# UK-Born Black Caribbeans: Generational Changes in Health and Well-being

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Section One: Introduction

1.1) The Black Caribbean Population in the UK

Demography and Migration

Black people have lived in the British Isles for many centuries; historical observers note the presence of Black soldiers in the Roman Legions (Fraser, 1994). However, in the 20th century, significant, large-scale migration of Black Caribbean people occurred in the post-war period when British companies (in a bid to fill labour force shortages) recruited individuals living in the British Commonwealth. As Smaje (1995) has observed: ‘These migrations were not numerically the largest in British history, but in important respects they were definitive of the ethnic composition of Britain today’ (p.27). Numerically, the most important Black Caribbean migrant group were Jamaicans, though Guyanese and Barbadians also constituted about 20% of the original migrant population (Plaza, 2000). By 1991, the Black Caribbean population (the original immigrants and their offspring) numbered around 500,000 (about 1% of the population of England and Wales) and over 50% of Black Caribbeans are born in the UK (OPCS, 1992).

Identifying Black Caribbeans

Identifying Black Caribbean individuals using survey data is problematic. Generally, two strategies have been employed to ascertain the ethnic status of individuals: by using information on country of birth or by asking people which ethnic group they think they belong to. Both strategies have their disadvantages; the former is likely to miss UK-born ethnic minorities or to attribute the ‘wrong’ ethnicity to the foreign-born whilst the latter is entirely dependent on subjective, self-report measures of ethnicity (Smaje, 1995).

This latter point becomes salient when the descendants of migrants are asked to define themselves. People of Black Caribbean descent (second and later generations) may identify themselves as ‘Black Other’ or ‘Black British’ rather than ‘Black Caribbean’. Harding and Balarajan (2000a) noted that a minority of those born in the Caribbean had identified themselves as ‘Black African’ rather than as Black Caribbean in the 1991 Census. The effects of having a Black British identity need to be explored further given the growing numbers of interethnic unions (Berrington, 1994) (and, therefore, the likelihood of an increase in the numbers of children born to parents with differing ethnicities) and the increasing generational distance between British-born Black Caribbeans and the Caribbean ‘homeland’. The ambiguous, ‘fluid’ ethnic identity of second and later generation Caribbeans is described by Chamberlain (1997), when she says of one of her south London-born, Barbadian respondents that:

His identity he defines as black; but his allegiances within and beyond that emerge as mobile and migratory. Within one statement, he moves between black British and British West Indian…most migrant children, of whatever ethnic origin, stay bound to the cultural reins of their parents and juggle with ambiguous and sometimes contradictory allegiances (p.115).

It is recognised by the authors that there are a number of terms that can be employed instead of the one used here: Black Caribbean. Other terms include: West Indians, Afro-Caribbeans, African-Caribbeans, and Blacks. Although all these terms are used in the review of the literature to reflect the way that authors use them, we decided to use the term ‘Black Caribbean’ in other sections of the paper, as it was employed in both the 1991 and 2001 censuses and in the ethnic monitoring strategy of NHS in-patients.
1.2) Overview of the Main Health Issues for Britain’s Ethnic Minorities—with Special Reference to the Black Caribbean Population

There is a growing body of research on the health and well-being of ethnic minorities in the United Kingdom, and a larger body of research in the United States. Most of the British research is of comparatively recent origin, and the need to extend it has been recognized. Within this body of research, individuals of Black Caribbean descent stand out as being disadvantaged—in some respects—in relation to individuals from other ethnic groups.

Ethnicity and Health

There are a small number of significant studies that have demonstrated the existence of mortality and/or morbidity differentials by ethnic group. The most comprehensive analyses to date are ones where mortality rates were constructed using information on the age distribution of the population from the census and age distribution of deaths from death registrations. These studies were published mainly in the decennial volumes. Marmot, Adelstein and Bulusu (1984), using population data from the 1971 Census and information on deaths in the period 1970-78, undertook the first of these analyses. The second, using data from the years around the 1981 census, was by Balarajan and Bulusu (1990) and, in the third (Harding and Maxwell, 1997), data from the period around the 1991 census data was used. The two earlier studies focused mainly on outlining the cause-specific mortality profiles of different groups and explored the impact of selection effects on these profiles. The analysis by Harding and Maxwell focused on the contribution of social class to the mortality differences between the ethnic group and the host population.

Significant though these studies are, they are all limited by the use of country of birth as a proxy measure for ethnicity. In 1971, this would have been relatively unimportant but by 1991, the use of this proxy measure meant that significant numbers of second and later generation individuals would have been excluded from the analyses. Although the 1991 Census was the first to collect data on ethnic origin, these data could not be used to construct mortality rates because ethnicity is not recorded at death registration. As such, the findings of these mortality studies refer to first generation migrants. There are virtually no known studies on the mortality of the children of first generation Black Caribbeans (this is also the case for most other ethnic groups, except the Irish) and one of the important research questions yet to be addressed is to examine whether health patterns have changed between the generations.

Building on the findings of mortality studies, researchers at the Policy Studies Institute (PSI) have produced substantial analyses of the health of British ethnic minorities using data from the Fourth National Survey (Modood, Berthoud, Lakey, Nazroo, Smith, Virdee et al., 1997). These remain the most comprehensive studies of morbidity differentials amongst ethnic groups. PSI has a long history of research in this area (dating back to the mid 1960s) and the focus of these reports is not solely on the health of ethnic minorities, but also on other aspects of well-being (such as income level and employment, educational attainment, family structure etc.). The earliest publication in the series provided useful information about the nature and scope of racial discrimination, and explored how this affected employment, housing and provision of services to ethnic minorities (Daniel, 1968). Whilst the PSI reports have been invaluable in extending our understanding of British ethnic minorities, they are not without their limitations. They rely on self-report measures and sample sizes are sometimes small, which may explain why the findings on morbidity were sometimes at variance with the findings from the mortality studies.
The breadth and scope of the PSI studies of British ethnic minorities highlights the importance of considering health and well-being ‘holistically’. These studies also underline the significance of racism on the well-being of ethnic minorities in Britain. Research conducted in the US indicates that acts of racism can have observable, detrimental effects on the physiology of those victimised. Krieger and Sidney (1996) demonstrated that discrimination, and responses to it, can affect blood pressure in Black men and women; they argue that these results suggest that public health researchers should routinely consider the impact of racism on health.

**The Health of Black Caribbeans**

A distinctive feature of the mortality experience of individuals of West African heritage (whether they were born in the Caribbean or in West Africa) is the overall low mortality relative to the national average for England and Wales. This is primarily because coronary heart disease (CHD) mortality—though a main cause of death in these groups—is lower than the national average. It is paradoxical that, although mortality from CHD itself is relatively low, the prevalence of risk factors for CHD (such as diabetes and hypertension) is high (Cappuccio, Cook, Atkinson and Strazzullo, 1997). Unpublished analysis of General Household Survey data shows a low prevalence of smoking amongst Black Caribbeans; this may be one reason why CHD mortality is lower than expected in this population.

Cancer is an important cause of illness and mortality, with approximately a third of all deaths in England and Wales attributable to it. For Black Caribbeans, cancer mortality rates are lower than those found in the general population (Balarajan and Bulusu, 1990), though lung cancer is a leading cause of death among Black Caribbean men (as it is for all men). Prostate cancer is almost as common as lung cancer amongst Black Caribbean-born men (Harding and Rosato, 1999) and mortality from this cancer is high, relative to the national average (Harding and Allen, 1996). Among Black Caribbean women, breast cancer incidence and mortality rates are lower than the national average but it is the most prevalent cancer. In earlier analyses, excess deaths from cervical cancer had been noted, but in the most recent analysis, this appeared to be non-significant. Excess deaths from liver cancer have been observed in this population, possibly related to hepatitis B infection since alcohol consumption is low (Haworth, Raleigh, and Balarajan, 1999).

Another significant area of concern for people of Black Caribbean heritage is mental illness, as indicated by the large and growing body of literature on the mental health of Black Caribbeans. Paradoxically, Black Caribbeans have low rates of suicide (Raleigh and Balarajan, 1992) yet apparently higher rates of schizophrenia and other psychotic conditions (Littlewood and Lipsedge, 1988). Some research has indicated that Black Caribbean women may have higher rates of depression than White women (Shaw, Creed, Tomenson, Riste, and Cruickshank, 1999).

In summary, the main health issues for Black Caribbeans are similar to those for the whole population. These are, primarily, cardiovascular disease, lung/breast/prostate cancers and hypertensive diseases. There are other health-related issues that are of concern to the Black Caribbean community, but these account for less deaths. For example, pregnancy outcomes are poor in comparison with the national average, as reflected by higher maternal mortality (Department of Health, Welsh Office, Scottish Office Department of Health, Department of Health and Social Services, Northern Ireland, 1998) and higher rates of perinatal mortality (Davey Smith, Chaturvedi, Harding, Nazroo and Williams, 2000). Also, the sexual health of Black Caribbeans is generally recognised to be poor compared with Black Africans and Whites, with Black Caribbeans demonstrating higher rates of sexually transmitted disease, adolescent childbearing (Modood et al., 1997) and a younger age at first intercourse (Evans, Bond and MacRae, 1999) than other groups. In addition, sickle cell disease affects both Black Caribbeans and Black Africans (Smaje, 1995).
1.3) Indicators of Disadvantage in the Black Caribbean Population

A history and health profile of the Black Caribbean population in the UK has been briefly presented. How else are Black Caribbeans disadvantaged, and what are the implications of this for second and later generations?

Black Caribbeans have a relatively unfavourable socio-economic profile (though they are less disadvantaged than Bangladeshi and Pakistani populations in the UK) (Modood et al., 1997). Black Caribbean women have high rates of economic activity but, generally, unemployment rates are high in the Black Caribbean community (Modood et al., 1997). Black Caribbean males are especially at risk of unemployment, even though they are just as likely as White males to stay on at school to further their education after age 16 (Berthoud, 1999).

The disproportionate number of Black Caribbean children excluded from school has become a cause for concern in recent years. Gillborn (1995) notes that, in the Inner London Education Authority in the period 1986/7, Black Caribbean students accounted for 14% of all pupils but made up more than 30% of exclusions. He also points out that, in less than one academic year, more than one in ten of Nottingham’s Black Caribbean students were involved in exclusion procedures. Exclusion does not affect the sexes equally; boys are four to five times more likely than girls to be excluded. Black Caribbean children are also disproportionately found amongst children in care.

Another area where Black Caribbeans might be considered disadvantaged is in relation to family formation and partnership behaviour. There is less marriage and more lone parenthood amongst British Black Caribbeans, compared with the general population, a situation that may lead to poorer outcomes in a number of areas, including health (McAllister, 1995). However, analysis of 1991 census data (Maxwell and Harding, 1998) suggests that marital status does not have the same effect on the health of Black Caribbean women as it does for other populations. In this study, married Black Caribbean women had lower mortality from diseases such as ischaemic heart disease and lung cancer compared with their unmarried sisters, but these differences did not reach statistical significance. The authors note the importance of considering health outcomes within a ‘culturally appropriate context’. The relative abundance of unmarried Black Caribbeans, many of whom will be lone parents, may mean that marriage has a different meaning within the Black Caribbean community, and failure to marry may not have the same detrimental consequences that it has in other groups.

Lone parenthood is common in the Caribbean though the context within which lone parent families live is different. There, children are often born into a single female-headed household, though they may be the offspring of a ‘visiting union’ or other non-residential relationship and thus benefit from assistance (material or otherwise) provided by a non-resident father. In addition, mothers in female-headed households in the Caribbean are able to draw on the help and support of a wide network of kin. This is a central focus in the literature on the Caribbean family, much of which resonates with vivid accounts of life in these extended family units.

See, for example, Barn (1993), Garnett (1992) and Rowe, Hundleby and Garnett (1989). The disproportionately high numbers of Black Caribbean and mixed race children in care is discussed in these studies.
Section Two: The Literature Review Process

2.1) The Utility of Generational Analysis

We have outlined the situation for Black Caribbeans in the UK in relation to population characteristics, socio-economic situation and health. Here, we are not concerned with the situation of all Black Caribbeans but rather with ‘generational changes’ in this population; this warrants some consideration of what this term means.

The use of the concept of ‘generation’ is common in the social sciences. Goulbourne (1999) and Chamberlain (1999a, 1999b) recently used a ‘transgenerational’ approach to explore the evolution of Caribbean family forms in the diaspora. Individuals representing the first, second and third generations were interviewed about a variety of issues relating to family life. Many of the themes that emerged from this research are not unique to Black Caribbeans; issues of change, diversity and continuity are common to many studies of family life. What is distinct about the Black Caribbean group in Britain, however, is their experience of migration. This experience has implications, not just for the migrant population, but also for subsequent generations. In a British setting, this experience of migration makes our understanding of the health and well-being of second and third generation Black Caribbeans a more complex task. This can be seen in the literature, which is replete with comparisons: those between the migrant generation and their children, between the migrant generation and their Caribbean counterparts, between second and third generation Black Caribbeans and their White counterparts. Whatever the nature and direction of the comparison, ‘ethnicity’ and ‘generation’ are the key themes here and guide the choice of material included in this review.

Epidemiologists also utilise the concept of generation, often in their analyses in their study of the health of migrant groups and their children. Generational analysis in migrant populations is used to examine the effects of environmental factors, as well as biological ones, on diseases in these populations. From this perspective, studies of migrants and their descendants represent a ‘...natural experiment that allows for the investigation of the effects of social environments on human health’ (Dunn and Dyck, 2000, p.1574). There is a long tradition in epidemiology and related sciences of analysing generational changes in specific populations. Generational change has been an important theme in analysis of the health of the Irish (Harding and Balarajan, 2001b) and, in the United States, there are substantial bodies of research associated with generational changes in health and health-related behaviour amongst, for example, the Japanese (Syme, Marmot, Kagan, Kato and Rhoads, 1975) and Mexicans (Burnam, Hough, Karno, Escobar and Telles, 1987; Markides, Krause and Mendes de Leon, 1988).

How is generational analysis operationalised? There is not the space here to consider fully the meanings implied by the word ‘generation’. In brief, however, generation can be said to imply vertical or genealogical change (i.e. the changes that occur between one population and their descendants over a specific period of time). This is probably the most popular understanding of the word. It became clear during the search for and reading of research items, however, that the term ‘generation’ is often used in different ways by different researchers, which can be confusing for the reader. It is important to clarify exactly how it has been used in this review.

We take the view that to be strictly generational a study would have to examine changes over two or more generations in a given population. Ideally, of course, the best way to do this would be to observe respondents and their children over time. This approach is not feasible for the most part; it would be too expensive, time-consuming and there would be high rates of sample
attrition. In addition to the problems inherent in studying changes across generations, we are also concerned with the long-term effects (on health, economic status, occupational attainment, family structure) of movement across geographical space (in this case, from the Caribbean to the UK, US, Canada etc.) We are especially concerned with these effects down the generations.

As a consequence, the literature that explores generational changes and outcomes for migrants is usually concerned with a number of things as well as ethnicity—such as birthplace, age at migration, period of migration and length of residence in the host country. Very few datasets can measure all of these factors, and researchers have to be imaginative in their efforts to measure generational change. The most frequently used proxy measurement of generational change using population-based data is the analysis of differentials by birthplace (or ‘nativity’ as American researchers prefer), with some measure of length of residence for the foreign-born.

As stated above, the concept of ‘generation’ is used in different ways by different researchers. In Britain, a country that received the bulk of its Caribbean migrants in the post-war period and has had very few new Caribbean migrants since, generational analysis is more obviously genealogical, in that researchers are concerned with how the descendants of the original migrants are faring. Are they moving closer to the White host population as time goes by, in their patterns of health, their socio-economic status, their family formation behaviour? Or do these second and third generation Black Caribbeans retain distinctive features of their Caribbean heritage?

In the United States, where migration for some groups is more recent and often very staggered, generational analysis is more complicated. We cannot assume (as we can, to a certain extent, in the UK) that younger members of the ethnic minorities are US-born. Some of these will be first generation migrants; some will be second or third.

3 In the US, a common type of study is one where variations in outcome between Black ethnic groups of differing birthplace are examined. This is especially true of studies that examine pregnancy outcomes. For example, Kleinman, Fingerhut and Prager (1991) make a distinction by birthplace in their study of infant mortality amongst Black and White ethnic groups, and conclude, as many researchers have, that infant mortality rates are lower in babies born to foreign-born Black women compared with their US-born counterparts. Unfortunately, no indication is given of length of time in the USA for the foreign-born group, or their generational status. This is a serious omission since length of time in the host country might affect health or other outcomes (Mullan Harris, 1999).

