Parenting Behavior, Health, and Cognitive Development among Children in Black Immigrant Families:

Comparing the United States and the United Kingdom

Margot Jackson

A project of the Migration Policy Institute's National Center on Immigrant Integration Policy

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For more on the Young Children in Black Immigrant Families Research Initiative, please visit: www.migrationpolicy.org/cbi.

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Executive Summary

As children with immigrant parents make up an increasingly significant share of Black children, it is important to examine whether their development parallels that of their Black peers in native-born families, or whether it is more similar to that of children in other immigrant families. In addition, it is useful to compare children in the United States to those in the United Kingdom, where there is a large Black immigrant population but a notably different policy context of reception. Using data from two national samples that include Black African and Caribbean mothers in the United States and the United Kingdom, this report examines parenting behaviors that might affect children's early health and cognitive development (from birth to age 5), as well as later health and cognitive outcomes.

The largly similar direction and magnitude of parenting and development patterns among Black children in immigrant families across the countries is notable.

In both countries, there is evidence of favorable breastfeeding patterns among Black immigrant mothers, and high usage of early prenatal care among all mothers. Black immigrant mothers' healthy prenatal behavior is paralleled by the healthy birth weight of their children and, in the United Kingdom, by these children's lower asthma risk at age 5. However, Black children have weaker verbal development and, in the United Kingdom, this disadvantage is particularly pronounced among children whose mothers are immigrants. The largely similar direction and magnitude of parenting and development patterns among Black children in immigrant families across the two countries is notable — numerous differences in policies related to immigration, health care, governmental support for new parents, and social services would suggest substantial cross-country variation. These analyses provide a first and necessary step toward understanding what underlies the relative advantages and disadvantages experienced by Black immigrant families. The findings suggest that the development of children in Black immigrant families exhibits both favorable and disadvantaged patterns, as do these children's social integration in their host societies.

I. Introduction

In the United States, racial disparities in child development are striking, with a particularly pronounced disadvantage among Black children. They are more likely than both their white and nonwhite peers to be born with a low birth weight, to have asthma and other chronic physical health conditions, to demonstrate symptoms of certain behavioral disorders such as attention deficit hyperactivity disorder (ADHD), and to be overweight or obese.[1] There are also strong racial disparities in school readiness and academic achievement, with Black children demonstrating weaker cognitive development and academic achievement in early childhood and during the school years.[2] In fact, some research suggests that part of the racial disparity in academic performance may be driven by disparities in health.[3]

Racial inequalities in health and cognitive development are more ambiguous among children in immigrant families, who often experience more favorable developmental outcomes than would be expected on the basis of their families' socioeconomic resources.[4] Most research on the development of children in immigrant families has focused on Latin American and Asian populations, who comprise the majority of US immigrants. Yet a sharp increase in the number of Black immigrant families in the United States in recent decades — 11 percent of Black children in the United States are the children of immigrants — makes it important to measure race in a more complex way that accounts for many families' recent immigration histories.

A primary goal of this report is to compare children in the United States to those in the United Kingdom, where there is a large Black immigrant population (about 22 percent of foreign-born adults and 12 percent of children in immigrant families) but a notably different context with respect to immigration policy, health care, and social welfare provision. Existing research using UK data has established racial disparities in children's health and academic achievement, with Black children experiencing poorer health and academic achievement than their peers in other racial and ethnic groups.[5] Research examining children with immigrant parents, however — especially children in Black immigrant families — has been largely limited until recently because of a lack of survey data allowing for the identification of these children.

Using data from national samples in the United States and the United Kingdom that include Black African and Caribbean mothers, this report examines parental behaviors that might affect children's early health and cognitive development (from birth to age 5), as well as later health and cognitive outcomes. Concern for the welfare of young children in immigrant families is motivated by several factors, including recent evidence of the enduring impact of early environments on children's brain

1 Janet Currie, "Health Disparities and Gaps in School Readiness," *Future of Children* 15 (2005): 117–38; Michael C. Lu and Neil Halfon, "Racial and Ethnic Disparities in Birth Outcomes: A Life-Course Perspective," *Maternal and Child Health Journal* 7 (2003): 13–30; Marla McDaniel, Christina Paxson, and Jane Waldfogel, "Racial Disparities in Childhood Asthma in the United States: Evidence from the National Health Interview Survey, 1997 to 2003," *Pediatrics* 117 (May 2006): e868–77.

