to groups that are subject to racialisation and are also minoritised, marginalised or underrepresented based on various characteristics such as skin colour, migration status, citizenship, religion, culture, language or geographic location . To emphasise the process of racialisation, some authors use either this wording (Milner and Jumbe, 2020 ; Rai et al., 2022) or “marginalised racial groups” (Barber, 2020).

This quote from Selvarajah et al. (2020: 2-3) is particularly interesting for a reflection on the term ‘minoritised’ : “We recommend the term minoritised, which emphasises active processes, shifting beyond binary discussion of minority versus majority. We build on existing explanations to define minoritised, as ‘individuals and populations, including numerical majorities, whose collective cultural, economic, political and social power has been eroded through the targeting of identity in active processes that sustain structures of hegemony.’ Power is emphasised as central to racism and intersecting forms of discrimination. It highlights maintenance of structures which diminish minoritised people’s capability to lead healthy lives. It neither singles out nor creates groups, and adds more nuance than words like marginalised by connecting back to terms such as ethnic minority, thus acknowledging existing literature while resisting its coupling with dubious assumptions about ethnicity.

And we have added Footnote 12:
p.6: We would like to thank one of the reviewers of the first version of this protocol for their criticism, which helped us to refine our thinking on the risks of falling into binary categorisations and the centering of Whiteness.

And this:
p7: It is important to acknowledge the fact that racially minoritised groups are not homogenous groups, given the intersecting forms of oppression within minoritised groups. Although we clearly want to avoid any form of oversimplification, and we acknowledge the fact that health inequities cannot be reduced to race alone, we see a stark omission of research analysing racism in health in Europe ; therefore, we see this one-dimensional study as a first essential step to enable the development of more complex research using intersectional lens in the future.
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Additionally, ‘disparity’ is often used in the protocol to imply 'worse', which is not always the case. Disparity only refers to the difference or inequality between groups, which means that groups racialised as White are also part of the 'disparity equation'.

Response:
We would like to thank the reviewer for pointing out this pertinent issue and by this helping us in communicating more clearly. We have revised our use of the word ‘disparity’ throughout the review and changed it where this was deemed necessary.

For example:
p2: In many countries, there is a lack of national data systems using race/ethnicity data, which means that there is limited statistical evidence on health disparities between racially minoritised and majoritised groups.

Identical corrections have been made throughout the text.

Furthermore, definition 8 (health disparities) and 9 (racial health disparities) have been adapted accordingly:
p7: Health disparities: Refers to a condition in which different social groups have different health outcomes. Generally, disadvantaged social groups such as the poor, racial/ethnic

minoritised groups, women and other groups who have persistently experienced social disadvantage or discrimination systematically, experience worse health or greater health risks than more advantaged social groups (Braveman, 2004, 2007). When systemic barriers to good health are avoidable yet still remain, they are often referred to as 'health inequities'.
p7-8: Racial health disparities: Refers to health disparities that occur between racially minoritised groups and the racially majoritised group. It describes the increased presence and severity of certain diseases, poorer health outcomes, and greater difficulty in obtaining healthcare services. Usually, it is the racially minoritised groups who are at a disadvantage compared to the racially majoritised one.
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The phrasing of data and research 'on' racialised groups can imply objectification, detachment, or othering of the communities of focus. Consider revising this language used throughout the protocol when discussing racialised and other minoritised or marginalised groups. The use of 'with' - also used in the protocol - better conveys the inclusivity advocated for throughout the protocol and wider research, and acknowledges the collaboration and partnership between researchers and the communities of focus.

Response:
We thank the reviewer for their important observation and valuable suggestions.
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Throughout the text, we have changed 'research on racially minoritised groups' into 'research on/with racially minoritised groups'. In instances where the phrasing 'data and research on racially minoritised groups' is used, we have changed this into 'data on and research on/with racially minoritised groups'. To be consistent, we have also modified this in the title of our review.