2.2) The Search Strategy and Process

Inclusion and Exclusion Criteria
Drawing on the issues discussed in Section One and above, we present here details of the research literature that fulfills three conditions. It must:

1) Measure generational changes
Although studies that are explicitly generational in orientation (i.e. the author uses the term in the title or abstract) are preferred here, many other studies that are more ambiguously generational are also cited. For example, as mentioned above, our concern is also with

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3 For an example of this, see Harker (2001). In this study of psychological functioning amongst ethnic minority adolescents, ‘generation’ is not defined as membership of a particular age-based cohort (since all respondents are adolescents) but rather based on birthplace of the respondents and of parents. Thus, all foreign-born adolescents are the first generation, US-born adolescents with foreign-born parents are the second and US-born adolescents with US-born parents are the third generation. See also, Hernandez and Charney (1998) and Mullan Harris (1999).
exploring the influence of changing environments on health and other outcomes, so we have also included some research that compares health or well-being in the home countries of migrants (here, the Caribbean) with health or well-being in the host countries.

Inclusion criteria here, in order of importance, are studies where:

a. The term (s) ‘generation/al’, ‘intergenerational’ or ‘transgenerational’ or other variants appear in the title or abstract, or in a prominent way in the text or analysis. ‘Prominent way’ here means that generational differences are referred to/utilised in the analysis, and are not merely mentioned in the description of the sample.

b. A distinction is made between populations by generational status and/or birthplace (and preferably, by duration of residence and/or age at migration).

c. The focus of the research is on family life and the theme is implicitly generational (i.e. relationships between the generations is explored).

d. There is a comparison of measures of health or other outcomes in home countries with the same outcomes for the migrant population in host countries.

2) **And be concerned with the Black Caribbean population in the UK or elsewhere (but outside the Caribbean)**

Here, the population of interest is the Black Caribbean population outside the Caribbean. In a British context, the research literature we are concerned with is that relating to the second or third generation Black Caribbean population. In the US, much of the research uses data on ‘Blacks’ and uses birthplace in the analysis to distinguish the foreign-born from the US-born. It is often not clear what the exact ethnicity of some of these Black populations is; US-born Blacks are usually African American though they may also be of Black Caribbean origin. In reality, it is not always easy to distinguish between the two groups, since Black Caribbeans have been migrating to the US for generations. There is some research that looks specifically at the different situations of Black Caribbeans and African Americans, especially in socio-economic position, and details of some of this research has been included here.

We have not included, however, details of all research items on African Americans (even though they may or may not be of Black Caribbean ancestry). There is a large body of literature that deals with many aspects of African American life, and there is not the space here to cover it. Where an item is concerned solely with African Americans (or ‘Blacks’)—but does not refer to West Indians or Caribbeans—and is explicitly generational, its details have been included in the review. However, since we are concerned here with Black Caribbeans, the search that produced details of generational changes amongst African Americans (or ‘Blacks’) is not exhaustive and the reader is advised to consult a more authoritative source. Details of research from some continental European countries that have Black populations of Caribbean descent have also been included (such as the Surinamese in the Netherlands, for example).

3) **And measure health and/or another aspect of well-being.**

‘Well-being’ for the purposes of this paper, falls into two broad categories. The first is that which examines literature on family structure and living arrangements. The second includes details of research on the other determinants of health, and includes details of literature on educational attainment, occupational circumstances and earnings and socio-economic position. In addition, all the research cited below dates from the late 1980s to the present.

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4 Sowell (1983) points out that more than one million Caribbeans have moved to the United States since the 19th century and about a third of these migrated in the first three decades of the twentieth century. Black Caribbeans constitute the largest Black immigrant group and are concentrated in specific locations. In New York in the 1920s, one quarter of the Black population of Harlem were of Caribbean origin.
Search Terms and Results

The search terms entered into the databases included combinations of the following terms: generation; intergenerational; ethnicity; nativity; birthplace; Black; Black health; African American; Caribbean; Afro-Caribbean; West Indian; Caribbean-born; UK-born; mortality; morbidity; family structure; marriage. In all, 26 different combinations of terms were used. Only English language items were considered. The health-related research was generally found by searches of Medline (PubMed), PsychInfo, PsychLit, Science Direct and the ESTOR database (which holds details of a wide variety of journals). Items related to changes in family structure and partnership behaviour were mostly found via searches of Sociological Abstracts (1963-2000), Cambridge Scientific Abstracts, Assia and Popindex. Items on the social determinants of health (education, occupation, income) were retrieved via EconLit (1969-2000), the International Bibliography of Social Sciences (Via Web Of Science) (1981-2000) and ERIC. Details about additional items were taken from the bibliographies of some of the studies listed above and from experts in the respective areas.

Approximately 70 separate items that initially appeared useful were found by a search of the databases named above. Many more items were found when the terms used above were entered into the databases, but many of these could be discarded at the beginning because they clearly did not meet the criteria. Of these 70 or so items, 40 met inclusion criteria (either entirely or with reservations), and thus appear in the review. Additional items were found in the bibliographies of these 40, through more general reading of the literature and by recommendation. Even where an item was found to conform to the criteria outlined above, it does not necessarily appear in the review. It might, on closer scrutiny, have proved to be not so useful. In some cases, a hard copy of the item could not be obtained so it could not be included in the review.

A Note about Methodology and Excluded Items

Most of the research studies cited below appear in peer-reviewed journals so it is assumed that they are methodologically robust, despite their limitations. In addition, research items have been included that are book chapters or working papers. The latter are obviously less subject to scrutiny than journal articles. There are a number of issues relating to methodology that arose during the search and an abstracting stage of this paper (the difficulty of defining and measuring 'generation' is discussed in some detail above and need not be repeated here, as are issues relating to defining the Black Caribbean population). The inclusion criteria outlined above should indicate clearly which items of research are included. Where it is unclear that an item should be included, or where the methodology does not allow inferences about generational change to be made, the item has been excluded.

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5 There were a large number of research items that did not meet the inclusion criteria. Many of these included Black Caribbeans as the study population and included measures of generational status. Generally speaking, most of these studies are ones where the outcome(s) for Caribbean Blacks, and the effect of generational status, could not be determined because:

1) Black Caribbeans could not be sufficiently distinguished from other Blacks, or from other non-White groups;
2) And/or generational status is referred to in the description of the sample, but is not sufficiently used in the analysis;
3) And/or generational analysis is only used for some groups, and not for Black Caribbeans;
4) And/or ethnicity and birthplace are described for the sample, but these are not used together for Black Caribbeans alone, so that generational status cannot be properly determined.


6 Although it is probably the case that most Black Caribbean children are UK-born and, therefore, second or third generation, it was decided that studies that examine aspects of health and well-being amongst Black Caribbean children would not be included unless the author(s) uses birthplace or some other measure of generational status in the study. It was very rare for authors to do this, however. Useful recent studies that have examined one or more
Section Three: Summaries and Overview of the Literature

3.1) Summaries
To reiterate, the theme of this review is on presenting details of research that examines generational changes in health and the determinants of health (such as changes in family structure, economic status and educational attainment) of the Black Caribbean population in the UK. Literature that focuses on Black Caribbean populations living elsewhere in the developed world is drawn on, but much less extensively than is the case with the British material.

The search that produced details of the literature presented here was as comprehensive as possible (especially so in the case of the British research). This does not mean, however, that every item of research in the field has been included. This review is meant to be selective, as the discussion above about criteria for inclusion indicates. The aim here is to explore aspects of health and well-being amongst second and third generation Black Caribbeans, and to consider, more generally, how changes in the environment affect health and other outcomes and how these changes are transmitted across the generations.

The main findings of studies in each area are summarised in Tables One to Three below. The health-related literature is easily summarised. Material from the other areas of the literature review is less easily summarised because of its qualitative or exploratory nature. This should be borne in mind when appraising these tables. Only details of empirical studies are summarised below (excluding studies that are reports of preliminary findings). Details of literature reviews are not included in the tables.
### Table One. Summary of Selected Studies: Health

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</tr>
<tr>
<td>Cochrane and Howell</td>
<td>1995</td>
<td>Alcohol consumption.</td>
<td>Survey. Birmingham and Wolverhampton, UK.</td>
<td>Black Caribbeans have lower rates of alcohol consumption than Whites (16.5% Black Caribbeans drink regularly compared with 35.3% Whites). No generational differences observed.</td>
<td>Local sample. Self-report measures.</td>
</tr>
<tr>
<td>Elian et al.</td>
<td>1990</td>
<td>Multiple Sclerosis.</td>
<td>Analysis of hospital records. Greater London and West Midlands, UK.</td>
<td>Second generation Black Caribbeans have similar rates of multiple sclerosis to general population, but more rapid and severe course of illness compared with other ethnic groups</td>
<td>Local samples. Small numbers. Problems with estimating prevalence rates.</td>
</tr>
<tr>
<td>Evans et al.</td>
<td>1999</td>
<td>Sexual behaviour and sexually transmitted disease.</td>
<td>Self-completed questionnaire. West London.</td>
<td>18% Black Caribbeans have gonorrhoea compared with only 2% of Africans. Higher association of first intercourse under age 16 and gonorrhoea/chlamydial infection with Black Caribbeans</td>
<td>Local, clinic sample.</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Year</td>
<td>Study Type/Topic</td>
<td>Methodology/Details</td>
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<tr>
<td>Harding and Balarajan</td>
<td>2000</td>
<td>Limiting long-term illness</td>
<td>Analysis of 1991 census data. England and Wales. Second generation Black Caribbeans have high rates of limiting, long-term illness (relative risk=1.45 compared with Whites, reduced by controls for socio-economic status). Limitations of census data.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrison et al.</td>
<td>1999</td>
<td>Outcome of psychosis</td>
<td>Comparison of groups within existing study. Nottingham, UK. Course of psychosis does not vary substantially by ethnic group. Diagnostic stability observed over the three-year period. Small Black Caribbean sample.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrison et al.</td>
<td>1997</td>
<td>Psychotic disorders</td>
<td>Prospective study, comparison with others. Nottingham, UK. First and second generation Black Caribbeans have seven times higher risk for schizophrenia and other psychotic conditions compared with other ethnic groups. Small Black Caribbean sample.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Harrison et al.</td>
<td>1988</td>
<td>Mental disorder</td>
<td>Prospective study, comparison with others. Nottingham, UK. Second generation have incidence rate of schizophrenia of 36.4 per 10,000 (age group 16-29); 18 times the rate in the general population. Small Black Caribbean sample.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>King et al.</td>
<td>1994</td>
<td>Psychotic illness</td>
<td>Screening of patients presenting at community and hospital services. North London, UK. Black Caribbeans present to services at younger age. The incidence of schizophrenia in Black Caribbeans lower than reported elsewhere. Small numbers of Black Caribbeans. Problems of diagnosis of first onset psychosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low et al.</td>
<td>2001</td>
<td>Sexually transmitted</td>
<td>Cross-sectional study. High rates of gonorrhoea and chlamydia in Black Other groups (mostly UK- No precise data on country of birth presented for Black Caribbeans.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Table: Summary of Studies

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Title</th>
<th>Setting</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>McGovern and Hemmings</td>
<td>1994</td>
<td>Attitudes to illness and services</td>
<td>South east London, UK</td>
<td>No major differences between Black Caribbeans and Whites. Black Caribbean relatives more likely to blame illness on substance use and to see services as racist.</td>
</tr>
<tr>
<td>McGovern and Cope</td>
<td>1991</td>
<td>Schizophrenia</td>
<td>Birmingham, UK</td>
<td>Black Caribbeans more likely to live alone, to be in contact with police/prison before admission, to be admitted compulsorily than Whites.</td>
</tr>
<tr>
<td>McGovern and Cope</td>
<td>1987</td>
<td>First psychiatric admission rates</td>
<td>Birmingham, UK</td>
<td>Rates higher for second generation compared with Whites and first generation (second generation Black Caribbean male schizophrenia first admission rate=138 per 100,000 compared with 20.5 for White counterparts).</td>
</tr>
<tr>
<td>Molokhia et al.</td>
<td>2001</td>
<td>Systematic lupus erythematosus</td>
<td>South London, UK</td>
<td>Systematic lupus erythematosus prevalence rates highest in second generation Black Caribbeans (177 per 100,000) lower in West Africans (110) and Europeans (35).</td>
</tr>
<tr>
<td>Parkman et al.</td>
<td>1997</td>
<td>Satisfaction with mental health services</td>
<td>South London, UK</td>
<td>Second generation Black Caribbeans express less satisfaction with services than first generation Black Caribbeans and Whites.</td>
</tr>
<tr>
<td>Rose et al.</td>
<td>2001</td>
<td>Tuberculosis</td>
<td>England and Wales</td>
<td>Black Caribbeans (UK-born and foreign-born) have lower rates of tuberculosis than other ethnic groups (about 20 per 100,000) but higher than Whites (3.89 for UK-born Whites).</td>
</tr>
<tr>
<td>Sharma et al.</td>
<td>1999</td>
<td>Nutrient intake</td>
<td>Manchester, UK</td>
<td>Second generation Black Caribbeans have higher per cent energy from total</td>
</tr>
</tbody>
</table>

**Notes:**
- Small sample.
- Broad definition of second generation.
- Local sample. Brief description of study only. Not all Black Caribbean group are second generation.
- Underreporting of cases.
and saturated fat and eat less fruit and vegetables than first generation. Siblings of UK-born Black Caribbeans have high morbid risk compared with Whites and siblings of foreign-born Black Caribbeans (27.3% compared with 1.8 for White counterparts).

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Disease</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sugarman and Crauford. 1994</td>
<td>Schizophrenia</td>
<td>Analysis of in-patient admission case notes and interviews. Manchester, UK.</td>
<td>and saturated fat and eat less fruit and vegetables than first generation. Siblings of UK-born Black Caribbeans have high morbid risk compared with Whites and siblings of foreign-born Black Caribbeans (27.3% compared with 1.8 for White counterparts).</td>
<td></td>
</tr>
<tr>
<td>Thomas et al. 1993</td>
<td>Psychiatric morbidity and compulsory admissions</td>
<td>Analysis of psychiatric admission data. Manchester, UK.</td>
<td>Second generation Black Caribbeans have highest rates of admission compared with the other groups.</td>
<td></td>
</tr>
</tbody>
</table>

**American Research**

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Disease</th>
<th>Methodology</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fang et al. 1999</td>
<td>Low birth weight</td>
<td>Analysis of birth records and census data. New York, US.</td>
<td>More favourable birth outcomes for foreign-born Black Caribbeans compared with US-born Blacks (adjusted odds ratios for Black Caribbeans=0.95 compared with Whites; southern US-born Blacks=1.52). No information on length of residence for foreign-born.</td>
<td></td>
</tr>
<tr>
<td>Fang et al. 1997</td>
<td>Cancer mortality</td>
<td>Analysis of death records and census data.</td>
<td>Variation by birthplace and race. Generally, foreign-born Black Caribbeans have lower No information on length of residence for foreign-born.</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Year</td>
<td>Research Area</td>
<td>Methodology</td>
<td>Location</td>
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<tr>
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<tr>
<td>Harker.</td>
<td>2001</td>
<td>Psychological well-being</td>
<td>Analysis of national data.</td>
<td>US</td>
</tr>
<tr>
<td>Hummer et al.</td>
<td>1999</td>
<td>Infant mortality</td>
<td>Analysis of national data.</td>
<td>US</td>
</tr>
<tr>
<td>King et al.</td>
<td>1999</td>
<td>Cigarette smoking</td>
<td>Survey.</td>
<td>US</td>
</tr>
<tr>
<td>Kleinman et al.</td>
<td>1991</td>
<td>Infant mortality</td>
<td>Analysis of national data.</td>
<td>US (exc.some)</td>
</tr>
<tr>
<td>Study (Author(s))</td>
<td>Year</td>
<td>Study Title</td>
<td>Method</td>
<td>Location</td>
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<tr>
<td>------------------</td>
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</tr>
<tr>
<td>McCalla et al.</td>
<td>1991</td>
<td>Cocaine and other drug use and effect on infant health</td>
<td>Analysis of urine samples</td>
<td>New York, US</td>
</tr>
<tr>
<td>Mullan Harris.</td>
<td>1999</td>
<td>Health risk behaviour in immigrant youth</td>
<td>Analysis of longitudinal data</td>
<td>US</td>
</tr>
<tr>
<td>O'Malley et al.</td>
<td>1999</td>
<td>Identification of health information</td>
<td>Random-digit telephone survey</td>
<td>New York City, US</td>
</tr>
<tr>
<td>O' Malley et al.</td>
<td>1997</td>
<td>Use of screening services</td>
<td>Telephone survey</td>
<td>New York City, US</td>
</tr>
<tr>
<td><strong>Dutch and International Comparative Research</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Bhugra et al.</td>
<td>2000</td>
<td>Schizophrenia</td>
<td>Survey</td>
<td>London and Trinidad</td>
</tr>
<tr>
<td>Authors</td>
<td>Year</td>
<td>Condition</td>
<td>Study Type</td>
<td>Findings</td>
</tr>
<tr>
<td>--------------------</td>
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</tr>
<tr>
<td>Cooper et al.</td>
<td>1997</td>
<td>Non-insulin dependent diabetes mellitus.</td>
<td>Survey.</td>
<td>Rates of diabetes in four, genetically similar Black populations vary from 2% in Africa to 9% in the Caribbean and 11% in the US and UK. Possible underestimation of individuals affected by diabetes.</td>
</tr>
<tr>
<td>Cruickshank et al.</td>
<td>2001</td>
<td>Diabetes and high blood pressure.</td>
<td>Survey.</td>
<td>Despite genetic similarity in four Black populations, strong variation in diabetes and hypertension occur by location. Highest rates found in the UK and lowest in rural Cameroon. No information on additional population characteristics.</td>
</tr>
<tr>
<td>Hickling and Rodgers-Johnson.</td>
<td>1995</td>
<td>Schizophrenia.</td>
<td>Survey.</td>
<td>Jamaican age-corrected incidence rates for schizophrenia=2.36 per 10,000. This is lower than the rates for Black Caribbean populations in the UK (which range from 13.5 to 36.4 per 10,000). Possible underestimation of cases.</td>
</tr>
<tr>
<td>Mahy et al.</td>
<td>1999</td>
<td>Schizophrenia.</td>
<td>Survey.</td>
<td>Barbados incidence rate lower than UK rate, schizophrenia=3.2 per 10,000 in Barbados and 6.6 for Black Caribbeans in London. Possible ‘leakage’ of cases. Small sample.</td>
</tr>
<tr>
<td>Mbanya et al.</td>
<td>1999</td>
<td>Glucose intolerance.</td>
<td>Survey.</td>
<td>Variation in outcomes across geographic location and in four Black populations: low diabetes in Africa, high rates of impaired glucose tolerance in Jamaica and Manchester. Low body mass index in rural Cameroon population compared with other groups. Small British sample.</td>
</tr>
<tr>
<td>Selten et al.</td>
<td>2001</td>
<td>Psychotic disorders.</td>
<td>Analysis of data from contact study.</td>
<td>Second generation Black Surinamese have higher rates of disorder than first generation Surinamese and Dutch-born, non-Surinamese peers (relative risks=4.6 compared with same age Dutch-born for second generation and 2.0 for first). Small numbers for some groups. Crude adjustment for socio-economic status. Surinamese of Asian ancestry as well as African.</td>
</tr>
</tbody>
</table>
### Table Two. Summaries of Selected Studies: Family Structure and Living Arrangements