2 Charles T. Clotfelter, Helen F. Ladd, and Jacob L. Vigdor, "The Academic Achievement Gap in Grades 3 to 8," *Review of Economics and Statistics* 91 (2009): 398–419; Christopher Jencks and Meredith P. Phillips, eds., *The Black-White Test Score Gap* (Washington, DC: Brookings Institution, 1998).

3 Currie, "Health Disparities and Gaps in School Readiness."

4 Ana Abraido-Lanza, Maria T. Chao, and Karen R. Florez, "Do Healthy Behaviors Decline with Greater Acculturation? Implications for the Latino Mortality Paradox," *Social Science and Medicine* 61(6) (2006): 1243-255.

5 Lorraine Dearden and Luke Sibieta, "Ethnic Inequalities in Child Outcomes," in *Children of the 21st Century (Volume 2): The First Five Years*, eds., Kirstine Hansen, Heather Joshi, and Shirley Dex (Bristol, UK: Policy Press, 2010), 169–85; Yvonne Kelly, Amanda Sacker, Ron Gray, John Kelly, Dieter Wolke, and Maria A. Quigley, "Light Drinking in Pregnancy, a Risk for Behavioural Problems and Cognitive Deficits at 3 Years of Age?" *International Journal of Epidemiology* 38(1) (2009): 129-40; Julien O. Teitler, Nancy E. Reichman, Lenna Nepomnyaschy, and Melissa Martinson, "A Cross-National Comparison of Racial and Ethnic Disparities in Low Birth Weight in the United States and England," *Pediatrics* 120 (November 2007): e1182.

development[6] and well-being into adulthood.[7] An important part of this investigation is its cross-national focus, which offers insight into Black immigrant families' integration in both the United States and the United Kingdom, where varying policy structures may create differences in the context of reception.

II. Background

A. Racial Differences in Children's Health and Cognitive Development

There is a strong correlation between socioeconomic status and health in many industrialized nations: the higher the education and income, the better the health.[8] While much of the work on this connection has centered on adults, a growing body of research suggests that it also exists among children.[9] The lower socioeconomic status of many racial and ethnic minorities, on average, is an important reason why Black children are more likely to be in poorer health than their non-Black peers. However, abundant evidence documents poorer health among Black children, even after accounting for differences in socioeconomic resources. At all age groups and socioeconomic levels, for example, Black children are more likely to be obese or overweight than non-Latino whites.[10] Life expectancy at birth is generally about six years lower for Blacks than for whites, at 72 years versus 78 years, respectively.[11] Black children are also more likely than whites to have low birth weight and to struggle with asthma, ADHD, nutrient deficiencies, impaired glucose tolerance predictive of diabetes, and even elevated blood pressure and higher total cholesterol.[12] Thus, on several key health indicators, Black children fare worse than white children in the United States.

Abundant evidence documents poorer health among Black children, even after accounting for differences in socioeconomic resources.

6 Eric I. Knudsen, "Sensitive Periods in the Development of the Brain and Behavior," *Journal of Cognitive Neuroscience* 16 (2004): 1412–25.

7 Margot I. Jackson, "A Life Course Perspective on Child Health, Cognition and Occupational Skill Qualifications in Adulthood: Evidence from a British Cohort," *Social Forces* 89 (2010): 89–116; Ingrid Schoon, John Bynner, Heather Joshi, Samantha Parsons, Richard D. Wiggins, and Amanda Sacker, "The Influence of Context, Timing, and Duration of Risk Experiences for the Passage from Childhood to Mid-adulthood," *Child Development* 73 (2002): 1486–504.