We have also added the following footnote n.4:
p2: The term 'on/with' is used deliberately. On the one hand, we want to acknowledge that in reality, much research is not done 'with' the communities it focuses on. On the other hand, however, we do not wish to reify and normalise the formulation 'doing research on' and the associated academic culture throughout our text. In addition, we only have access to the data that researchers have chosen to publish, so we do not always know whether the research is actually done 'on' or done 'with' the community in question. For all these reasons, using the formulation 'on/with' seems to be the most nuanced and correct way.
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With acknowledgement that only the positionalities of the authors are explicitly described, the claim of a 'racially diverse' team may need to be re-evaluated to ensure that it accurately reflects meaningful diversity and avoids tokenism. If the positionality of the authors is reflective of the entire team, then what has been demonstrated is not racialised 'diversity'. Perhaps expand on what is meant by 'racially diverse' to acknowledge the range of racialised and ethnic backgrounds represented in the research team, which would also strengthen the robustness of the methods that are informed by the positionalities of all of the team members involved.

Response:
We thank the reviewer for their valuable comment.

Indeed, the team expanded after the review protocol was drafted. In light of your comment and for clarity, we are removing the claim of "racial diversity" in the review protocol, and will further elaborate on the positionality of all team members, and their respective contributions to the project, when we publish the article presenting the results of the study.

Therefore, we removed the claim as follow:
p.2: This race-conscious approach forms the basis and the goal of this project, conducted by a racially diverse team (see below Review team / Positionality).

For better clarity, we also added this section in the Description of the review team:
p.14: Following ITM guidelines on authorship (2017), the core team has carried out the following tasks: 1) conception of the work; 2) design of the study and drafting of the review protocol.
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The research would benefit from a clearer distinction between the definitions of ‘race’ and ‘ethnicity’. As written, it is unclear how some of the characteristics used to define race are meaningfully distinct from the ‘cultural’ aspects used in the definition for ethnicity. The authors may also need to evaluate critically whether the non-phenotypic characteristics offered, such as clothing and speech, should be considered as aspects of race, as this can perpetuate reification and stereotypes of racialised groups (as warned against in CIHI 2022, cited in the protocol). If they do wish to retain these non-phenotypic characteristics as components of race their operational definition, the authors need to strengthen their argument by providing explicit rationale for the purposes of this protocol.

Response:
We thank the reviewer for pointing out the confounding nature of these two definitions. We take this as an opportunity to further sharpen our definitions and our writing.

The definition of ‘Race’ has been rewritten as such:
p5: Race: Refers to socially and politically constructed perceptions of differences among people based on phenotypic characteristics such as skin colour. Although the sciences have been (and still are) heavily involved in the production of race and racial categorisations, there is no scientifically supported biological basis for racial categorisation. However, various societal actors construct races as real, which has a variety of detrimental implications for economic, political, social, and cultural life (CIHI, 2022).
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The definitions offered for ‘inequality’ and ‘inequity’ in the protocol should be clearly referenced to establish the basis for these particular conceptualisations in this research and context. Depending on the field, area, or sector, these words have varying operational definitions, so the definitions offered are not necessarily universally accepted. Moreover, the definition of ‘inequity’ reads confusingly, and uses ‘equitable’ - a term not defined in the protocol - to explain it. The definitions could be revised to offer more straightforward explanations of the concepts; possibly by alternatively providing definitions in positive terms (i.e., ‘equality’ and ‘equity’) rather than (only) in negation.

Response:

We thank the reviewer for pointing this out and have revised the definitions. We have brought in a more specific focus on health inequality and health inequity, rather than attempting to define the concepts in general (separately from health). This will help us make the definitions less abstract and more relevant and to the point. Therefore, we have removed the definitions of Inequality and Inequity. In addition, we have merged the definition of health inequality with the definition of health disparities:
p7: Health disparities or health inequalities: Refers to a condition in which different social groups have different health outcomes. Generally, disadvantaged social groups such as the poor, racially/ethnic minoritised groups, women and other groups who have persistently experienced social disadvantage or discrimination systematically, experience worse health or greater health risks than more advantaged social groups (Braveman, 2004, 2007). When systemic barriers to good health are avoidable yet still remain, they are often referred to as 'health inequities'.

p7: Health equity: Refers to the absence of differences in health associated with social disadvantages that are modifiable, and considered unfair. This means everyone has a fair chance to reach their full health potential without being disadvantaged by social, economic and environmental conditions (CIHI, 2022 ; NCCDH, 2014).
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The protocol would also benefit from clarification and/or additional citations when referencing the definition for ‘xenophobia’. The protocol is mindful against conflation, however the definition given for xenophobia appears to conflate race and ethnicity. The use of terms such as ‘native’ and ‘host-country’ have been used uncritically, as though those who are racialised as minorities are necessarily ‘non-native’ and those who are not are necessarily ‘native’ and ‘hosts’. These terms can be problematised as reinforcing stereotypes or assumptions about individuals based on their racialised or ethnic backgrounds - as not all Europeans are part of a racialised majority, not all who are racialised as minorities are migrants, and especially with free movement within the European Union, not all who are racialised as part of a majority are from the location where they are living.

