

119TH CONGRESS
1ST SESSION

H. R. 6767

To amend the Public Health Service Act to include Middle Eastern and North African (MENA) individuals in the statutory definition of a “racial and ethnic minority group”, to direct the Secretary of Health and Human Services to conduct a comprehensive study of MENA population health, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 16, 2025

Ms. TLAIB (for herself, Mrs. DINGELL, Ms. KELLY of Illinois, Ms. STANSBURY, Ms. BARRAGÁN, Mr. CARSON, Ms. CLARKE of New York, Mr. CORREA, Mr. GARCÍA of Illinois, Mr. GOLDMAN of New York, Ms. NORTON, Mr. JOHNSON of Georgia, Ms. LEE of Pennsylvania, Ms. MCCOLLUM, Ms. OCASIO-CORTEZ, Ms. POU, Ms. SCHAKOWSKY, and Ms. SIMON) introduced the following bill; which was referred to the Committee on Energy and Commerce

A BILL

To amend the Public Health Service Act to include Middle Eastern and North African (MENA) individuals in the statutory definition of a “racial and ethnic minority group”, to direct the Secretary of Health and Human Services to conduct a comprehensive study of MENA population health, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Health Equity and
3 Middle Eastern and North African Community Inclusion
4 Act of 2025” or the “Health Equity and MENA Commu-
5 nity Inclusion Act of 2025”.

6 **SEC. 2. DEFINITION.**

7 In this Act, the terms “Middle Eastern and North
8 African” or “MENA”, with respect to individuals or popu-
9 lations, includes individuals or populations who identify
10 with or belong to one or more nationalities or ethnic
11 groups originating in a country (or portion thereof) in the
12 Middle Eastern and North African region (such as Leba-
13 nese, Iranians, Egyptians, Moroccans, Yemenis,
14 Chaldeans, Imazighen, Kurds, Palestinians, and Yazidis).

15 **SEC. 3. FINDINGS.**

16 Congress finds the following:

17 (1) On March 28, 2024, the Office of Manage-
18 ment and Budget formally recognized Middle East-
19 ern and North African populations in Statistical Pol-
20 icy Directive Number 15 (in this section referred to
21 as “SPD 15”), which established, since its issuance
22 in 1977, the minimum standards for the collection,
23 management, and presentation of data on race and
24 ethnicity.

25 (2) In 1985, the Secretary of Health and
26 Human Services produced a “Report on Black and

1 Minority Health”, which analyzed persistent health
2 differences between the general population and the
3 non-White populations recognized in SPD 15 and
4 served as the basis for the foundation of the Office
5 of Minority Health (in this section referred to as the
6 “OMH”).

7 (3) Through the establishment of the OMH in
8 1986, the Secretary of Health and Human Services
9 has developed health policies and programs that
10 eliminate health disparities and improve the health
11 of racial and ethnic minority populations.

12 (4) Congress has funded the OMH to ensure
13 improved health status of racial and ethnic minori-
14 ties, and to develop measures to evaluate the effec-
15 tiveness of activities aimed at reducing health dis-
16 parities and supporting the local community. The ac-
17 tivities of the OMH have addressed health dispari-
18 ties, including with respect to physical activity and
19 nutrition, clinical conditions, individual social needs,
20 and the social determinants of health for “racial and
21 ethnic minority groups”.

22 (5) Before the amendments made by this Act,
23 section 1707(g)(1) of the Public Health Service Act
24 (42 U.S.C. 300u–6(g)(1)) defined the term “racial
25 and ethnic minority group” (for whom the OMH

1 works to improve health outcomes and eliminate
2 health disparities) to exclude Middle Easterners and
3 North Africans, and thereby prevented MENA popu-
4 lations from accessing critical resources intended to
5 assist historically marginalized communities.

6 (6) Independent researchers and private sector
7 research initiatives have found significant health dis-
8 parities between MENA individuals and the non-
9 Hispanic White population, as well as significant
10 overlap between the health outcomes and health con-
11 ditions of MENA individuals and those of other ra-
12 cial and ethnic minority groups.

13 (7) Poor health outcomes are often connected to
14 impoverishment in other aspects of life and are exac-
15 erbated by additional barriers to access high-quality
16 health coverage, whether in terms of language, eligi-
17 bility, health literacy, or discrimination at the point-
18 of-service.