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Focus</th>
<th>Method &amp; Location</th>
<th>Major Findings</th>
<th>Major Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chamberlain.</td>
<td>1997</td>
<td>Caribbean families.</td>
<td>Analysis of life-story interview data with three generations of Black Caribbeans. UK and Caribbean.</td>
<td>The role of the family in Caribbean migration is explored. The wider family is involved in migration and support is given across geographical distance.</td>
<td>Generalisability.</td>
</tr>
<tr>
<td>Chamberlain.</td>
<td>1996</td>
<td>The role of men in ethnic minority families.</td>
<td>Analysis of life-story interview data with three generations of Black Caribbeans. UK and Caribbean.</td>
<td>All aspects of the migratory experience are considered.</td>
<td>Generalisability.</td>
</tr>
<tr>
<td>Dench.</td>
<td>1996</td>
<td>The role of men in ethnic minority families.</td>
<td>Interviews. London, UK.</td>
<td>Black Caribbean families, especially second generation, more likely to have ‘alternative’ family orientation.</td>
<td>Highly exploratory study. Small numbers of Black Caribbeans.</td>
</tr>
<tr>
<td>Author</td>
<td>Year</td>
<td>Title</td>
<td>Methodology</td>
<td>Findings</td>
<td>Generalisability</td>
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</tr>
<tr>
<td>Owen.</td>
<td>1998</td>
<td>Marital status and families.</td>
<td>Analysis of census and survey data. UK and Caribbean.</td>
<td>First generation Black Caribbeans are more likely to be married than second. Their marital behaviour is more like that of individuals in the Caribbean.</td>
<td>Limitations of survey data.</td>
</tr>
<tr>
<td>Plaza.</td>
<td>2000</td>
<td>Role of grandmothers.</td>
<td>Analysis of life-story interview data with three generations of Black Caribbeans. UK and Caribbean.</td>
<td>Black Caribbean grandmothers in the UK play a less active role in family life than in earlier times. Grandmothers' roles have changed and they are becoming 'transnational'.</td>
<td>Generalisability.</td>
</tr>
<tr>
<td><strong>American Research</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jama Adams.</td>
<td>2000</td>
<td>Family reunification.</td>
<td>Case study. US.</td>
<td>There are adjustment difficulties when families are reunited. Intervention is necessary.</td>
<td>Generalisability.</td>
</tr>
<tr>
<td>Jarrett and Burton.</td>
<td>1999</td>
<td>Dimensions of family structure.</td>
<td>Analysis of qualitative data. Midwest and northeast US.</td>
<td>Four aspects of family life are identified. One of these, the age structure of family members, describes problems of small generational size. Local samples. African American population (not specifically Caribbean).</td>
<td></td>
</tr>
<tr>
<td>Johnson.</td>
<td>1999</td>
<td>Family life of older Black men and generational relationships.</td>
<td>Analysis of interview data. San Francisco Bay area, US.</td>
<td>No significant differences between men and women in family participation. Men have strong vertical family ties. Small, local sample. Black (not specifically Caribbean) sample.</td>
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<tr>
<td>Southeast US.</td>
<td></td>
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</tbody>
</table>
Table Three. Summary of Selected Studies: Other Determinants of Health

<table>
<thead>
<tr>
<th>Author</th>
<th>Year</th>
<th>Focus</th>
<th>Method &amp; Location</th>
<th>Major Findings</th>
<th>Major Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>British Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Berthoud.</td>
<td>1999</td>
<td>Labour market participation.</td>
<td>Analysis of Labour Force Survey data. UK.</td>
<td>Young Black Caribbean males take longer to complete studies, are less likely to be married than first generation, more likely to have a White partner than other groups and suffer from high unemployment (dependent on personal circumstances). Individuals who migrated after age 16 are less likely to be unemployed than UK-born counterparts.</td>
<td>Limitations of survey data.</td>
</tr>
<tr>
<td>Leslie et al.</td>
<td>1998</td>
<td>Earnings.</td>
<td>Analysis of census and Labour Force Survey data. UK.</td>
<td>UK-born Black Caribbeans, with other groups, have better earnings prospects than the first generation but suffer from unemployment.</td>
<td>Limitations of census and survey data.</td>
</tr>
<tr>
<td>American and Canadian Research</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kalmijn.</td>
<td>1996</td>
<td>Socio-economic assimilation.</td>
<td>Analysis of census data. US.</td>
<td>Black Caribbeans (especially second generation) are more successful than US-born Blacks.</td>
<td>Limitations of census data.</td>
</tr>
<tr>
<td>Model et al.</td>
<td>1999</td>
<td>Socio-economic differences in labour market outcomes.</td>
<td>Analysis of census data. US, France, Canada and UK.</td>
<td>Foreign-born Black Caribbeans in four countries have similar outcomes.</td>
<td>Limitations of census data. No measure of length of time in host country.</td>
</tr>
<tr>
<td>Nii-Amoo Dodoo.</td>
<td>2000</td>
<td>Labour force participation.</td>
<td>Analysis of census data.</td>
<td>US-born Black Caribbeans are not less motivated to work than</td>
<td>Limitations of census data.</td>
</tr>
</tbody>
</table>
3.2) Overview

This review covers literature in a variety of areas: health, family structure and living arrangements and the other determinants of health. Below, the material is briefly summarised, conclusions are drawn and suggestions are made for future research.

Health

There is a comparatively large body of research on the mental health of (first and second generation) British Black Caribbeans. Smaje (1995) remarks in his discussion of the literature on the mental health of British ethnic minorities that: ‘By far the greatest amount of attention has been paid to schizophrenia in the Caribbean population’ (p.65). He also maintains that the researchers in this area can be (approximately) divided up into two camps: those who maintain that elevated rates of schizophrenia in Black Caribbeans are the consequence of faulty data and poor methodology; and those who accept the accuracy of the data and instead seek an explanation for the high rates of disorder in Black Caribbeans. However, in a recent review by Sharpley, Hutchinson, Murray and McKenzie (2001) the former explanation is doubted and the authors maintain that it can now be shown, beyond methodological doubt, that a higher incidence of schizophrenia is diagnosed amongst Black Caribbeans in the UK. The high rates of schizophrenia in UK-based Black Caribbeans can be contrasted with much lower rates of the illness in the Caribbean (Mahy, Mallet, Leff, and Bhugra, 1999), which would seem to suggest that there are environmental factors that affect the onset and course of schizophrenia and other psychotic conditions.

It appears that there is scope for still more research, given the disagreements between researchers about the level of mental illness in the Black Caribbean population, and better measurement of the mental health status of second and later generation Black Caribbeans in the UK is needed. International comparisons would also be useful, since there is some evidence that second and later generation Caribbeans (of Surinamese descent) are more likely to suffer psychotic disorders than their same-aged Dutch-born peers (Selten, Veen, Feller, Blom, Schols et al., 2001). There are sizeable populations of Caribbean descent in the US and, to a lesser extent, Canada, though we know very little about their mental health.

Other issues that are important for second and later generation Black Caribbeans include those relating to sexual and reproductive health. Further research into sexual behaviour and the transmission of sexually transmitted disease in this population is needed. A recent study by Low, Sterne and Barlow (2001) suggests that rates of gonorrhoea and chlamydia are high amongst British-born Black Caribbeans, and there is an association between these rates and
early sexual debut. Evans et al. (1999) have also described sexually transmitted infection amongst young Black Caribbean men and note the high rates of infection amongst them.

Low et al. (2001) maintain that the high rates of infection in their sample may be attributable to the patterns of sexual mixing in population subgroups and propose that 'sexual networks within ethnic groups should...be considered' (p.19) as a possible area of future research. The existence of sexual networks amongst British-born Blacks Caribbeans has not been fully described, and it would be instructive to ascertain not only if they exist, but also how they function (Barlow, Daker-White and Band, 1997). Would such networks, for example, be less restricted amongst the second generation compared with the first generation? Do they bear any resemblance to the sexual networks of Caribbean populations? Are they affected by the ease with which UK-born Black Caribbeans select partners from outside their own ethnic group? (Berrington, 1994).

These aspects of sexual health need to be considered alongside other indications that the reproductive health needs of young people of Black Caribbean descent are not sufficiently understood and, even less, sufficiently addressed. For example, whilst there is very little generally known about the numbers of young parents who are from ethnic minority groups, there is some evidence that young Black Caribbean women are more likely to become teenage mothers than their White peers (Modood et al., 1997). This may be related to a greater reluctance to resolve (unplanned or unwanted) pregnancy through the use of induced abortion, which may itself be influenced by cultural norms governing motherhood, particularly the age and conditions under which it commences.

Another area that warrants the attention of researchers is coronary heart disease (CHD) in second and later generation Black Caribbeans. We know a little more about the risk factors for CHD and associated conditions. Cappuccio et al. (1997), for example, assessed the prevalence of cardiovascular risk factors in three south London ethnic minority populations, including African descent populations. Compared with the White population, individuals of African descent had raised levels of hypertension, were more likely to be diabetic and obesity was more common in women of African descent. Some researchers have examined intergenerational changes in nutrient intake in the Black Caribbean population, since changes in diet might affect cardiovascular health (Sharma, Cade, Riste and Cruickshank, 1999). The results of this research indicate that second generation Black Caribbeans have higher energy intake, and lower fruit and vegetable consumption compared with the first, Caribbean-born generation; a finding which has important implications for the health of UK-born Black Caribbeans.

Overall, CHD prevalence remains low in Black Caribbeans living in the Caribbean, but whether patterns have changed with length of residence or across generations is not well understood. Similarly, mortality from prostate cancer is high among first generation Black Caribbean men but prostate cancer incidence and mortality amongst second and later generation men remains unexplored. More generally, there appears to be little of monitoring of diseases or risk behaviour across the generations, which is of concern given the very high incidence of hypertensive and diabetic mortality in this population.

While British researchers seem overly concerned with the mental health of first and second generation Black Caribbeans, their American counterparts appear to be preoccupied with measuring birth outcomes in Caribbean-born Black populations and comparing them with US-born Blacks. Birth outcomes, such as low birth weight, infant mortality and prematurity, have

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7 American researchers have pointed out that, rather than early childbearing in Black populations being depicted as pathological, it should be considered as an adaptation to poor economic conditions, limited educational and vocational opportunities, early health deterioration and the low ‘marriageability’ of Black males. For an articulation of this view, see Geronimus (1996).
been found in almost every study to be better for infants with foreign-born Black mothers compared with infants born to Black US-born women. In many studies this is attributed to variations in maternal behaviour (such as cigarette smoking). Even when maternal factors such as education or use of prenatal care are controlled for, there is often still an unexplained advantage for infants born to Caribbean-born Black mothers (Kleinman et al., 1991).

Comparisons between these Black populations in the American literature are problematic, since Caribbean-born and US-born African Americans are quite different, their common ‘Blackness’ notwithstanding. Crucially, African Americans are the descendents of involuntary migrants who were transported from West Africa to the US as slave labour and have endured hardship and discrimination ever since. Black Caribbeans, too, are mainly the descendents of slaves, but their origins are in Black majority societies and they are voluntary migrants to the US, which presumably means that they are a selected population.

**Family Structure and Living Arrangements**

It is reasonable to assume that the nature and quality of family life is linked to the health and well-being of individuals, and that is why we have included material here on family structure and living arrangements. We were not able to find research that links family structure and/or process to health or health-related behaviour in UK-born, second generation Black Caribbeans, though American research indicates that generational status can affect health-related behaviour in Black Caribbeans, and family structure and process may be an important component of this (Mullan Harris, 1999).

This is an important issue for British Black Caribbeans, who demonstrate lower rates of marriage and higher rates of lone parenthood than the general population (Owen, 1998). Black Caribbeans in the UK are also more likely to have experienced greater family disruption than the general population; the process of migration was accompanied by frequent family separations, which often adversely affected mothers’ relationships with their children (Arnold, 1997). We know almost nothing about how these aspects of family life affect health in this population.

Viewed from the mainstream, the patterns of family formation and living arrangements in the UK-born second and third generation Black Caribbeans can appear dysfunctional. A high prevalence of lone parenthood and low rates of marriage are seen as signs of pathology by some researchers. Yet, we are also exhorted not to pay especial attention to the conjugal bond, which may be of lesser importance in Caribbean families (Chamberlain, 1999a).

It has been noted that Black populations are, in some respects, in the vanguard of changes in family structure. This observation has been made in both the UK (Berthoud, 2000) and the US (Furstenberg, 1994). It is true that, for example, the high rates of lone parenthood that were once largely confined to Black populations in both countries have extended to other groups. Marriage rates fell quickest in Black groups in both countries, though Whites and others are ‘catching-up’. Quite why this has happened is the subject of some speculation. In the US, the economic marginalisation of men (which has its greatest impact on Black men) and their consequent low ‘marriageability’ is typically cited as an important factor in this respect (Wilson, 1987).

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8 For a discussion of some of the problems inherent in comparing these two populations, see Davis (1998).
8 A small number are the descendents of the indentured labourers who were brought to the Caribbean after slavery was abolished.
9 The classic expression of this (albeit in an American context and not with a specifically Black Caribbean population) is found in Monynihan (1965).
10 Staples (1985) emphasises the greater stated ‘conservativeness’ of Blacks on issues of family formation. He attributes the gap between professed intentions/aspirations in family formation behaviour and the reality to the effects of discrimination and the poor economic prospects of Black men.
Some commentators have argued that family structures found amongst British-born Black Caribbeans are distinct from their parents and that young Black Caribbeans have adopted a more libertarian British attitude to marriage and family life (Dench, 1996). Owen (1998) demonstrated that second and third generation Black Caribbeans have lower marriage rates than their Caribbean-born parents, and their partnership and marital behaviour more closely resembles that found in the Caribbean. From this perspective, it is the first (migrant) generation who are unique. However, Berrington (1994), in her analysis of the Labour Force Survey, noted the low marriage rates amongst Black Caribbeans but discovered less consistent (and less significant) differences between the generations.

What has not been sufficiently addressed—and is possibly of greater importance than simply describing changes in family structure between generations—is the effect of changes in the social context of Caribbean family life. The first, second and third generation Caribbeans who provided such evocative accounts of family life for Chamberlain (1999a) talked in detail about the beneficial effects of extended kin networks which, for those who had childhoods in the Caribbean, extended to the entire neighbourhood or village. Chamberlain describes the different situation that prevails for second or third generation Black Caribbeans in the UK. She says that smaller family size and ‘...a generation not brought up in the close proximity of a “neighbourhood family” may have an impact on the development and formation of those families in Britain...’ (p.141). It might also be suggested, by extension, that these developments might affect health, educational attainment, economic advancement and other aspects of well-being amongst Black Caribbeans.