Response:
Once again, we thank the reviewer for their comment. In fact, their remark is the point we are trying to make in this paragraph discussing the definition of xenophobia and especially discussing how it is distinct from racism. As this is not understood as such, we have rewritten the definition to make it more to the point and the message clearer.

p9: Xenophobia: “Attitudes, prejudices and behaviour that reject, exclude and often vilify persons, based on the perception that they are outsiders or foreigners to the community, society or national identity.” (European Commission, Migration and Home Affairs) As such, xenophobia needs to be distinguished from racism, which concerns (systemic) acts of discrimination towards someone based on their perceived affiliation to a racially minoritised group, regardless whether this person is seen as a foreigner or not (Suleman et al., 2018: 2). This distinction is important, as the mechanisms and outcomes of both forms of discrimination are different and can affect different groups.
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Approval Status
Based on the above assessment of the “Review of Health Research and Data on Racialised

Groups: Implications for Addressing Racism and Racial Disparities in Public Health Practice and Policies in Europe" study protocol, the approval status given is: 'approved with reservations'.
Whilst the study protocol demonstrates several strengths and merits, there are areas that require improvement or clarification to enhance its effectiveness and impact. The strengths of the study protocol, including the clear rationale and objectives and appropriate study design, contribute to its overall value and support the 'approval with reservations' status. However, certain areas need attention to address reservations and ensure the quality and relevance of the protocol for this part of the research, as well as the wider research project. Recommendations have been provided regarding the need to consider and address potential biases and refine some of the language and key definitions used in the protocol. By implementing these recommendations, the study protocol can strengthen its potential for making a meaningful contribution to addressing racism and racialised disparities in public health practice and policies across Europe.

Response:
We thank the reviewer for their thorough feedback and helpful suggestions. We will share our results with you when they are ready.

Competing Interests: No competing interests

Reviewer Report 10 May 2023

https://doi.org/10.5256/f1000research.140910.r164519

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Elie Azria
INSERM, Université de Paris, Paris, France

I would like to thank the editorial team for allowing me to review this very interesting project which I found very instructive. Research on racialized groups is a major issue in informing policies to reduce health inequalities.

The authors present the protocol for a systematic review of research on the health of racialized groups. The aim of this systematic review is not to assess the health of these groups through health indicators or to measure health inequalities that might exist with a reference group, but to produce a critical analysis of this research and the concepts it mobilises, particularly in the categorisation of social groups. Based on this critical analysis, the authors aim to promote a race-conscious approach to health research and to strengthen the use of health research data in Europe.

The authors start from the assumption, which is unfortunately poorly supported by arguments and references, that research on racialized groups in Europe is mostly insufficient and inadequate. This assertion should be further documented.

While this is an extremely interesting approach, the authors argue that exposure variables other than those that can identify racialized groups are proxies or euphemisms. I find this problematic in that these variables can be used to good effect for specific purposes. For example, using ethno-racial variables to characterise a group when the research question concerns the study of health inequalities between migrants and native-born patients would be misguided. Place of birth is much more interesting here and is in no way a proxy. Without denying the use of proxies in many research studies, thinking that this is systematically the case when the exposure variables do not allow for the identification of a racialized group risks putting this analysis on the wrong track.

Furthermore, the choice not to assess the risk of bias seems to me unfortunate in that reporting on the quality of research on this issue could add to the project, even if the study of outcomes is not the objective of this review.

Finally, this protocol should be registered on the Prospero platform, which leads to the discussion of the relevance of another publication.

I wish the authors of this interesting project great success.

Is the rationale for, and objectives of, the study clearly described?

Yes

Is the study design appropriate for the research question?

Partly

Are sufficient details of the methods provided to allow replication by others?

Yes

Are the datasets clearly presented in a useable and accessible format?