19 (8) A recent study published in the journal,
20 Proceedings of the National Academy of Sciences,
21 suggested that MENA individuals are not perceived
22 as White and do not perceive themselves as White.

23 (9) Research on the health outcomes and health
24 conditions of MENA individuals is troubling and
25 suggests that efforts must be made on the Federal

1 level to disaggregate the demographic data of
2 MENA individuals from the demographic data of in-
3 dividuals in the non-Hispanic White category and
4 fully understand the social determinants of health
5 for health disparities and outcomes experienced by
6 MENA individuals.

7 (10) MENA individuals are not included among
8 the groups for whom the OMH works to improve
9 health outcomes and eliminate health disparities,
10 which further limits the opportunity of MENA indi-
11 viduals to access programs designed to address their
12 experiences and health conditions.

13 (11) The OMH could better assess and elimi-
14 nate health disparities by conducting a comprehen-
15 sive study of the health of MENA individuals and
16 recognizing MENA individuals as a racial and ethnic
17 minority group.

18 **SEC. 4. INCLUSION OF MIDDLE EASTERNERS AND NORTH**
19 **AFRICANS IN DEFINITION OF RACIAL AND**
20 **ETHNIC MINORITY GROUPS.**

21 (a) IN GENERAL.—Section 1707(g)(1) of the Public
22 Health Service Act (42 U.S.C. 300u–6(g)(1)) is amended
23 by striking “Blacks; and Hispanics” and inserting
24 “Blacks or African Americans; Hispanics; and Middle
25 Easterners and North Africans”.

1 (b) SENSE OF CONGRESS.—It is the sense of Con-
2 gress that subsection (a) should be implemented so as to
3 ensure that—

4 (1) the definition of a “racial and ethnic minor-
5 ity group” in section 1707(g)(1) of the Public
6 Health Service Act (42 U.S.C. 300u–6(g)(1)), as
7 amended by subsection (a), is applied in the imple-
8 mentation and execution of Federal programs and
9 activities that reference such definition; and

10 (2) no racial or ethnic minority group served by
11 such programs and activities is negatively impacted
12 by the amendment made by subsection (a).

13 (c) UNDEFINED REFERENCES.—Not later than 2
14 years after the date of enactment of this Act, the Sec-
15 retary of Health and Human Services shall—

16 (1) identify all regulations, guidance, orders,
17 and documents of the Department of Health and
18 Human Services for establishment or implementa-
19 tion of a health care or public health program, activ-
20 ity, or survey that—

21 (A) use the term “racial and ethnic minor-
22 ity group” or similar terminology; and

23 (B) do not define such term or termi-
24 nology; and

1 (2) take such actions as may be necessary to
2 clarify whether the definition of “racial and ethnic
3 minority group” in section 1707(g)(1) of the Public
4 Health Service Act (42 U.S.C. 300u–6(g)(1)), as
5 amended by subsection (a), applies to such term or
6 terminology.

7 (d) REPORT TO CONGRESS.—Not later than 2 years
8 after the date of enactment of this Act, the Secretary of
9 Health and Human Services shall submit to Congress a
10 report on the implementation of this section.

11 **SEC. 5. REPORT ON HEALTH OF MIDDLE EASTERN AND**
12 **NORTH AFRICAN POPULATION.**

13 (a) STUDY REQUIRED.—The Secretary of Health and
14 Human Services (referred to in this section as the “Sec-
15 retary”) shall conduct or support a comprehensive study
16 regarding the unique health patterns and outcomes of
17 MENA populations.

18 (b) REQUIREMENTS FOR STUDY.—The comprehen-
19 sive study under subsection (a) shall include an enumera-
20 tion of MENA populations across the United States,
21 disaggregated by subpopulation, and with respect to each
22 such population and subpopulation—

23 (1) the rates of—

24 (A) health risk factors, including—

1 (i) behaviors, such as tobacco use, ex-
2 cessive alcohol consumption, physical inac-
3 tivity, and unhealthy diet;

4 (ii) physiological factors, such as obe-
5 sity, diabetes, high blood pressure, high
6 blood sugar, and high cholesterol;

7 (iii) environmental factors, such as ex-
8 posure to toxic chemicals, air and water
9 pollution, and unsafe working conditions,
10 including prevalence of work-related inju-
11 ries;

12 (iv) genetic factors, such as family
13 history of chronic diseases, presence of
14 specific gene mutations, and racial and
15 ethnic predisposition to certain conditions;