Other Determinants of Health

The British research in this area is focused on the differentials in labour force participation, occupational attainment, economic status and educational attainment amongst ethnic minorities. One group that appear disadvantaged in this respect is young men of Black Caribbean descent, as Berthoud shows (1999). His analysis questions the role that discrimination plays in the relatively poor educational and occupational achievement of some ethnic minorities. He remarks that, to the ‘untutored eye’ of prejudice, Pakistanis, Bangladeshis and Indians look the same, yet Indians outperform Pakistanis, Bangladeshis and Whites in some areas.

Berthoud also refers to the possible disaffection of young, Black Caribbean men. He points out that, for a substantial minority of Black Caribbean men, their poor educational success; lack of employment and detachment from family and social commitments puts them at risk of ‘alienation and resentment’. This warning should not be taken lightly. Resentful young men, already vulnerable to the effects of discrimination and social exclusion, may not be well disposed towards their hard-working Black sisters (and are therefore unlikely to make desirable husbands or fathers) and probably will not be any better inclined towards others in their orbit.

It is important that we do not paint too gloomy a picture of the socio-economic situation of Black Caribbeans. Leslie, Drinkwater and O’Leary’s (1998) analysis indicates there are tentative signs of optimism for UK-born Black Caribbeans in relation to earnings, at least, if not employment. And the US research does show that Black Caribbeans are a comparatively successful group, certainly in relation to their African American counterparts (the problem with comparing these two groups is noted above). Furthermore, as Waters’ (1999) work indicates, they are viewed as capable, responsible workers in the eyes of their White co-workers and managers. In fact, such is their success that many of Waters’ African American respondents expressed chagrin and resentment when West Indians secured employment promotion. The West Indians, in turn, derided their US-born counterparts as lazy and unreliable.
3.3) References for Sections One to Three


Section Four: UK-Born Black Caribbeans: Generational Changes in Health and Well-being. The Research Literature

4.1) Health

British Research


The authors describe the findings of a 'sero-epidemiological' study of the prevalence of herpes simplex antibodies (HSV) in a sample of pregnant women (n=533) in a west London hospital in 1980/1. Birthplace and ethnicity were used in the analysis with other demographic variables. The UK-born Black Caribbean population were the 'Black, British Isles' group.

The initial results indicate that foreign-born Black Caribbean women are more likely to be HSV-1 and HSV-2 seropositive than UK-born Black women (92.3% of Black, Caribbean-born women are HSV-1 seropositive compared with 75.3% of British-born Black women). The results of a logistic regression show that seropositivity is strongly associated with ethnicity and social class (Black Caribbean women from manual classes have higher rates of HSV-1 antibodies). Controlling for ethnicity, age and marital status removed the association with social class. Seropositivity is associated with marital status: Black Caribbean-born women who are single are more likely to have antibodies to HSV-2. The authors estimate seroconversion rates: for all Black women (the data on all Black women is pooled for the purposes of analysis) rates are higher for HSV-2 than Whites (35.4 per 1000 for Black women and 11.9 for British-born single White women). The authors conclude that HSV-1 rates are high across all groups, though there are some differences by birthplace, ethnicity and socio-economic status. HSV-2 rates are probably related to sexual activity, and are strongly linked here to ethnicity, with Black women having higher rates than Whites and Asians.


Bhugra and Bhui provide a useful discussion of mental illness in British-born ethnic minorities, though the focus is not specifically on Black Caribbeans. The authors discuss the mental health problems that are associated with migrants and their children and draw on the literature in this area. Specific conditions, and the impact of them on minority populations are considered. For the Black Caribbean UK-born, it is noted that issues of concern to them are the elevated rates of schizophrenia (and the possible association of schizophrenia with environmental factors, such as discrimination and deprivation) and childhood disorders. Black Caribbeans tend to have lower rates of depression than other UK-born minority groups and lower alcohol use. The authors suggest planners who use place of birth or ethnicity as the sole marker of culture are shortsighted; they must take into account the ‘degrees of belonging’ and ‘shades of identity’ of many second generation ethnic minorities.


Bhugra and colleagues selected the two London health districts of Ealing and South Southwark and East Lambeth as the sites for their examination of schizophrenia amongst immigrant groups. The former location has high numbers of Asians and the latter has high numbers of...
Black Caribbeans (here described as ‘Afro-Caribbean’) and both have similar rates of deprivation. All patients who presented to services in the two areas were screened for psychotic illnesses between 1991-1993.

The results indicate that, of the 100 patients selected, the incidence rate for schizophrenia was highest amongst Afro-Caribbean men (n=38) at 14.7 per 10,000 in the age group 18-29. Most of these patients (71.1%) had been born in the UK. The authors address the problem of under-enumeration by calculating an adjusted denominator for all populations. Linear logistic modelling shows that rates are still high amongst Afro-Caribbeans. At follow-up (after one year), outcomes were assessed and Afro-Caribbeans were found to have had poor (i.e. ‘relapse, still in episode of inclusion, or suicide’) outcomes. The authors point out that (possibly due to more accurate denominator populations and assessment via structured interviews) the lowest differential they found was only a two-fold excess (Afro-Caribbean: White), which is lower than other studies have found. Bhugra and colleagues highlight the importance of social and economic factors, with unemployment being very important for Afro-Caribbeans. This is a comparatively small-scale study using local samples which limits its generalisability.


The authors present major findings using data from the Camberwell study. Many of the chapters are not relevant here since not all of them consider ethnicity and schizophrenia (and the second generation Black Caribbean group are often not distinguished from the first generation, which limits the usefulness of this work here). Chapter two is given over to a consideration of the Camberwell study (data were mainly taken from the study period 1965-1984) and methodology. Schizophrenia in the Black Caribbean community is addressed more fully in chapters 8 to 10 (Black Caribbeans are described as ‘African-Caribbeans’).

Using data from four different cohorts (1965-9, 1970-4, 1975-9 and 1980-4) and data on ethnicity, the authors demonstrate that Black Caribbeans (regardless of generational status) are five to six times more likely than the general (Camberwell) population to have a diagnosis of schizophrenia. When first and second generation data are combined, this figure increases (40% of individuals in the sample who are diagnosed as having schizophrenia are first or second generation Black Caribbeans). Chapter 9 contains details of a case-control study (see Wessely et. al. 1991 below).


The authors describe the findings of a study designed to measure alcohol use amongst Black Caribbean (here, simply ‘Black’) and White men in the West Midlands. One of the research questions was explicitly generational: are there differences in alcohol consumption amongst Black men by generational status? The sample was drawn from six GP lists in Birmingham, and surgery staff confirmed the ethnicity of respondents (n=370). Data were collected using questionnaires administered by trained interviewers.

The results confirm previous research in this area, with Black Caribbean respondents reporting lower consumption of alcohol (8% of Black men report heavy consumption, compared with 22% of White men). Generational differences are not significant. Slightly more first generation Black Caribbeans are regular drinkers, and slightly more are abstainers, but these figures do not reach statistical significance. Analysis of data by Caribbean region indicates that Jamaican-born Black males drink less, and less frequently, than other Caribbean-born males.
Birthplace is not used further in the analysis. The study is limited primarily by reliance on self-report measures.


The authors report the findings of a multi-site study (London, West Midlands, Leicester, Bradford, Halifax and Huddersfield) designed to measure multiple sclerosis (MS) in ethnic minority groups, with special reference to age at immigration. The results indicate that age at immigration does not affect prevalence of MS in Black Caribbeans (referred to here simply as ‘Caribbean’). See below (Elian et al. 1990 and Elian and Dean 1987) for fuller discussion of this study.


Eagles discusses possible reasons for an excess of schizophrenia in Black Caribbeans (here, ‘West Indians’). His discussion is relevant to both the migrant and UK-born generations, but he specifically considers hypotheses that are especially pertinent in the case of the UK-born.

The literature on schizophrenia and immigration is described, and Eagles maintains that most theories advanced to explain the higher rates of schizophrenia in Black Caribbeans are psychosocial in nature (that is, they stress the selective migration of schizophrenia-prone individuals migration and the stress encountered during the period of migration). Here, he describes biological explanations for schizophrenia. These include the ‘viral and other infectious agent’ hypothesis (that schizophrenia is caused by a virus) and the ‘obstetric complications’ hypothesis (that schizophrenia is associated with obstetric complications). For the UK-born Black Caribbean generation, the former explanation is improbable (it is unlikely, for example, that more virulent infectious agents are operating in the UK than in the Caribbean). The second explanation is more likely; there is evidence that Black Caribbean women suffer from higher rates of obstetric and perinatal complications and this may affect the development of schizophrenia.

Other theories that Eagles considers are ‘genetic mutations’ theories (chromosomal abnormalities, season-of-birth effects) but these are less convincing. In conclusion, Eagles maintains that the evidence that obstetric complications contributes to the development of schizophrenia is ‘much more suggestive for second-generation than for first-generation migrants’.


The authors extend previous work (see below, Elian and Dean 1987) to include the UK-born children of other immigrant groups (as well as Black Caribbeans, here described as ‘West Indians’) and the geographic location of respondents (the study locations are Greater London and the West Midlands). Data were taken from patients’ case notes. The results suggest that, of the 28 UK-born Black Caribbeans, the course of multiple sclerosis (MS) was rapid and severe. The authors conclude that second generation immigrant groups have MS prevalence rates comparable to those found in the general population. The limitations of the study are discussed, these include: small sample sizes, methodological problems with estimation of prevalence rates, likely underestimation of numbers with MS etc.

The authors report the findings of a study to measure prevalence of multiple sclerosis (MS) amongst the children of Black Caribbean migrants (here described as ‘West Indians’). Data were taken from hospital case notes in Greater London (n=16). Details of the respondents’ birthplace, along with demographic and medical details are presented. The course of the disease appears unusually severe in the second generation, with a short time between onset of symptoms and diagnosis. For study limitations, see details presented above (Elian and Dean 1990). Also important (from a methodological point of view) are issues relating to the problems of detecting UK-born children of West Indians, which here is dependent on the reports of hospital staff and others and not routinely recorded.


Evans and colleagues present the findings of an examination of the sexual behaviour and sexual infection prevalence amongst African and Black Caribbean men in London (n=180) (the latter are referred to as ‘Caribbean’ here). The data were taken from a (self-completed) questionnaire given to men attending a west London genitourinary clinic (GUM). Of the Black Caribbean respondents, 73% were UK-born (second and later generation), though no further distinction was made in the analysis between first and second generation Black Caribbeans. The results show that Black Caribbean men are significantly more likely than their African counterparts to initiate sexual intercourse before age 17 (70% compared with 48%), and to have gonorrhoea (18% compared with 2%). Multivariate analysis indicates that sexual intercourse before age 16 and chlamydial infection is associated with being of Black Caribbean ethnicity, as is gonorrhoea in Black Caribbeans who initiate sex before age 16.


The findings of a study comparing second generation Black Caribbean (here described as ‘Afro-Caribbeans’) children with White children attending a child psychiatric clinic are reported (n =1,603). The results indicate that the ratio of emotional to conduct disorders is lower amongst Afro-Caribbeans but psychotic and autistic disorders are disproportionately more common in second generation children. The authors conclude that the different psychiatric profile of Black Caribbean children is evident from the 1970s on and warrants further attention. The authors note that the results depend on the reliability of data collected in the clinic setting, which may be deficient.


Analysis of the ONS Longitudinal Study (LS) data was undertaken to compare the risks of limiting long-term illness among UK-born ethnic minority populations and to compare illness in these second generation ethnic minority groups with their first generation (foreign-born) counterparts. The (age-adjusted) results indicate that all groups, except the Chinese, have higher risks than Whites of suffering limiting long-term illness. There are no significant differences in limiting long-term illness between the British-born and the foreign-born Black Caribbeans after adjustment for socio-economic position (here measured by housing tenure.
and access to a car), which substantially lowers the risks for illness for all groups except Indians. The poor health of Black Caribbeans is, therefore, largely attributable to low socio-economic status. The authors discuss the problems inherent in defining ethnicity using this type of data.


Harrison and colleagues use data from a previously studied sample of individuals with psychosis (see Harrison et al. 1997, below). Most of the Black Caribbean population (here referred to as ‘African-Caribbean’) were UK-born, second generation (n=33). The authors report the results of a study designed to assess outcomes and the stability of diagnosis after three years; they hypothesise that there would be little variation by ethnic group after controls for socio-economic status etc., that diagnoses would be stable after that time and that use of service would vary. Face-to-face interviews, hospital records and interviews with hospital staff and family members were conducted and diagnosis was reassessed for each respondent.

The results indicate that, overall, there are few differences between African Caribbeans and others at three years follow-up, with the former showing slightly better outcomes for social disability and symptoms. There is no evidence of greater diagnostic instability in African Caribbeans. The authors note the limitations of the study (small numbers of African Caribbean patients and the difficulty inherent in defining ‘better’ or ‘worse’ outcomes).


The authors test the hypothesis that there is no difference in schizophrenia and other psychotic conditions between first/second generation Black Caribbeans (here referred to as ‘African-Caribbean’) and the rest of the population; previous studies that have demonstrated an elevated incidence in the second generation have suffered from poor methodology. Here, greater emphasis was given to defining the denominator population (those at risk of illness) and case ascertainment and definition. The setting for the study was Nottingham and the sample consisted of 168 psychotic patients, of whom 32 were first or second generation Black Caribbeans. The Black Caribbeans were compared with the other respondents (of various ethnicities).

The results indicate that the Black Caribbean respondents have incidence ratios above seven for psychotic disorders and schizophrenia. Separate rates could not be calculated for first compared with second generation Black Caribbeans, though 81% of the respondents are UK-born. The authors conclude that age-adjusted rates for psychotic disorders and schizophrenia are up to eight times higher in both first and second generation Black Caribbeans. The study is limited by small sample size.


The authors present the findings of a prospective study of schizophrenia in Black Caribbeans (here described as ‘Afro-Caribbeans’) presenting (for the first time) at psychiatric services in Nottingham. The theme of the study is explicitly generational; the authors explore schizophrenia in the second generation as well as the first.
There were 42 Black Caribbean individuals in the sample of whom 38% received a diagnosis of schizophrenia and 14% were diagnosed as not being schizophrenic. This compared with 37% and 11% for the general (non-Black Caribbean) sample (n=99). Of 28 Black Caribbean patients who received a diagnosis of restricted schizophrenia, 18 were UK-born. The incidence rate for this group was calculated at 36.4 per 10,000 for young (aged 16-29) individuals; 18 times the rate in the general population. The other 10 Black Caribbean individuals who received a diagnosis of restricted schizophrenia had all come to the UK as children.

The authors discuss the limitations of the study, which include problems estimating the denominator population and the limitations of measuring incidence (which relies on referral to services) and not prevalence. The authors did not observe significant differences between Black Caribbean patients and the rest of the sample in mode of onset or symptomatology, especially for those who had received a diagnosis of restricted schizophrenia (who were mostly UK-born or had migrated as children). Harrison and colleagues discuss explanations for the high rates of schizophrenia amongst Black Caribbeans. These include theories that it is caused by racism and discrimination, selective migration or biological factors.


It has been suggested that pregnancy and birth complications (PBCs) may be the reason for higher rates of psychosis amongst Black Caribbeans in Britain. The authors test this by analysing data taken from the Camberwell Collaborative Psychosis Study (n=164). The sample consisted of White, Caribbean-born Black and UK-born Black Caribbean individuals (here, these groups are described as ‘African-Caribbean’). The results suggest that Whites are more than twice as likely to have a history of PBCs (23% compared with 11.5%) and first and second generation Black Caribbeans have similar rates of the latter (10% compared with 12.9%). The differences between Whites and Black Caribbeans do not reach statistical significance (p=0.062). The authors acknowledge that the study is based on small numbers. These findings conflict with studies that have shown poorer obstetric outcomes for Black Caribbean women (see Department of Health et al., 1998 in Section Three above).


Hutchinson and colleagues report the findings of a study designed to measure the extent of schizophrenia in relatives of patients with psychosis. Respondents were recruited from two hospitals in south London, 1987-1992. The Black Caribbean (here described as ‘Afro-Caribbean’) respondents were differentiated by generation (Caribbean and UK-born), and first-degree relatives of the patients were interviewed to determine the presence, or otherwise, of schizophrenia. Of the 184 respondents, 35 were first generation Afro-Caribbean and 38 were second generation.

The results indicate that the morbid risk for the parents and siblings of White and first generation Black Caribbeans are similar, as are the risks for the parents of the second generation Black Caribbeans. The siblings of second generation psychotic Black Caribbeans have up to seven times higher morbid risk of schizophrenia than their White counterparts, and the siblings of schizophrenic second generation Black Caribbeans have four times higher risk than their White peers. The authors emphasise the role of adverse, environmental factors in the development of schizophrenia in the second generation. The study is limited in a number of
ways; there is reliance on self-report, there are small numbers of Black Caribbean respondents and the younger age profile of the second generation is potentially confounding (since individuals with an earlier age of onset have higher morbid risk amongst family members).