8 Michael G. Marmot, G. Davey Smith, S. Stansfeld, C. Patel, F. North, J. Head, I. White, Eric J. Brunner, and A. Feeney, "Health Inequalities among British Civil Servants: The Whitehall II Study," *Lancet* 337 (1991): 1387–93; Scott M. Lynch, "Cohort and Life-Course Patterns in the Relationship between Education and Health: A Hierarchical Approach," *Demography* 40 (2003): 309-31; James P. Smith, "The Impact of Socioeconomic Status on Health over the Life-Course," *Journal of Human Resources* XLII (2007): 739–64.

9 Anne Case, Darren Lubotsky, and Christina Paxson, "Economic Status and Health in Childhood: The Origins of the Gradient," *American Economic Review* 92 (2002): 1308–34; Brian K. Finch, "Early Origins of the Gradient: The Relationship between Socioeconomic Status and Infant Mortality in the United States," *Demography* 40 (2003): 675–99.

10 National Center for Health Statistics, *Health, United States, 2004, with Chartbook on Trends in the Health of Americans* (Hyattsville, MD: National Center for Health Statistics, 2004), 241–45.

11 Ibid., 143.

12 Currie, "Health Disparities and Gaps in School Readiness;" Lu and Halfon, "Racial and Ethnic Disparities in Birth Outcomes;" McDaniel, Paxson, and Waldfogel, "Racial Disparities in Childhood Asthma in the United States;" National Center for Health Statistics, *Health, United States, 2004, with Chartbook on Trends in the Health of Americans.*

Disparities in cognitive development between Blacks and their non-Black peers are equally pronounced. Black children do not perform as well as their non-Black peers on assessments of cognitive development and academic achievement in early childhood and during the school years.[13] Some, but not all, of the disparity between Black children and their peers is explained by differences in parents' socioeconomic resources.[14] There is also evidence that the Black achievement disadvantage is particularly persistent as children age, compared to other groups.

Charles Clotfelter, Helen Ladd, and Jacob Vigdor[15] find consistently lower performance among Black students between grades three to eight, compared to declining achievement gaps between Latinos and Asians as compared to non-Latino whites. Though the bodies of research on racial disparities in child health and academic achievement rarely overlap, there is some speculation that racial inequalities in children's health may explain part of the strong racial disparity in academic performance.[16]

B. *The Complicating Role of Immigration*

Relative disadvantage in child health and academic achievement is much less pronounced among Latinos and Asians, the other two large ethnic and racial minority groups in the United States. In fact, despite their greater likelihood of social and economic disadvantage, Latinos exhibit the "Latino paradox"— that is, they experience lower rates of many diseases than non-Latino whites, lower rates of infant mortality, and higher life expectancy.[17] In trying to understand this pattern, it is important to consider the role of immigration. A large body of research, carried out mostly in the United States, documents an immigrant advantage in mothers' health behaviors and in children's birth outcomes. This research shows that foreign-born mothers are more likely than native-born mothers to fully immunize and breastfeed their children,[18] less likely to smoke and drink during pregnancy,[19] and less likely to have babies with a low birth weight.[20]

Evidence of academic achievement is more mixed, with both relative advantage and disadvantage in cognitive development documented among children with foreign-born parents, depending on the population and age group examined. While some research exposes an immigrant advantage in parenting behaviors related to analytic and verbal development among Filipino, Chinese, Mexican, and Central and South American youth in immigrant families,[21] other studies find a disadvantage in the cognitive

13 Jencks and Phillips, *The Black-White Test Score Gap.*

14 Roland G. Fryer and Steven D. Levitt, "The Black-White Test Score Gap through Third Grade," *American Law and Economics Review* 8 (2006): 249–81; Richard J. Murnane, John B. Willett, Kristen L. Bub, Kathleen McCartney, Eric Hanushek, and Rebecca Maynard, "Understanding Trends in the Black-White Achievement Gaps during the First Years of School [with Comments]," *Brookings-Wharton Papers on Urban Affairs* (2006): 97–135.