Not applicable

Competing Interests: No competing interests were disclosed.

Reviewer Expertise: Obstetrics & gynecology; epidemiology; health inequalities

I confirm that I have read this submission and believe that I have an appropriate level of expertise to confirm that it is of an acceptable scientific standard, however I have significant reservations, as outlined above.

Author Response 30 Nov 2023

Marie Meudec

APPROVED WITH RESERVATIONS

I would like to thank the editorial team for allowing me to review this very interesting project which I found very instructive. Research on racialized groups is a major issue in informing policies to reduce health inequalities.

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Response: We thank the reviewer for their interest.

The authors start from the assumption, which is unfortunately poorly supported by arguments and references, that research on racialized groups in Europe is mostly insufficient and inadequate. This assertion should be further documented.

Response: These are indeed our hypotheses, but the scale of the problem needs to be demonstrated in our study. We wanted to highlight certain trends in the field of health research, and in particular the fact that the categories and variables used in a certain number of publications (out of a total of 700 articles) are not necessarily in line with the research objectives or with the interpretations made of the results. Although our research has some limitations (we study mostly published articles in scientific journals, and we know that some research is not published (yet)), our objective is indeed to prove our hypotheses. Based on the results of our review, we will be able to give a better idea of the research landscape on/with racially minoritised groups in these 3 countries.
For better clarification, we have added this in a revised version of our review protocol:
(Page numbers are those of the version with track changes)
p.2: Yet, we start from the assumption that, in many countries across Europe, there is often inappropriate, inadequate, or insufficient use and deployment of data and research* on racially minoritised groups. The reasons for this assumption can be grouped into two main categories. One is the continuous emergence of biologically or genetically based race research which is often linked to scientific racism (Roberts, 2011a, 2011b; Saini, 2019).

While this is an extremely interesting approach, the authors argue that exposure variables other than those that can identify racialized groups are proxies or euphemisms. I find this problematic in that these variables can be used to good effect for specific purposes. For example, using ethno-racial variables to characterise a group when the research question concerns the study of health inequalities between migrants and native-born patients would be misguided. Place of birth is much more interesting here and is in no way a proxy. Without denying the use of proxies in many research studies, thinking that this is systematically the case when the exposure variables do not allow for the identification of a racialized group risks putting this analysis on the wrong track.

Response: We thank the reviewer for their comment and fully agree with their remarks. We agree that concepts are not inherently a proxy or a euphemism, that this is relative to the

research question and that different variables can be useful for different purposes.
We take this comment as an encouragement to explain our understanding of proxies and euphemisms in a more clear and nuanced way. We do this by rewriting Key definition 3:
p5: Racial and ethnic euphemisms and proxies: A word or expression used inappropriately or inadequately to designate and describe racially minoritised groups. We understand concepts as racial and ethnic euphemisms and proxies when there is a clear mismatch between 1) the used concepts or variables and 2) the aim of the research or the interpretation of the results. This includes the use of terms which are related to concepts like migration, religion, language, origin, postcode (= place-based discrimination), citizenship, nationality, and culture. Note however that the concepts mentioned above are not inherently proxies or euphemisms for race and ethnicity , and can be of adequate use depending on the topic of research.

Furthermore, the choice not to assess the risk of bias seems to me unfortunate in that reporting on the quality of research on this issue could add to the project, even if the study of outcomes is not the objective of this review.

Response: We thank the reviewer for their comment. Because we do not plan to study the outcomes of the studies, we have decided not to make assessments for the risk of bias by study. We understand that this could have benefited the project. However, although we do not use a tool to systematically assess risk of bias, we believe that we largely account for the quality of the research in our critical analysis by examining the concepts and terms used, the types of data, and the methodologies employed in each study. We also added some information in the Risk of bias section.

Finally, this protocol should be registered on the Prospero platform, which leads to the discussion of the relevance of another publication.

Response: We thank the reviewer for their suggestion. On the website of the Prospero platform the following is stated: “from 1st October 2019, we will only accept reviews provided that data extraction has not yet started.” We have already taken significant steps in the data extraction, thus we are not eligible anymore to register on the Prospero platform at this stage of the research.

I wish the authors of this interesting project great success.

Response: Thank you very much! We will share our results with you when they are ready.

Competing Interests: No competing interests