The annual incidence and rate ratios of individuals with psychotic disorders in all ethnic groups in a north London hospital in 1991 were calculated, and assessment was made by face-to-face interview. The results indicate that, of the 93 respondents, most were male, 19 were Black Caribbean (described here as ‘African Caribbeans’) and 39 of the total had been born abroad. Age-standardised rates for schizophrenia and non-affective psychosis are higher for all ethnic groups, and the incidence of schizophrenia in African Caribbeans (all second generation) is lower than has been found elsewhere. The authors conclude that the emphasis on Blacks and schizophrenia is ‘misleading’. Small numbers, local populations, and problems with diagnosis of illness and under enumeration of Black Caribbean men limit the study.


Louden presents a concise review of the literature on the epidemiology of schizophrenia in both first and second generation Black Caribbean migrants. The studies cited are described in some detail and summarised in table form. He also considers the variation in rates in the Caribbean and a variety of explanations for this excess of schizophrenia (which are broadly grouped into biological and chemical factors and psycho-social factors).


The authors describe the results of a study designed to measure rates of gonorrhoea and chlamydia amongst Black Caribbean individuals in the London health authority of Lambeth, Southwark and Lewisham. Data were collected from individuals attending sexually transmitted disease (STD) clinics in the authority’s area in the period 1994/5. The authors maintain that many studies do not distinguish between different Black groups, though there are important differences between them. Here, individuals were categorised by ethnicity using census categories and information on country of birth. The ‘Black Other’ group consisted mostly of people of Caribbean origin who had been born in the UK (and, therefore, are probably second or later generation Black Caribbeans). Denominator populations were estimated using 1991 census data.

The results indicate that, in the period under study, there were 1996 episodes of gonorrhoea in 1768 people and 1376 episodes of chlamydia in 1257 women. The highest rates of infection for both diseases are found in the Black Caribbean group and the Black Other group. For infection with gonorrhoea, the rates are: Black Caribbean males=1381.9 per 100,000 and for Black Others=1688.1 and Black Caribbean women=640.7, Black Other women=886. For infection with chlamydia, the rates are: Black Caribbean women=1085.3 per 100,000 and Black Other women=1038.5. Analysis of rates by age group is not available for the Black Other group. Multivariate analysis indicates that poverty (as measured by the Townsend score in the ward of residence), age and ethnic group are associated with infection. Black Other males, for example, still have rate ratios of 12.4 compared with the White group after controlling for age and deprivation. Black Other females have rate ratios of 12 and, for chlamydia, 5.2 compared with the White reference group.
The authors discuss the limitations of the study, which include: possible underestimation of infection; exclusion of infections diagnosed outside clinics; overestimation of differences between groups and the inability to fully control for socio-economic circumstances by the use of ward level poverty measures.

The authors test a number of hypotheses concerning the attitudes of Birmingham-based Black Caribbean and White individuals with schizophrenia and their relatives to mental health services. All Black Caribbean individuals (here described as ‘Afro-Caribbeans’) in the study were either born in the UK or migrated as children, and are treated as second generation. A variety of issues relating to psychiatric care are explored, including emergency access to staff, consultation with staff about treatment, continuity of care etc. In all, 28 White patients and 40 Afro-Caribbean patients were interviewed and 27 White and 32 of their relatives were interviewed.

The results indicate that many of the White/Afro-Caribbean differences do not reach statistical significance (in the areas of global satisfaction, aspects of health care, conceptualisations of problems) though Afro-Caribbeans are less satisfied than Whites in a number of areas. The relatives of Afro-Caribbean individuals are more likely than White relatives to attribute illness to substance use and to consider mental health services to be influenced by racism.

Using case notes from a Birmingham hospital, McGovern and Cope analyse first admissions amongst Whites and second generation Black Caribbeans (referred to here as ‘Afro-Caribbeans’) with a diagnosis of schizophrenia in the period 1980 to 1983 (n=62). Second generation Black Caribbeans are defined broadly (UK-born and migrants aged under 30 at time of migration). The results indicate that Black Caribbeans in the study are more likely to live alone (42% compared with 10%) to have an onset of illness of less than a week, to be admitted from prison and to have higher rates of readmission in the two years follow-up period than Whites (48% compared with 28%). There is no evidence that misdiagnosis is a significant factor. The authors recognise that the small numbers make it difficult to generate statistically significant results. The analysis is further limited by reliance on case notes and broad definition of second generation Black Caribbean.

First admission rates of young Whites were compared with those of second generation Black Caribbean (defined broadly, as above McGovern and Cope 1991, and referred to as ‘Afro Caribbeans’) using case notes from a Birmingham psychiatric clinic in the period 1980-1983.

The results indicate that British-born Afro Caribbeans and migrants aged 16-29 have elevated rates of admissions compared with same-age Whites. More Black Caribbean migrants and British-born Blacks than White individuals are classified as psychotic (White males aged 16-29=49%, Black Caribbean migrant same age=82% and British-born Black Caribbean=92%). The data for the two latter groups are pooled and they comprise the ‘second generation’ categories, who have higher first admission rates compared with Whites. The authors address
the limitations of the study, these relate to overestimate of first admissions (though not disproportionately affecting any ethnic group), false identification of first admissions and the exclusion of individuals with no address and from outside the catchment area.


The authors briefly describe the findings of a study designed to measure the prevalence of systematic lupus erythematosus (SLE) in two Black populations (mostly second and later generation Black Caribbeans living in the UK and Black Africans. The former are described as ‘Afro-Caribbean’ here) and non-Black, European populations. The results indicate that SLE may not be as rare in West African populations as commonly believed. The prevalence rate for Afro-Caribbeans is 177 per 100,000, for West Africans it is 110 and for Europeans it is 35.


Parkman and colleagues describe the findings of a study designed to measure degree of satisfaction with mental health services amongst groups in south London (n=184). The study is explicitly generational, with a division of the study population by ethnicity and birthplace. The results of the questionnaire administered to the study population indicate that the UK-born Black Caribbean population express less satisfaction with services (p=0.04). Regression analysis suggests that number of hospital admissions is important, with evidence that satisfaction decreases with number of hospital admissions. The study appears to contradict earlier findings (McGovern and Hemmings, 1994) but is limited by small sample sizes (the second generation Black group number just 27) and a definition of ethnicity based on case notes.


The results of a survey conducted in England and Wales in 1998 are presented. Of the 5,658 individuals with tuberculosis, 56 % are foreign-born. The rates of tuberculosis (per 100,000) for Black Caribbeans are: for the UK-born=20.4; for the foreign-born=20.6; for the foreign-born who had entered the UK in the five years before the survey=16.3; and for the foreign-born who had been in the UK for more than five years=21.9. Foreign-born Black Caribbeans of unknown year of entry have a rate of 16. These rates are favourable compared with the rates for people of Black African ethnicity and individuals who originate in the Indian subcontinent.


The authors examine nutrient intake by place of birth, age and gender in UK-based Black Caribbeans (here described as ‘African-Caribbeans’). Data were collected by questionnaire from a random sample (of health centre registers) of African-Caribbeans living in Manchester (n=255). The results indicate that Caribbean-born individuals have lower energy from total and saturated fat than their younger, British-born Black Caribbean counterparts. In addition, the former eat more fruit and vegetables.

The authors explore the role of genetic factors in schizophrenia by examining the risk of schizophrenia amongst the relatives of Black Caribbean (here, ‘Afro-Caribbean’) and White schizophrenia patients admitted to Central Manchester in the period 1982-1988. Black Caribbean patients were differentiated by generational status (UK-born versus Caribbean-born). The results indicate that the siblings of Black patients have a much higher lifetime morbidity risk (15.9% compared with 1.8% for White siblings). Amongst the second generation, this was even higher at 27.3%. The authors emphasise the role of environmental factors in contributing to illness amongst young Black Caribbeans. The study is limited by small sample size.


Thomas and colleagues report the findings of a study designed to explore admission, modes of referral, compulsory detention and diagnoses in a sample of second generation Black Caribbeans (here described as ‘Afro-Caribbeans’) and Asians and Europeans. Data were collected from psychiatric admissions to Central District of Manchester in the period 1984 to 1987 (n=1534). Ethnicity was determined by consultation with staff and examination of case notes. The results indicate that second generation Black Caribbeans have significantly higher rates of first admission compared with same age Europeans (nine times higher for schizophrenia and five times for ‘other psychoses’). Readmissions are also significantly higher for second generation Black Caribbeans. The authors discuss the methodological flaws with the study; these include small numbers and problems with estimating ethnic minority populations.


The authors present the findings of a case-control study of changes in the risk of schizophrenia by ethnic group (Black Caribbeans are here described as ‘Afro-Caribbeans’). Individuals were matched by ethnicity but not illness (individuals with schizophrenia were matched with controls who had a mental illness, but not schizophrenia). Data on all individuals with (first-contact) schizophrenia were taken from the Camberwell Psychiatric Case Register in the period 1964-1984 and case notes. Data were available on ethnicity and place of birth (n=130).

The results indicate that the overall risk of illness increased in the study period (1964 to 1984) for all Black Caribbeans (regardless of generational status) and there is evidence of an increase in risk of schizophrenia in the second generation Black Caribbean. The sample were divided up by year of birth, so that those born after 1955 (when second generation Black Caribbean children began to be born) were considered the second generation, and those born before 1955, the first. Comparison of schizophrenia in individuals of Black Caribbean ethnicity (and using year of birth information) with all other ethnic groups in the sample reveals evidence of an increase in the risk of schizophrenia. The authors also consider the effects of age of migration on risk of schizophrenia. They divided up the Black Caribbean sample into those that migrated before age 18 and those who migrated after age 18. The results indicate that the risk of developing schizophrenia amongst individuals born in the Caribbean but entering the UK before age 18 was 2.7 (odds ratio) compared with individuals born elsewhere.

The authors point out that this study avoids some of the methodological problems that are present in other studies. They do note, however, that the age at onset of schizophrenia is decreasing in the Black Caribbean population so that there was an increase in the number of
cases towards the end of the study period, which will give a false impression of increasing risk. Wessely et al. report two major findings from the study. Firstly, that Black Caribbeans are at greater risk of schizophrenia than other groups and, secondly, that this risk has increased between 1965 and 1980. This contrasts with evidence of a decline in incidence of schizophrenia in other countries. This increase may be due to the increase in social deprivation over the study period. Obstetric complications amongst Black Caribbean mothers may also be a factor in the development of schizophrenia in this population.

American research


Using data from a survey conducted at a Boston Hospital (n=817), the authors examine the health behaviours of foreign and US-born Blacks. Foreign-born Black women tend to be older, married, to have received a longer period of education, to be wealthier and to attend more prenatal visits than US-born Black women. They also were less likely to smoke, consume alcohol or take illicit drugs than US-born Blacks. This was reflected in birth outcomes, with the babies of foreign-born Blacks benefiting from larger birth weights, larger head circumferences and longer gestation.

The authors controlled for the confounding effects of: gestational age, weight gain during pregnancy, pre-pregnancy weight for height, marital status, maternal age, level of education, prenatal care visits and the use of substances during pregnancy. The differences in birth outcomes are reduced by the introduction of controls, but there are still differences (odds ratios of low birth weight, foreign-born versus US-born=0.81, prematurity=0.54). The authors acknowledge that the characteristics of the sample may be specific to the location, and other limitations of the study (such as the exclusion of non-English and non-Spanish speaking women from the sample). A further limitation is the absence of information on age at migration to the US or length of residence for the foreign-born.


The authors report the results of an investigation into the interaction between tuberculosis and a number of factors, including ethnicity and birthplace. Using Bureau of Census data, the researchers link each tuberculosis case notified to Centers for Disease Control (CDC) in the period 1987-1993 to information about socio-economic conditions (including data on overcrowding, unemployment etc.) (n=159,070).

The results suggest an increased prevalence of tuberculosis amongst US ethnic minorities with rates five to 10 times higher after controlling for age, sex and birthplace. Adjustment was important in reducing rates amongst US Blacks but less important for foreign-born Blacks, which suggests that foreign-born Blacks and others may have been more exposed to infection. The authors acknowledge the limitations of the study; the most important of which is that the analysis utilises ecological-level data and the results are therefore subject to the ‘ecological fallacy’ which may ‘….erroneously assign group-based measures of disease-exposure association to individuals within the group’. No information is presented on length of residence for the foreign-born.

The purpose of this study was to explore the impact of community income, as well as maternal factors such as birthplace and ethnicity, on birth outcomes. Data were taken from New York City birth records in the period 1988 to 1994. Income level was gauged using census tract data. Length of time in US or age at migration was not given for foreign-born Black Caribbeans.

The results show (as many similar studies have) that Caribbean-born mothers have higher socio-economic status than their US-born Black counterparts, and this affects birth outcomes (over 20% of Black southern US-born mothers have preterm births, compared with 13.9% of Caribbean-born Black women). Logistic regression appears to indicate that birthplace is an independent predictor of low birth weight for babies, though level of community income modifies this relationship. The authors acknowledge that the study is limited by lack of data on acculturation.


The authors report the results of study of the effect of birthplace on cancer mortality amongst Blacks in New York City. Census data from 1988-1992 were used to compute age-adjusted cancer death rates by ethnicity and place of birth. The populations studied were: Blacks born in the US (in the northeast and south), Blacks born in the Caribbean and New York City Whites.

Southern US-born Black males have higher death rates than northeastern US-born Black males and Caribbean-born Black males. Lung cancer deaths show significant variation, with Caribbean-born Blacks having only one third of the death rates of southern US-born Blacks and half those of New York City Whites. Death from prostate cancer is highest in Caribbean-born Black men, especially in the under 65s.


The authors examine mortality rates from cardiovascular causes, the leading cause of death for all Americans irrespective of ethnicity. As with the cancer study above (Fang, Madhavan and Alderman, 1997) the populations under study were: US-born Blacks (south and northeast-born), Caribbean-born Blacks and northeast US-born Whites. Data were taken from the US Census and New York City Health Department records. The categories of mortality analysis were: all cause mortality, death from cardiovascular disease (CVD), death from coronary heart disease (CHD), death from stroke and death from hypertensive disease.

The results show that age-adjusted mortality rates for New York City residents are higher than for the country as a whole. The overall mortality rate for Blacks (all groups considered as one, irrespective of birthplace) is higher than that for Whites. Black males born in the southern US have higher all-cause mortality than northeast US-born Blacks and Caribbean-born Blacks. The higher death rate for Blacks compared with Whites masks substantial variation in mortality between the Black groups. The (all age) Caribbean-born Black male population, for example, have lower CVD and CHD death rates than all other Black groups and the northeast US-born White group (though they have higher stroke mortality than Whites and northeast US-born Blacks). Black Caribbean women (all age) have slightly higher CVD death rates than northeast US-born Whites and slightly lower rates than the other Black groups. Their CHD death rate is slightly higher than northeast US-born Blacks but lower than the rate for northeast US-born Whites and substantially lower than the rate for southern US-born Blacks. Stroke mortality
amongst Black Caribbean women is similar to that of northeast US-born Blacks, higher than northeast US-born Whites and lower than that for southern US-born Blacks.

Once these death rates are broken down into age groups, a slightly different picture emerges. The advantages of Black Caribbean men in relation to CVD and CHD death rates are lost or reduced in older (aged over 65 years) men (CVD death rates are higher in this age group in comparison with all other groups and CHD rates are lower only to northeast US-born Whites). For Black Caribbean women, their advantageous position over southern US-born Blacks is maintained in all age groups, although stroke mortality is high for the eldest Caribbean-born Black women (compared with all groups). In all age groups, Black Caribbean women have lower death rates from CHD than northeastern US-born Whites.

Standardised mortality ratios (SMRs) for Black Caribbean men aged 25 to 64 years (with White northeast US-born males as the reference group) are: all causes= 0.92, CVD= 0.74, CHD= 0.48, stroke=2.32, hypertension=1.90. For Black Caribbean-born women, of the same age, the SMRs are: all causes=0.96, CVD=1.10, CHD=0.75, stroke=2.09, hypertension=3.47. The comparable figures for southern US-born Black males aged 25 to 64 years are: all causes=2.17, CVD=1.75, CHD=1.21, stroke=4.09, hypertension=4.89. For southern US-born Black females, the figures are: all causes=1.81, CVD=2.28, CHD=1.65, stroke=4.15, hypertension=6.42. No SMRs are available for individuals aged over 65 years. The authors suggest that the relatively favourable profile of Black Caribbeans may be attributable to a healthy (low fat) diet and moderate alcohol consumption. Information on length of residence is not available for the Caribbean-born though Fang and colleagues suggest (on the basis of census data) that, on average, most Black Caribbeans have been in the US for 13 years.