16 (v) demographic characteristics, such
17 as age, geographic location, and English
18 language proficiency; and

19 (vi) social determinants of health,
20 such as household income, health insurance
21 coverage, socioeconomic status, education
22 level, housing instability, educational and
23 employment opportunities, and access to
24 culturally and linguistically appropriate
25 service providers;

1 (B) prevalence of chronic disease or illness,
2 including—

3 (i) cancers, such as breast, lung, cer-
4 vical, prostate, colorectal, liver, stomach,
5 and oral cancer;

6 (ii) cardiovascular conditions, such as
7 heart disease, atrial fibrillation, and stroke;

8 (iii) respiratory conditions, such as
9 asthma, chronic obstructive pulmonary dis-
10 ease, and lung disease;

11 (iv) musculoskeletal conditions, such
12 as osteoporosis and carpal tunnel syn-
13 drome;

14 (v) neurological conditions, such as
15 Parkinson's disease, Alzheimer's and other
16 related dementias, epilepsy, and cerebral
17 palsy;

18 (vi) infectious diseases, such as HIV/
19 AIDS, hepatitis B and C, and tuberculosis;
20 and

21 (vii) autoimmune diseases, such as
22 lupus, multiple sclerosis, ulcerative colitis,
23 and rheumatoid arthritis;

24 (C) prevalence of disability and disorder,
25 including—

1 (i) vision impairments, such as blind-
2 ness and low vision;

3 (ii) hearing conditions, such as deaf-
4 ness and varying degrees of hearing loss;

5 (iii) physical impairments, such as
6 musculoskeletal conditions, amputation,
7 paralysis, repetitive strain injuries, and
8 other conditions that affect movement or
9 require assistive devices;

10 (iv) intellectual or developmental con-
11 ditions, such as Down syndrome, Prater-
12 Willi syndrome, Angelman syndrome, au-
13 tism, and attention-deficit/hyperactive dis-
14 order (ADHD), as well as other conditions
15 that affect cognitive abilities, learning, and
16 adaptive behaviors;

17 (v) mental or behavioral conditions,
18 such as depression, anxiety, insomnia,
19 sleep apnea, bipolar disorder, schizo-
20 phrenia, and traumatic brain injury;

21 (vi) substance use disorders, such as
22 disorders in use of alcohol, opioids, stimu-
23 lants, and cannabis, and risk factors stem-
24 ming from such disorders, such as liver
25 damage and gastrointestinal issues;

1 (vii) genetic or blood disorders, such
2 as sickle cell anemia, G6PD deficiency, hy-
3 pertension, and thalassemia; and

4 (viii) endocrine disorders, such as dia-
5 betes, polycystic ovary syndrome (PCOS),
6 and hypothyroidism;

7 (D) maternal and reproductive health out-
8 comes, including maternal morbidity and mor-
9 tality, infertility, and postpartum depression;

10 (E) nutritional health outcomes, including
11 malnutrition, vitamin D and iron deficiencies,
12 among other vitamin deficiencies;

13 (F) child and adolescent health outcomes,
14 such as pediatric developmental delays, child-
15 hood obesity, and early-onset chronic condi-
16 tions;

17 (G) dental and oral health outcomes, in-
18 cluding tooth loss, gum disease, and tooth
19 decay;

20 (H) domestic violence, dating violence, sex-
21 ual assault, sexual harassment, and stalking;
22 and

23 (I) morbidity and mortality, including the
24 rates of morbidity and mortality associated with

1 the rates referenced in subparagraphs (A)
2 through (H);

3 (2) analysis of—

4 (A) the factors and conditions that con-
5 tribute most to—

6 (i) the rates described in paragraph
7 (1); and

8 (ii) the rates by which MENA sub-
9 populations reported the outcomes ref-
10 erenced in subparagraphs (B) and (C) as
11 a disease, illness, disorder, or disability;

12 (B) the leading causes of morbidity and
13 mortality and pregnancy-associated morbidity
14 and mortality;

15 (C) the extent to which access to health
16 care facilities contributes to the associated out-
17 comes of care, including the rates described in
18 paragraph (1); and

19 (D) the disparities between MENA sub-
20 populations and between the aggregate MENA
21 population and other racial and ethnic popu-
22 lations in the rates described in paragraph (1);

23 (3) analysis, enumeration, or quantification of
24 any other health or health-related parameters the
25 Secretary determines necessary; and

1 (4) analysis of the extent to which any or all of
2 the design, implementation, and evaluation of Fed-
3 eral health programs contribute to the health fac-
4 tors, outcomes, and conditions described in para-
5 graphs (1) through (3).