The objective of this study was to examine the relationships between maternal birthplace, ethnicity and low birth weight in California using 1992 Californian birth certificate data. Only data on singleton infants born to White, Black, Asian and Native American were used and the dependent variable was birth weight (which was classified into four groups from very low to high). Maternal ethnicity and birthplace were the primary explanatory variables. Other variables used were: maternal status, tobacco use, gestational age and prenatal care. The analysis consisted of bivariate analyses, then logistic regression. Birth weight data on 497,868 babies were used in the analysis. Of the Black mothers, only 6% were foreign-born and they tended to have a more ‘favourable’ profile than their US-born counterparts (they had more years of schooling, were less likely to be unmarried and were less likely to smoke).

The results indicate that babies born to foreign-born Black women have better birth outcomes (higher birth weights and are less likely to be premature) compared with their US-born counterparts. Once the characteristics of the mothers are taken into account (prenatal care, smoking, education etc.) these advantages for babies of the foreign-born disappear (adjusted moderately low birth weight odds ratios for foreign-born Black women and US-born Black women compared with US-born White women=1.59 and 1.88 respectively). Foreign-born and US-born Black women remain at higher risk of having very low birth weight babies compared with US-born White women. No data is provided on length of residence or age at migration for foreign-born women, and no information is provided on the exact location of the birthplace of foreign-born Black women.

Greenberg et al. examine the effect of internal migration and migration from the Caribbean, on the diet (and the health) of Blacks in Harlem, New York City (n=621). Data were collected by in-depth interview. The authors constructed a ‘health diet’ score for each respondent based on their consumption of certain foodstuffs (fruits and vegetables attracted a high score, and high consumption of sweets, fats and salt a low score). The results indicate that young, Black southern US-born men have the highest dietary risk and Caribbean-born Blacks have the lowest. The analysis is limited by a reliance on self-report measures, small sample sizes for some groups, lack of information on length of residence or age at migration and comparatively simple statistical analysis which does not control for the effects of income or education.


Harker presents a generational analysis of psychological health amongst US immigrants using National Longitudinal Study data and making use of contextual variables as well as individual level variables in this study of over 13,000 respondents. The outcome variables are depression and positive well-being; explanatory variables include family background, educational factors and degree of social support. The results suggest elevated depression and less positive well-being in the US-born compared with the first generation, other factors held constant. Second generation immigrants are similar on these dimensions to their US-born peers, which implies that assimilation can lead to a ‘wearing off’ of protective mechanisms. Age at migration does not affect well-being. African and Black Caribbean groups are considered together, which limits the usefulness of this study here.


A comprehensive exploration of the literature on the health and well-being of children in US immigrant families. Generational status is defined thus: foreign-born immigrant children are first generation, US-born children in immigrant families are second and US-born children in US-born families are third generation. There are a number of references to children of Black Caribbean origin of different generational status. For example, evidence is cited that Black Caribbean adolescents in the third and second generation engage in more high risk behaviours (early sexual activity, substance use etc.) than their first generation counterparts and that children with their family origins in the Dominican Republic and Haiti suffer from high poverty rates in the first and the second generation. A number of recommendations are made, some of which are concerned with improving data collection systems.


The aim of this study is to examine infant mortality (IMR) by reference to ethnicity, birthplace, maternal health behaviour and demographic factors in the US population in the period 1989-91. Data were taken from IMR files (n=10,061,787) and a distinction made between foreign and US-born Blacks. The former have more advantageous outcomes (IMR=7.9 compared with 11.4 for US-born Blacks). This is partly attributable to lower rates of smoking and favourable sociodemographic characteristics (4% of foreign-born Blacks smoke compared with 16.1% for US-born Blacks). Multivariate analysis indicates that, when risk factors are controlled for, the foreign-born still have more advantageous outcomes, especially for Blacks.

The authors examine the effect of birthplace on diabetes during pregnancy among 15 ethnic US groups (including Black, Asian and White groups) in the period 1994-6. Data on Native Americans is also examined; the vast majority of whom are US-born though small numbers are foreign-born. Data on 10,854,224 birth certificate records were analysed and ethnicity was determined by maternal self-report. The place of birth of the Black women was not described (they could be African-born as well as Caribbean-born).

The results suggest that women born outside the US are more likely to have diabetes during pregnancy. After adjustment for age at childbearing, prenatal care and other sociodemographic variables, birthplace continues to be important for Asian-Indian women, Blacks and others. For foreign-born Black women compared with their US-born Black counterparts, the increased risk of diabetes is 14% after adjustment. Foreign-born Japanese, Native American and Mexican mothers are the only women to have a lower risk of maternal diabetes than their US-born counterparts. The authors acknowledge the limitations of the data (abortions are not considered and no data is presented on length of residence). Also, the prevalence of diabetes during pregnancy could be substantially underestimated.


The authors report the findings of an analysis of National Health Interview Survey data on nearly 17,000 African Americans (US and foreign-born). Results show that prevalence of smoking is twice as high amongst US-born compared with foreign-born Blacks. The association between smoking and birthplace remains after controls for age, education etc. Amongst foreign-born Blacks, women are less likely to smoke than men. Some consideration is given to the effects of residence in the host country; the results of the logistic regression show that residence of more than 15 years in the United States is associated with increased smoking for foreign-Born Blacks, which is marginally significant. The limitations of the study include: underestimation of smoking prevalence due to sampling error, the cross-sectional nature of the data and use of self-report measures.


The authors examine racial differences in rates of infant mortality (IMR) by race, birthplace and other factors using national data on infant births and deaths (1983 and 1984). The country of birth of the foreign-born mothers was not referred to, nor was length of residence in the US. Respondents were divided up into risk groups: the high risk group were unmarried mothers with less than 12 years education and maternal age of under 20 or over 30 years of age or with high parity; low risk group were married mothers, with more than 13 years of education and a maternal age of 20-29 or low parity; and the moderate risk group were women with other combinations of maternal characteristics.

The results show that Black foreign-born mothers are more likely to have low risk characteristics compared with their US-born counterparts (17.6% compared with 10.1%) and to have better pregnancy outcomes (low birth weight=75.4 per 1000 compared with 117.4 for US-born Blacks). The results of the regression analysis suggest that birthplace continues to exert a strong effect on outcomes, with neonatal mortality risk 22% lower for foreign-born Blacks after adjustment. The authors discuss the sources of bias in the study, the most important one being the possible ‘selection’ of migrants with a favourable health profile. Length of residence
and place of birth are not referred to here, though the authors note that previous work has shown that most Black foreign-born women have been resident in the United States for more than five years and that they come mostly from the Caribbean.

The authors report the results of a study designed to measure cocaine use (and other drug use) in women who had just given birth in a New York hospital. Cocaine metabolites were found in the urine samples of 11.5% of the respondents (n=1111); signs of marijuana and other drug use were found in a smaller proportion of the sample. Cocaine users are more likely to be Black US-born (rather than Caribbean-born) and have received no prenatal care. The study does not focus especially on the effects of birthplace or ethnicity on drug use, but on the effects of drug use on infants’ health at birth.

The author describes the results of an analysis of the health behaviours of three groups: US-born adolescents (third generation), US-born adolescents of foreign-born parents (second generation) and foreign-born adolescents (first generation). The data were taken from the National Longitudinal Study of Adolescent Health (n=20,457) and the measures were those that relate to: sexual debut, violence, substance use and delinquency. The ethnicity and family context of adolescents was also used in the analysis. A two-stage analytic approach was used: the first was descriptive and also examines the persistence of behaviours by generational status and ethnicity. The second stage involved the use of multivariate logistic regression. The analysis was not focused solely on the health behaviours of Black Caribbeans, but rather on the changes in behaviour across generations in a number of migrant groups.

Mullan Harris maintains that the assimilation process can be observed in differentials in health behaviours across generations. In the initial analyses, the observed changes in behaviours across the generations (towards more risky behaviour) is indicative of the assimilation of youth into American culture. There is also a link between length of time in the US and risky health behaviour; those youth who have been in the US the longest have the riskiest behaviour (for example, the risk of having had sex increases from a mean of 22.8 for those youth who have been in the US 0-5 years to 35.8 for those who have been in the US more than 11 years). Analysis of the variation in changes in behaviour by ethnicity shows that there is evidence of increases in risk behaviour by generational status in all ethnic groups (though the trend is not the same for all; European and Canadian second generation youth have the same risky behaviour profile as the third generation). Black Caribbean youth (here described as ‘Afro-Caribbean’) show a clear gradient in increases in risky health behaviour by generational status.

The results of the multivariate analysis (which examines the effects of family context on four risky behaviours: sexual intercourse, delinquent behaviour, violent behaviour and substance use) indicate that, once the effects of family structural conditions (poverty, low education, family size etc.) are held constant, the protective effect of first generation status is enhanced for many groups including Black Caribbeans. This suggests that family structural conditions in many first generational groups are disadvantageous to youth and, once these are controlled: ‘...the beneficial influence of foreign birth increases’. For Black Caribbeans, holding constant the effects of family process (parental supervision, parent-child closeness etc.) on the health...
behaviours of youth, has the effect of depressing the beneficial effects of second generational status.

Mullan Harris next considers the effect of cultural adaptation (language spoken, religiosity, social support etc.) characteristics on behaviours. Once the effects of these are held constant, the beneficial effect of first generational status is greatly reduced for all groups, including Black Caribbeans. The author performs the same type of analysis on individual risk behaviours for all groups and finds similar results. Foreign birth is consistently beneficial for all groups (and some more than others). In conclusion, Mullan Harris maintains that the empirical results summarised here support classical theories of the assimilation process amongst migrants. She points out that whilst assimilation usually confers socio-economic and educational benefits, it has a detrimental effect on health outcomes. Afro-Caribbean youth is one group (amongst others) that she cites as showing the greatest degree of assimilation.

O’Malley and colleagues report the findings of a random-digit telephone survey of nearly 2,500 ethnic minority respondents, the aim of which was to ascertain the health information sources of ethnic minorities in New York in 1992. A distinction was made between Blacks in terms of birthplace (Caribbean, Haitian and US-born Blacks) and most of the respondents were immigrants.

The results show that more recent immigrants are likely to report being unable to get health information. As time in the US increases, magazines become a more important source of health information. Caribbean and Haitian-born Blacks are more likely than US Blacks to consult a clinician for information. The authors do not discuss the limitations of the survey. The response rate was 62.3% (and obviously excludes those without telephones) and eliciting information over the telephone can affect the nature and type of responses.

The authors report the results of a study that aims to explore how continuity of care affects the use of breast and cervical cancer screening in a multiethnic population. The population under study were US-born Blacks, Caribbean-born Blacks and foreign-born Hispanics (n=1420) in New York and data were collected by telephone interview. Outcomes measured included: use of clinical breast examination, mammography and smear tests. The effect of acculturation was considered, with language, age at migration and length of time spent in the US used as control variables.

The results indicate that Black Caribbean-born women have high levels of continuity of care (as do US-born Blacks). The results for use of screening services show that Black Caribbean-born women have high rates of service use (over 92% have had a smear, over 82% have had a clinical breast examination). The results adjusted for degree of acculturation are not presented for each ethnic group separately, so how acculturation affects Black Caribbean-born women’s use of screening cannot be gauged. The authors do, however, calculate typical service use patterns based on the findings. They predict that, for example, an older Haitian-born, Creole-speaking female who came to the US after age 16, with no health insurance and no educational degree is likely to have low rates of smear, clinical breast examination and mammogram screening, and is thus at high risk. A low risk profile would belong to a hypothetical US-born Black, married, with insurance and an educational degree. The authors
discuss the limitations of the study, such as its cross-sectional design and reliance on self-report measures.


Pallotto and colleagues use Illinois vital records in the period 1985-1990 to analyse the factors that contribute to low birth weight in a population sample of US-born Black women, Caribbean-born Black women and US-born Whites. The results show that there is a clear gradient of risk, with birth weights amongst babies born to US-born Blacks the least favourable (the moderately low birth weight for US-born Blacks is 10%, for Caribbean-born Black women it is 6% and for US-born Whites, 4%). The overall distribution of birth weights is similar in babies born to Caribbean-born Black women and those born to US-born White women. The authors conclude that maternal birthplace is associated with birth outcomes, and that the pre-pregnancy experiences of US-born Black women are often unfavourable. The results are consistent with other studies that examine birth outcomes by birthplace amongst Blacks. No data is presented on length of residence in the United States and/or age at migration.


The authors examine differences in pregnancy outcome (infant mortality, low birth weights and premature birth) between US-born and foreign-born ethnic minority women in the US. National data were used (which is an improvement on many previous studies which have used only localised samples) from the mid to late 1980s.

The results show that foreign-born Blacks have better pregnancy outcomes than their US-born Black counterparts. Multivariate logistic regression analysis is used to control for a number of sociodemographic factors, and the results show that all US-born women have a higher risk of infant mortality and low birth weights than their foreign-born counterparts. US-born Black women have (after adjustment) 33% higher chance of infant mortality, 61% higher chance of low birth weight and 31% risk of premature birth compared with foreign-born Blacks. The authors hypothesise that foreign women are less likely to engage in behaviours (such as smoking) which will negatively affect pregnancy outcomes. Other behaviours, such as breastfeeding and degree of support, may also be important. The authors recognise that US-born Blacks are revealed as being particularly disadvantaged in relation to foreign-born Blacks in this study, but argue that this may be because foreign-born Blacks have not been exposed to the kind of discrimination and disadvantage that US-born Blacks have over such a long period. The limitations of the study are discussed, such as problems with estimating gestational age and missing data. No information is presented on length of residence.


The results of a study of smoking between in three Black populations (US-born Blacks, Caribbean-born Blacks and Haitian-born Blacks) is described. Data were collected in 1992 by telephone in New York from 933 respondents and measures included: smoking history, alcohol use, cancer knowledge, attitudes, beliefs, perceived risks and concern and health perceptions. The results indicate that US-born Blacks are more likely to be smokers (past and present). Caribbean-born Blacks who smoked are more likely to be retired or disabled and have a low income or a blue-collar occupation. For all three ethnic groups, high school graduation is
associated with smoking. Among Haitian-born Blacks, those who had lived in the US for more than the sample median number of years are marginally more likely to have ever smoked.

The results of the multiple logistic regression indicate that Caribbean-born and Haitian-born Blacks are only one-tenth and one-eighth as likely to have ever smoked as US-born Blacks. The authors maintain that this paper is the first to assess predictors of smoking status amongst Blacks by immigrant status. They point to important gender differences (with Caribbean-born and Haitian-born women much less likely to have ever smoked than their male counterparts). The authors also point out that the sample sizes for Caribbean-born and Haitian-born Black smokers are small and that the population is urban and, therefore, the results cannot be generalised to non-urban areas.

Dutch Research


The aim of this study is to compare the risk of first contact for psychotic disorders in immigrants (first and second generation) with the Dutch-born population (it is presumed that this group are all or mostly White). Data were collected from a two-year first-contact incidence study in The Hague in the period 1997 to 1999 (n=181) and information on place of birth and ethnicity was used.

The age and gender-adjusted relative risks for many second generation groups are elevated compared with the Dutch-born. For second generation Surinamese, the relative risk for all psychotic disorders is 4.6 and for schizophrenic disorders it is 5.5. Data is not available for the Antilleans. The major limitations of the study include small numbers and a crude method of socio-economic adjustment. The ethnicity of respondents is not fully explored, since birthplace is used to a greater extent in the analysis. Many of the Surinamese respondents are of Asian origin rather than Black African origin.

International Comparative Research


Bhugra et al. maintain that the high incidence of schizophrenia in London-based Black Caribbeans compared with their Trinidadian counterparts is probably attributable to environmental factors and may be the result of differences in education, employment or other factors between these two groups. They explore this by comparing social and other factors that might affect schizophrenia in two Black Caribbean (here referred to as ‘African-Caribbean’) samples, one in Trinidad (n=46) and one in London (n=38). Most (71%) of the London-based Black Caribbeans were UK-born. Respondents with first-onset schizophrenia were recruited to the study in both locations and data were collected on symptoms, help-seeking, and sociodemographic factors. Patients and relatives provided information and some data was taken from case notes.

The results indicate that Black Caribbean patients with schizophrenia in London are more likely to be male than the Trinidad sample and to be slightly younger than the Trinidadian sample. London-based Black Caribbeans are significantly more likely than Trinidadians to have been admitted to care because they were perceived to be a threat. Results from a comparison of the two samples in their manifestation of ‘abnormality’ suggest that London-based Black
Caribbeans are more likely to have assaulted others, ‘lost all interest’ and to have neglected themselves. The London sample are more likely to have had an ‘insidious’ onset of illness than the Trinidadians (incremental development of illness). London-based Black Caribbeans are also more likely to have been admitted into care after contact with the police (25% compared with none in the Trinidad sample). There are no significant differences in patients’conceptualisation of their problems between the two samples. There are large differences between the two groups in sociodemographic factors: 81% of the London sample is unemployed compared with just 15% of the Trinidad sample. Relatives identified premorbid personality traits in the two groups; the London sample are described as ‘generally gloomy’ and the Trinidad sample are more likely to have a ‘set routine’.

The study is limited in a number of ways. The sample numbers are small in places, different research personnel were used in the two locations (and no tests of inter-rater reliability were performed) and the Trinidad sample are not all Black Caribbean, some are of Asian ancestry.


Bhugra and colleagues report the results of a year-long study of the incidence of schizophrenia, the sociodemographic background of patients with schizophrenia and the situation at follow-up a year later in Trinidad. All individuals (n=56) presenting with illness (or individuals who had become known to the prison service or health personnel) at two locations (one rural and one urban) were assessed and schizophrenia incidence rates were calculated for the Island. Most individuals who presented with illness were male, under the age of 30, 35% were unemployed, only 30% were educated to secondary school level and most were religious. Most had presented to helping agencies because of odd behaviour, the duration of illness for most of the sample (72%) was less than three months and 56% had sought help via a psychiatrist. At one-year follow-up, 19% had a poor outcome (continuation of psychotic episode, suicide or a recurrence of symptoms after a symptom-free period).

Bhugra et al. compare the incidence rates for different types of schizophrenia in a variety of countries. The London rate for schizophrenia for Black Caribbeans (here described as ‘African-Caribbeans’) is the highest at 5.86, rural Chan has a rate of 4.20, London-based Asians have a rate of 3.56 and Trinidadians have a rate of just 2.15. Incidence rates for schizophrenia are lower in Trinidad compared with London. The authors discuss the findings; the principal one being the ‘normal’ range of the Trinidad rates. The authors maintain that environmental factors are important in explaining the high incidence rate for Black Caribbeans in London.


Non-insulin dependent diabetes (NIDDM) has become a major public health issue in the last 15 years (especially for ethnic minorities) and research in this area has focused on the role of genetic factors in the development of the disease. By measuring the prevalence of NIDDM in (genetically similar) Black populations in various locations, the effect of environmental and genetic factors on NIDDM can be considered.

The authors report the findings from the International Collaborative Study on Hypertension in Blacks (ICSHIB) in which respondents were recruited from sites in Africa, the Caribbean, the US and the UK. Measurements included: blood pressure, weight and diabetes. The results show that crude prevalence rates vary from 2.8% in Nigeria, to 7.7% in the Caribbean (with some variation amongst the different islands), 14.4% in the UK to 10.5% in the US. Body mass
index (BMI) values also show variation, with Nigerian men being the leanest group. BMI values strongly correlate with diabetes (controlling for age, sex and geographic location). Waist-to-hip (WHR) increases with prevalence of diabetes, as does overweight. The authors remark that: ‘The current report provides evidence of a finely graded population risk from a lower extreme among the lean and physically active Nigerians to the high levels in the largely sedentary population in the US’. The authors acknowledge that, since the study sample is drawn from diagnosed cases, many undiagnosed cases may be present in the population. In addition, diabetes-linked mortality in Africa may have led to underestimation of the prevalence of illness in the population.


Cruickshank and colleagues assess the genetic ‘causes’ of type 2 diabetes and high blood pressure by comparing African-origin populations in four locations: rural and urban Cameroon, Jamaica and the UK. The authors argue that genetic causes are unlikely to account for variation in frequency of disease, and use standardised methods to examine nutritional influences on blood pressure and glucose intolerance in the four, geographically diverse populations. About 80% of the British sample was born in Jamaica. The results indicate that the proportion of the population with diabetes varies according to site (age-adjusted rates=0.8% rural Cameroon, 2.4% urban Cameroon, 8.5% Jamaica and 16.4% Manchester). Similar results were found for hypertension (7% rural Cameroon, 16 % urban Cameroon, 21% Jamaica and 34% Manchester).

The authors maintain that this evidence points to a strong environmental role in the development of these conditions. The role of nutrition is discussed; the Manchester sample actually have higher fruit and vegetable intake than the national population, which protects against coronary heart disease (though this particular population has high blood pressure and diabetes rates compared with the other sample populations). This will probably change in the younger population; their diets are becoming similar to the national population. The authors acknowledge that the study does not explore the role of all possible environmental factors and limited information on the populations under study is presented.


The authors present the findings of a prospective, first contact study of schizophrenia in Jamaica using a standardised diagnostic instrument. Of an initial sample of 516 respondents referred from parishes on the Island, 317 had a diagnosis of schizophrenia (the rest of the sample were either excluded because they did not fulfill entry criteria or received a diagnosis of mania or psychotic depression). Age-corrected incidence rates indicate that Jamaica has a schizophrenia incidence rate of 2.36 per 10,000. This is substantially lower than the rates for Black Caribbean populations in the UK (which range from 13.5 to 36.4 per 10,000). The possibility of underestimation of cases is discussed; this could be attributable to the problems of diagnosing illness or ‘leakage,’ where no diagnosis can be made at all.


Mahy and colleagues report the findings of a year long study of everyone aged 18-54 presenting with psychosis in Barbados. They report an incidence rate of 3.2 for schizophrenia. By comparison, London’s African-Caribbeans have a rate of 6.6 per 10,000. The authors
attribute the higher rates in the UK to environmental factors. The study is limited by comparatively small samples, and possible ‘leakage’ of cases from the study (which the authors believe, however, is minimal).


The authors describe a four-site study of glucose intolerance in genetically similar African-origin populations. The four sites were: rural and urban Cameroon, Jamaica and Manchester, UK. Respondents in the four sites were questioned about established diabetes and were given an oral glucose tolerance test. Height and weight were also measured. Response rates varied, with rates of 90% in Cameroon, 60% in Jamaica and 66% in Manchester.

The (age-standardized) results indicate that there is a clear distinction in outcomes by geographic location. There is a five-fold difference in (male) overweight between the Cameroon sites (rural to urban) and a doubling between Jamaica and Manchester. Women in rural Cameroon are less affected by overweight, but overweight is 60% higher in the other populations. Overall, the prevalence of diabetes ranges from a low of under 3% in the African sites to a high of over 14% in the British site. Jamaicans have a middling rate of 6-11%. Impaired glucose tolerance rates are similar, with low rates in the African locations and high rates in Jamaica and the UK. The authors conclude that environmental factors, rather than genetic ones, affect diabetes. The authors acknowledge the limitations of the study; a primary one being the small UK sample.

4.2) Family Structure and Living Arrangements

British Research


A book chapter that considers how the children of the post-war migrants to the UK adapted to parental separation. Arnold points out that many migrants left children in the Caribbean, who later came to the UK to join their parents. Those migrants who brought their children encountered difficulties, many of which were associated with the loss of the extended networks of family and friends commonplace in the Caribbean. Attachment theory is used to explain the effects of parental separation from children. Mothers, especially, felt guilty and were anxious about the welfare of their children, and this may have contributed to the high rates of depression in Caribbean women. Arnold cites evidence that the process of migration and separation affected girls in particular. The effect of migration on ethnic identification and schooling are also discussed.


Berrington uses Labour Force Survey data to examine family structure and marriage amongst ethnic minority populations. A generational approach is utilised; explicit reference is made to differences between age groups and by birthplace. Her comparison of the marriage patterns of first and second generation Black Caribbeans indicates that there is no consistent difference in marital behaviour between the generations. For example, Black Caribbean men aged 30-34, but of different generational status, have very similar rates of marriage and the differences in marriage rates between first and second generation Black Caribbean women of the same age.
The differences in cohabitation between the first and second Black Caribbean generations are not significant either. The data on interethnic unions by generation indicates that Black Caribbean men of both the first and second generation have high rates of interethnic union, whether through marriage or cohabitation (the analysis is limited, however, by very small numbers). Other features of Black Caribbean family life are also explored, such as low rates of marriage, high rates of lone parenthood and the economic activity of Black Caribbean women.


Berthoud provides a comprehensive discussion of the marriage and family formation patterns of British ethnic minorities (and, in particular, Black Caribbean individuals). The situation of the second generation (UK-born) Black Caribbean population is referred to specifically using analyses from sources such as the Labour Force Survey and the Fourth National Survey. The low rates of marriage, high rates of marital dissolution, high rates of mixed race partnerships and comparative scarcity of the two-parent family amongst British-born Caribbeans is noted. The Caribbean family is contrasted with other ethnic minority families; the ‘modern individualism’ of Caribbean families is compared with the ‘old fashioned values' of South Asian families.


The author explores the social forces behind migration, and its effects on the migrants and their children, by drawing on material collected as part of a wider study, ‘Living Arrangements, Family Structure and Social Change of Caribbeans in Britain’; a study based on the life-stories of three generations of Caribbeans living in the UK (n=180). Chamberlain makes the point that the high numbers of mother-headed households seen in the UK amongst Caribbeans represents a cultural ‘constant’ rather than an adaptation to new conditions. She argues that Caribbean families need to be considered horizontally rather than vertically; ‘the horizons of kinship are extended’.


Chamberlain uses qualitative material from the project ‘Living Arrangements, Family Structure and Social Change of Caribbeans in Britain’ to describe Caribbean family life (particularly the role of siblings) in Britain.

Her discussion begins with a description of the ‘pathologising’ of the Caribbean family, which has a long history in social science research. She also points out that study of the effect of migration on family life has been neglected, but the work presented here highlights the importance of the family in the process of migration and the development of ‘transnational’ families. Chamberlain argues that Caribbean families should not be examined using a conventional framework; the conjugal role may not be as central in Caribbean families. This chapter uses material from three case studies, each very different from the next in terms of place of origin (Jamaica and Trinidad), race (African-Caribbean, mixed race and East Indian) and family organisation. Chamberlain concludes that, especially for those individuals raised in the Caribbean, the whole community undertook the socialisation and care of children. The situation of second and third Caribbeans living in the UK, who live in a context of smaller family size and the absence of a ‘neighbourhood family’, is different.
The theme of migration is explored in a sample of Barbadian migrants to the UK. Relationships between the generations are examined against the backdrop of migration (which in Barbados is significant: in the period 1951 to 1971, 12% of the population of Barbados migrated to the UK). All aspects of the migratory experience are considered, including gender differences and effects on family structure and dynamics (such as frequent separations and absences).

The role of men in ethnic minority families is explored through the analysis of interviews with a sample of 221 respondents. The focus is on Black Caribbean (here, 'Afro-Caribbean') families and the orientation of the study is explicitly generational. Dench devises a 'Family Culture' index based on the material collected. This comprises three groups: traditional, alternative and mixed. Afro-Caribbean families in the study are more likely to fall into the 'alternative' category than other minority groups. There is a clear distinction between generations; those born in the Caribbean have a more traditional view of family life whilst those born in the UK are overwhelmingly 'alternative' in their view of family life. Dench maintains that individuals of Black Caribbean origin are pro-marriage and inherently traditional in their outlook on the family (though they may not always be capable of achieving such high ideals). High rates of lone parenthood amongst them are adaptations to harsh economic conditions rather than 'cultural preferences'.

This is a highly exploratory, small-scale study from which no firm conclusions can be drawn given the sample size for Black Caribbean respondents. In conclusion, Dench argues (amongst other things) that, in our multi-cultural society, if there are issues about the family to be explored then we should look to the migrant generation, rather than their children.

Goulbourne uses data from the study 'Living Arrangements, Family Structure and Social Change of Caribbeans in Britain' described above (Chamberlain, 1999a). The theme of this paper is the transnational nature of Caribbean families, which is explored by discussing issues such as care and affection given to kin across national boundaries. Goulbourne also considers the formation of transnational identities. He concludes that caution is advised when considering the apparent deficiencies of the Caribbean family in the UK and maintains that the transnational evolution of the Caribbean family in the UK is a strategy for survival.

The authors use the Samples of Anonymised Records (SARs) from the 1991 census to analyse family formation patterns amongst young people by ethnicity, gender and birthplace. The results show that second generation Black Caribbean women (i.e. those born in the UK) are less likely than their non UK-born counterparts to be married at all ages. Heath and Dale also consider differences in living arrangements by ethnicity and educational attainment, but no distinction is made by generation. Data on Black Caribbeans is pooled with data on other Black groups (Black Other and Black Africans).
Holdsworth, C and Dale, A. (1995). Ethnic homogeneity and family formation: evidence from the 1991 household SAR. CCSR Occasional Paper no. 7. The authors provide a comprehensive discussion of the development and use of the ‘ethnicity question’ in the 1991 census and then proceed to explore ethnic variation in family formation using the Sample of Anonymised Records (SARs), paying attention to the ‘Black-Other’ groups. The relationship between age structure and birthplace is discussed, with the analysis showing clearly that most foreign-born individuals are concentrated in the older age groups. The authors note that the Black Caribbean population pyramid has a narrow base, which may ‘…suggest that the UK-born children of immigrants are choosing a different ethnic identity from their parents…’ This is reinforced by analysis of the ethnic group of the parent(s) of ‘Black-Other’ children. The marital status of women heading lone parent families shows that 52.7% of Black lone parent women are born in the UK (compared with only 17.7% of Indian women).

Owen, D. (1998). Marital status and families in the Caribbean and Great Britain compared. Working Paper W1/98. University of Warwick: National Ethnic Minority Data Archive. Patterns of marriage and family structure amongst individuals of Black Caribbean origin (here, ‘West Indian’) in the UK are explored. These patterns are compared with those in the Caribbean. Census data in both countries is used in the analysis, and differences by age group are examined.

The results show that there are clearly two groups in the Caribbean-origin population: the older migrant one and their descendants, and they have different marital and partnership behaviour. Owen also makes a distinction by birthplace; individuals born in the Caribbean but now living in the UK are more likely to be married than their same age counterparts born in the UK (there are, however, very small numbers of the latter). Comparison with some Caribbean islands (Jamaica, Barbados, Trinidad and Tobago) suggest that individuals in these Islands are less likely to be married than their counterparts living in the UK. Comparisons with the situation in the US are also drawn; the proportions of people married are higher than in their home countries. Analysis of changes in partnership (using data from the Family and Working Lives Study) depicts the growth of cohabitation amongst UK-born Caribbeans. Comparison of this group with the migrant generation indicates that marital and partnership behaviour is quite different between the two groups.

Plaza, D. (2000). Transnational grannies: the changing family responsibilities of elderly Caribbean-born women resident in Britain. Social Indicators Research 51, 75-105. Plaza describes the role and position of grandmothers in Caribbean families in Britain using data from the project ‘Living Arrangements, Family Structure and Social Change of Caribbeans in Britain’. He discusses Caribbean family life, describing, in particular, the special bond between mothers and children (especially sons) and the various roles that grandmothers play (before and after migration).

In the post-migration period, many Caribbean families found it hard to adjust to working life in the UK, with long hours and shift work common amongst the migrants. In addition, family life was difficult to maintain and the role of the grandparent was undermined by the ‘atomisation’ of the family unit. This had an effect on ideas about the role of a grandmother: ‘…Becoming accustomed to the British norms and values…when the third generation began to have their own children in the 1980s and 90s most did not see the importance of grandmothers…’ Plaza does point out that, for some respondents, grandmothers are still important, though in a modified role (for example, providing short-term childcare rather than ‘child shifting’ care). Plaza also describes the existence of ‘flying grannies’; grandmothers who spend part of their retirement visiting family in the US and Caribbean. He concludes that grandmothers provided invaluable assistance in an era when the Caribbean family was vulnerable to economic and
other disruptions, whereas in the modern British setting, assistance would be provided by the nuclear family or state.

**American Research**


A description of a case study that highlights the problems of reunification in families affected by migration. The case study is that of a Black Caribbean boy who, though reunited with his mother in the US, has problems adjusting to his new life. Jama Adams discusses the associated themes of gender relations and attitudes towards children and parenting and the (family-centred) therapeutic intervention is described. The cultural background against which Caribbean migration occurs is also described.


The authors' aim is to delineate the ‘dynamic dimensions’ of family structure in multi-generational African American households using data provided by respondents interviewed in a number of midwestern and northeastern US cities in the late 1980s and early 1990s. In all, over 120 individual respondents/families were interviewed, and all respondents came from poor backgrounds. The dimensions of family structure that emerged as important are: extended family networks; the socio-economic structure of the latter; the pace of change in family structure; and the age structure of the family. The interviews show that the existence of extended family networks is crucial in determining how single mothers cope against a backdrop of poverty, and that the economic resources of the extended families are often pooled.

The authors maintain that quantitative analyses of family structure fail to adequately capture the dynamics of the frequency of change in families, which their interviews illustrate so well. Finally, the members of the age-condensed family find it harder to establish their own roles vis-à-vis other family members. One respondent cited is a 35-year woman who began childbearing at age 13 (the fourth generation of her family to do so) and attributes poor parental authority to the small age distance between generations.