6 (c) CONSULTATION.—The Secretary shall—

7 (1) carry out this section in consultation, as ap-
8 propriate, with the Director of the Census Bureau,
9 the Director of the Centers for Disease Control and
10 Prevention, the Director of the National Institutes
11 of Health, the Assistant Secretary for Mental Health
12 and Substance Use, and other stakeholders (includ-
13 ing community-based organizations); and

14 (2) determine through such consultation the
15 subpopulations to be used for purposes of
16 disaggregation of data pursuant to subsection (b).

17 (d) ONLINE PORTAL.—Upon conclusion of the com-
18 prehensive study under this section, the Secretary shall
19 establish a public online portal to catalogue the results of
20 the study, its underlying data, and information in the re-
21 port submitted pursuant to subsection (e)(2).

22 (e) REPORTING.—

23 (1) INTERIM REPORT.—Not later than 2 years
24 after the date of enactment of this Act, the Sec-
25 retary shall submit to Congress a report outlining

1 the challenges associated with, and progress toward
2 implementing, health data collection for MENA pop-
3 ulations as a distinct category and the plan for com-
4 pleting a comprehensive study regarding the unique
5 health patterns and outcomes of MENA populations.

6 (2) FINAL REPORT.—Not later than 30 days
7 after the conclusion of the comprehensive study
8 under this section, and not later than 2 years after
9 the date of submission of the interim report under
10 paragraph (1), the Secretary shall submit to Con-
11 gress a report describing—

12 (A) the results of the study conducted
13 under this section; and

14 (B) the rulemakings and other actions the
15 agencies described in subsection (c)(1) can un-
16 dertake to more equitably include MENA indi-
17 viduals in their programs, including whether
18 and to what extent additional resources are
19 needed to increase rates of response among
20 MENA populations to Federal health surveys.

21 (f) PRIVACY.—

22 (1) IN GENERAL.—In carrying out the com-
23 prehensive study under this section, the Secretary
24 shall implement robust privacy protections to safe-
25 guard the personal data of the individuals involved.

1 (2) MINIMUM PROTECTIONS.—The privacy pro-
2 tections referred to in paragraph (1) include the fol-
3 lowing:

4 (A) Personally identifiable information,
5 such as names or addresses, shall not be col-
6 lected when unnecessary for the purposes of the
7 study.

8 (B) Any personally identifiable information
9 that is collected shall be securely destroyed
10 upon completion of the intended use of such in-
11 formation.

12 (C) All privacy protections and data han-
13 dling procedures shall be clearly communicated
14 to any individuals who may be subjects of the
15 study, including through informed consent if
16 applicable.

17 (3) PROHIBITION ON INCLUSION OF PII IN ON-
18 LINE PORTAL OR REPORTS.—The Secretary shall not
19 include any personally identifiable information on
20 the online portal under subsection (d) or in the re-
21 ports under subsection (e).

22 (g) VIOLATIONS.—Any person who, by virtue of an
23 official position or affiliation with the Secretary—

24 (1) has possession of, or access to, any record
25 containing individually identifiable information the

1 disclosure of which is prohibited by or under this
2 section; and

3 (2) knowingly discloses such a record to any
4 person or agency not entitled to receive the record,
5 shall be guilty of a misdemeanor and fined not more than
6 \$25,000.

7 (h) PERSONALLY IDENTIFIABLE INFORMATION DE-
8 FINED.—In this section, the term “personally identifiable
9 information” means individually identifying information
10 for or about an individual, including information likely to
11 disclose the location or specific identity of a participating
12 individual, regardless of whether the information is en-
13 coded, encrypted, hashed, or otherwise protected, includ-
14 ing—

15 (1) a first and last name;

16 (2) a home or other physical address;

17 (3) contact information (including a postal,
18 email or internet protocol address, or telephone or
19 facsimile number);

20 (4) a social security number, driver license
21 number, passport number, or student identification
22 number; and

23 (5) any other information, including date of
24 birth, racial or ethnic background, or religious affili-
25 ation, that would serve to identify any individual.

1 (i) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated such sums as may be
3 necessary to carry out this section.

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