Data from a study based in the San Francisco Bay area is used to explore family structure and functioning amongst 58 older Black men. Details of respondents were taken from voting rolls. The study is guided by three themes: the differences between Black men and women in roles and degree of integration; secondly, men’s perception of their roles and nature and qualities of relationships; and, thirdly, the allocation of resources to older males in the family.

The study is explicitly generational, though respondents are referred to simply as ‘Black’ and there is no reference to Caribbean ethnicity. The results of the study indicate that older Black males are not isolated compared with women, and that they are significantly more likely to be married and to be living with others compared with women. No significant findings are reported for the other dimensions of family functioning. There are also no significant gender differences in family participation. Differences emerge in relation to the second research question: men’s perceptions of their roles within the family. Males in this study benefit from marriage, had good relationships with children leaving nearby (and weaker ones with children living further away) and closer relationships.
with sons than daughters. The author reports that there are few loners in the study; if men had weak blood family ties, they benefited from the support of fictive and semi-fictive kin (i.e. distantly related or unrelated individuals, maybe friends, who offer assistance and support as if they are family).

In relation to the last research question, that pertaining to the availability of resources to older family members, Johnson concludes that, although the parent-child bond is often the strongest, that bond cannot be depended upon to lead to an ‘active kinship network’. The strength of collateral bonds (e.g. between siblings) makes up for deficiencies in generational bonds, and some males construct their own kinship networks out of more distant kin and friends. In conclusion, Johnson emphasises the need to examine sibling as well as parent-child relationships.


The focus of this book is the African American family, and West Indian or Caribbean families are referred to only briefly. The theme is generational, however, with the first part of the book in particular making use of historical studies of the African American family. In one chapter (by Sudarkasa) the roots of the present-day Black family back to West Africa are traced, and the author maintains that West African family forms are multi-generational; the disintegration of which in contemporary Black families is a source of many problems. In another chapter, Glick focuses on the changing demography of African American families over time (1970-1992). McAdoo’s chapter is devoted to an analysis of mobility across generations and she examines economic, educational and geographical mobility. She concludes that the continuation of middle-class Black upward mobility requires the support of the extended family. Other sections of the book examine socialisation within the family, gender relations and family policies.


An exploration of parenting knowledge across the generations. Data were collected from questionnaires administered to 110 low-income, Black families in the metropolitan southeast US. Families with, and without, a teenage parent present were compared. The two questionnaires used were designed to measure aspects of knowledge about the development of children. The results indicate that grandmothers are more knowledgeable than their daughters about aspects of infant development, though they were less aware of environmental influences on development. Teenage daughters in the sample became more knowledgeable if they had assumed parenting responsibilities.

4.3) Other Determinants of Health

British Research


Berthoud presents the findings from an analysis of the labour force experiences of young Caribbean men in the UK (he uses the census ethnic categories of ‘Black Caribbean’ and ‘Black Other’ as simply ‘Caribbean’ here). Labour Force Survey (LFS) data was used, and comparisons were made generationally (between older and younger Black men), between ethnic groups (young Blacks and young Whites) and between men and women. Three areas were examined: education, family structure and the labour market. Data on other ethnic groups was used in the analysis, but the focus was on young Caribbeans and on the second generation (n=2,780).
The analysis indicates that, despite high ‘staying on’ rates after age 16, young Black Caribbean men suffer educational disadvantage, in that they take longer to gain the same qualifications as young Whites (though other groups took even longer) and are less likely to gain degrees than Whites. In relation to family structure and partnership behaviour, the analysis confirms the existence of very high rates of single parenthood and low marriage rates in the Caribbean community (and the difference between the migrant and the second generation; the latter are more likely to experience higher rates of single parenthood than the former). Berthoud indicates there are increasing numbers of unattached men amongst Caribbean-origin individuals. The high incidence of mixed race relationships is also noted.

Berthoud’s analysis of Black Caribbean men’s labour market experience shows that they suffer from high rates of unemployment, which is at its highest in the teen years and declines thereafter. Amongst young Black Caribbean men, those who migrated after the age of 16 are less likely to be unemployed than their UK-born counterparts (which is the opposite situation to that found amongst other ethnic groups). Young Black Caribbean men who live alone are especially vulnerable to unemployment. Berthoud indicates that education and local rates of unemployment are important factors in determining a young Black Caribbean man’s chance of employment. The lesser earning power of young Black Caribbean compared with White men is noted; this difference persists after controls.

In conclusion, the author maintains that the educational profile of young Caribbean males is similar to their White counterparts, but that polarisation within the Black community is important in explaining variations amongst Blacks. Berthoud indicates that a substantial minority of Blacks (17% of young men) have no education, job or family: ‘Thus, there is a relatively large group of Caribbean men with so few social commitments that they must be at risk of…alienation and resentment…’


Heath and colleagues’ analysis of the 1991 census and the Labour Force Survey (LFS) focuses on the relationship between educational attainment and occupation amongst British ethnic minorities, and makes a distinction by generational status. The authors remark that some work has shown that the second generation still suffers from similar levels of disadvantage as the first generation. The results of analysis of the LFS indicate that there is less educational polarisation amongst the second generation, including Black Caribbeans. The results of the logistic regression indicate that unemployment is still problematic for the second generation but that there is less of an ‘ethnic penalty’ in relation to access to managerial and higher posts.


The authors look specifically at employment and earnings differentials by place of birth amongst ethnic minorities and use census data from 1991 and the Labour Force Survey (LFS). They examine the influence of background variables on unemployment, and then data on each ethnic group is subjected to a separate logit equation.

The analysis indicates that employment rates are higher amongst Black Caribbean individuals when women are considered, highlighting the high rates of economic activity amongst women in this group. Comparing the employment of foreign-born versus UK-born ethnic minorities, the
analysis reveals that the former are worse off, though most of this may be attributable to the personal characteristics of the group (such as poorer education). Age and marital status stand out as important; UK-born ethnic minorities are likely to be single and young which are risk factors for unemployment. The analysis of earnings shows that (once a number of factors including qualifications, marital status and health are held constant) the picture is more optimistic than that presented in relation to unemployment. The authors conclude that, despite higher unemployment amongst UK-born ethnic minorities, they have better earnings prospects.

Model examines the economic well-being (unemployment, Goldthorpe class and occupation) of immigrants and their children using the Sample of Anonymised Records (SARs) from the 1991 census. The Black Caribbean foreign-born group include ‘Black Others’ as well as Black Caribbeans.

The initial results indicate that some non-White groups (such as Indians and the Chinese) perform better than UK-born Whites. Success (as measured by occupation, earnings etc.) is highly dependent on educational attainment. The occupational levels of women in the sample varies by ethnicity and birthplace: foreign-born Black Caribbean women have better occupational outcomes than Indian-born women, whilst UK-born White women fare less well than UK-born Black Africans and UK-born Indians. When age, education, marital status and region are held constant in the analysis, UK-born White males rank ahead of all foreign-born men in terms of being the least likely group to be unemployed. In terms of class position (Goldthorpe), Black Caribbeans rank lower than African and other Indians. However, UK-born Black Caribbeans have higher class positions than their foreign-born Black Caribbean counterparts.

The author discusses the occupational success of foreign-born Black Caribbean women in relation to foreign-born Indian women, which she considers may be attributable to different marriage patterns. Foreign-born Black Caribbean women are more likely to be household heads and breadwinners and this may promote their occupational success (though this theory does not hold for foreign-born Black African women). In conclusion, Model highlights a number of issues. One is the existence of large differences in the economic situation of ethnic minorities after human capital factors are controlled (from this perspective, Black Caribbean women are ‘more successful than they appear’ given their personal profile).

The author describes the findings from a small-scale project of the educational experiences of children of Black Caribbean heritage. The children in the study were almost all third generation, UK-born Caribbean children, and the offspring of parents who had been through the British educational system. The study also explored generational relationships, in this case, in relation to education. Data were collected by interview and observation from a sample of parents residing in a metropolitan authority. No tabular information is provided on the demographic or other characteristics of the parents and/or children in the study (n=16), though most families are single parent families. The results indicate that all the parents of Black Caribbean heritage children value education and that there are a variety of strategies that parents use to promote educational success. Differences emerge in relation to the activities and behaviours that parents use to promote achievement, with some parents having greater time and energy to actively assist their children. The author concludes that in about half of the cases, parental involvement benefits children. The study is limited by a small sample and is largely exploratory; generalisations cannot be made on the basis of the findings here.
American Research

Kalmijn examines differences in occupation and earnings between Caribbean migrants to the US (who are regarded as a ‘Black success story’ and constitute about 6% of the Black population) and US-born Blacks using 1990 census data. He also looks at generational differences and makes a distinction between Caribbeans who have English as a first language and Caribbeans who have French or Spanish as a first language.

The analysis indicates that English-speaking Black Caribbeans have higher incomes than other Black groups. Regression models are used to control for background factors, such as education and marital status and indicate that *all* Black Caribbean men are more likely to be married than US-born Blacks. Kalmijn concludes that Black Caribbeans generally fare better than US-born Blacks, though this differs by linguistic group. English-speaking Black Caribbeans (first and second generations) do better than US-born Blacks, though not as well as Whites. Second generation Black Caribbeans generally have higher earnings and occupational status than their Caribbean-born parents. This extends to French and Spanish-speaking Caribbeans (though the first generation do less well than US-born Blacks). The author hypothesises that earnings and occupation differentials may be attributable to the reasons for migration; English-speaking Black Caribbeans tend to migrate for economic reasons whereas Spanish-speaking Caribbeans (such as Haitians) migrate for political reasons.

Model examines socio-economic differences between native-born and foreign-born Black Caribbeans in the USA, France, Canada and the UK. Four labour market outcomes were measured using census data, these were: labour force participation, unemployment, occupational status and earnings. The authors hypothesised that Black Caribbeans living in France will be the most fortunate group in relation to their White counterparts. Gender differences were also examined.

The results indicate there is little real difference between the four groups in their socio-economic status after controls are introduced into the analysis. The study contains a discussion of the possible socio-economic scenarios for foreign-born Blacks in the four countries. The authors draw on a number of theories that discuss the outcomes for migrants in their country of destination. France is believed to offer the best for its migrants for a number of reasons: Black Caribbeans in France are French citizens, with all that that implies (they are thus citizens of the ‘Republic’ in French eyes), they are French-speaking and their educational qualifications are comparable to those found in France (Black Caribbeans in France are mostly from the Antilles). The authors acknowledge the shortcomings of the study, not least of which is the problem of cross-national data comparison (the British data on income is not available) and identification of the relevant population groups. Education and length of migration are also not sufficiently controlled for.

The author compares labour force behaviour and outcomes for three Black populations: African Americans, Africans and Black Caribbeans. Data from the 1990 US census were used (Public Use Micro Sample) and the population under examination were all Black males aged 25-64
born in Africa or the Caribbean, with a random selection of US-born Black males (n=27, 856). Data were available on period of migration.

Initial results suggest that African-born males have the highest levels of work, followed by Black Caribbean immigrants then US-born Blacks. Multivariate analysis alters this pattern, with Black Caribbeans on par with Africans (and US-born Blacks behind both groups). The author suggests that income differences rather than motivation explain the differences in work-related behaviour.


Waters presents the findings of a qualitative study of the lives of English-speaking, Black Caribbean immigrants and their children in New York. Other people interviewed included the co-workers of immigrants and employers. The research also entailed some participant observation. In total, 59 interviews with migrants, 27 with Black Americans, 25 with White Americans, six with co-workers of various ethnicities and 83 children of immigrants were conducted (202 life history interviews).

The study revolves around a number of themes; migrant identity (especially 'island identity'), the identity and well-being of the children of migrants and the experience of discrimination. Waters reports that many Black Caribbeans are keen to distance themselves from Black Americans, who they often consider lazy and unreliable. Black Caribbean economic and occupational success is discussed, and the views of co-workers and employers towards the migrants are outlined (the latter often spoke highly of Black Caribbeans' work ethic). Intergenerational dynamics are discussed in some detail and theories of immigrant adaptation are outlined. Separation from parents, childcare, different codes of child discipline and a culture of long hours are all problems that the migrants have to deal with.

In conclusion, Waters makes a distinction between middle class Black Caribbeans, who are likely to have a strong West Indian identity, and poorer Black Caribbeans, who may see little difference between themselves and African Americans. This is related to the kind of environments (physical and cultural) that middle class Caribbeans live in. Waters also discusses the concept of Black Caribbeans as a 'model minority' in relation to African Americans, which in part in attributable to their 'easygoing' relations with Whites. She also points out, however, that the effects of structural deprivation and racism will affect the second generation.


The author examines the performance of US-born Black Caribbeans (here referred to as 'West Indians') in the US labour market and compares this with the experience of US-born Afro-American Blacks and Whites. The analysis of the 1980 US Census indicates that Black West Indian males have the highest occupational earnings compared with other Black minority groups. The key question here is whether the favourable situation of men of Black West Indian ancestry is simply the result of returns from schooling (this population have high rates of education compared with other Black ancestry populations) or not. Are there, for example, other 'cultural' factors that account for the differences between US-born Black Caribbeans and other Blacks in the US?

Woodbury uses a human capital earnings function to analyse the data. The results indicate that Black men with West Indian ancestry have earnings that are 8% higher than African Americans when a number of variables are controlled for (schooling, labour market experience, location, health and marital status). Woodbury concludes that some other factor must be
responsible for the better economic situation of US-born Black West Indian men. The author also compares the situation of Black US-born men of West Indian ancestry with US-born Whites. Although Black West Indian men perform better than other US-born Blacks, their earnings are still 19% below that of Whites (which is the smallest earnings gap between Whites and any Black group) and this difference in earnings cannot be explained by observable characteristics (such as education, age etc.). This would suggest that discrimination is affecting the earnings potential of Black West Indian men. Woodbury maintains that if the other Black groups examined here adopted the ‘cultural attributes’ of West Indians they would see only marginal benefits from it.

Overall, he concludes that the results show a ‘mixed picture of success’ and that the large earnings gap between Black men of West Indian ancestry and US-born Whites may indicate that economic success is not being transmitted generationally and that West Indian Blacks have assimilated with other Black groups and lost their earlier advantages.


Woodbury tests the belief that cultural differences (or some difference in ‘unobserved human capital’) might be the reason for the poorer earnings of Blacks in the US by analysing US Census data on the earnings of US-born versus foreign-born Blacks (noting that foreign-born Whites often attain parity or excel in their earnings in relation to US-born Whites).

The results indicate that the earnings of foreign-born Blacks varies according to whether English is their first language or not and length of time in the US. The earnings of Black English-speaking migrants who have been in the US for at least 10 years are about the same as US-born Blacks, whereas foreign-born Blacks who speak English as a second language have lower earnings than US-born Blacks. The position of Black immigrants vis-à-vis other immigrant groups is poorer, possibly because of discrimination, and they have poorer returns to education (that is, their occupational attainment is not commensurate with their educational attainment). Woodbury argues that these findings cannot be explained by reference to cultural differences and discrimination may be a factor.

Canadian Research


This study, using 1991 census data, examines the differences between Canadian ethnic minorities in education, income, occupation and socio-economic status. A distinction was made between visible and invisible minorities; Blacks as well as groups such as the Chinese and Filipinos fell into the former category. The authors analysed outcomes for minorities by birthplace and age at immigration, as well as period of immigration.

Immigration status is found to be detrimental for all visible minorities. The results of the logistic regression show that Blacks, as well as South Asians, suffer most from lower attainment. The two main conclusions that are drawn are that the integration processes for visible minorities are different from those for invisible minorities (such as Italians and Poles) and that there is still socio-economic variation by ethnicity.

This item is a conference paper that describes the initial (and highly preliminary) findings of a pilot study designed to explore socio-economic mobility amongst Black Caribbeans (here described as simply ‘Caribbean’) in Canada. Data were collected by: analysis of census data; a literature review; one-to-one interviews with 30 young Caribbean men and a survey of male and female Caribbeans. The authors describe the situation of Caribbeans in Canada, and include details of place of birth, occupation, education, etc. Initial results indicate that many respondents believe that they had experienced downward social mobility. Many respondents also mentioned the negative effects of racism on their lives. Most respondents believed that Caribbeans had contributed a lot to Canada.


The authors examine educational attainment and the intergenerational transmission of human capital in Canadian ethnic minorities. Data from the Canadian census from 1986 and 1991 were pooled for the purposes of analysis, and data from 1971 were used to estimate the characteristics of the preceding generation. Black Caribbeans were identified in the data, and the analysis was restricted to second and later generation migrants.

The results show that Black Caribbean individuals have above-average years of education and very high returns to education yet low wages, a finding that has been observed elsewhere (see Woodbury, 1993 above). The fertility of the previous generation is also examined (the assumption being that success in one generation is correlated with lower fertility in the previous, given the cost of investing in larger families) and the results suggest this might be the case. Intergenerational analysis of mobility in the different ethnic groups shows that this varies by gender. No additional information is supplied for Black Caribbeans.