15 Clotfelter, Ladd, and Vigdor, "The Academic Achievement Gap in Grades 3 to 8."

16 Currie, "Health Disparities and Gaps in School Readiness."

17 Ana F. Abraido-Lanza, Bruce P. Dohrenwend, Daisy S. Ng-Mak, and J. Blake Turner, "The Latino Mortality Paradox: A Test of the Salmon Bias and Healthy Migrant Hypotheses," *American Journal of Public Health* 89 (1999): 1543–48, www.ncbi.nlm.nih.gov/pmc/articles/PMC1508801/4pdf; Nancy S. Landale, R. S. Oropesa, and Bridget K. Gorman, "Migration and Infant Death: Assimilation or Selective Migration among Puerto Ricans?" *American Sociological Review* 65 (2000): 888–909.

18 Laurie M. Anderson, D. L. Wood, and Cathy D. Sherbourne, "Maternal Acculturation and Childhood Immunization Levels among Children in Latino Families in Los Angeles," *American Journal of Public Health* 87 (1997): 2018–21; Rachel T. Kimbro, Scott M. Lynch, and Sara McLanahan, "The Influence of Acculturation on Breastfeeding Initiation and Duration for Mexican-Americans," *Population Research and Policy Review* 27 (2008): 183.

19 Kim Harley and Brenda Eskenazi, "Time in the United States, Social Support and Health Behaviors during Pregnancy among Women of Mexican Descent," *Social Science and Medicine* 62 (2006): 3048–61; Landale, Oropesa, and Gorman, "Migration and Infant Death."

20 Robert A. Hummer, Monique Biegler, Peter B. D. Turk, Douglas Forbes, W. P. Frisbie, Ying Hong, and Starling G. Pullum, "Race/Ethnicity, Nativity, and Infant Mortality in the United States," *Social Forces* 77 (1999): 1083–117; Martha S. Wingate and Greg R. Alexander, "The Healthy Migrant Theory: Variations in Pregnancy Outcomes among US-Born Migrants," *Social Science and Medicine* 62 (2006): 491–98.

21 Andrew J. Fuligni, "The Academic Achievement of Adolescents from Immigrant Families: The Roles of Family Background, Attitudes, and Behavior," *Child Development* 68 (1997): 351–63; Andrew J. Fuligni, Vivian Tseng, and May Lam, "Attitudes

development of children in some of the same ethnic groups. In addition, some immigrant parents may be less likely to practice parenting behaviors rewarded by host-country educational norms, such as reading to children and participating in school activities.[22]

Relative disadvantage in child health and academic achievement is much less pronounced among Latinos and Asians.

C. Where Do Children in Black Immigrant Families Fit In?

As children with immigrant parents make up an increasingly significant share of Black children, it is useful to consider race alongside factors — such as parental nativity — that may strongly influence a child's development. In recent decades, the number of Black immigrant families in the United States has increased dramatically. While about 25 percent of US children have at least one foreign-born parent, 8 percent (about 1.3 million) of these children are Black, with the majority of parents born in African or Caribbean nations.[23] Between 2000 and 2008 alone, there was a 63 percent increase in the US African immigrant population.

Yet the majority of research on the development of children in immigrant families has focused on children with parents from Latin America and Asia, the two sending regions that account for the majority of US immigrants. As a result, it is difficult to know whether the development of Black children in immigrant families more closely resembles that of their Black peers with native-born parents, or whether they share the immigrant advantage observed among their peers in some other racial and ethnic groups. The small number of studies examining children in Black immigrant families has shown that these children are less likely to have a low birth weight[24] and asthma[25] than their peers in Black native families, but that they also perform more poorly than their white, Asian, and sometimes Latino peers on assessments of school readiness and academic performance in early childhood.[26] A slightly larger body of research on older youth and adults from Black immigrant families suggests that, despite any earlier performance disadvantage, they are ultimately more likely than their Black peers with native-born parents to attain finish high school and attend two- and four-year colleges.[27] These findings suggest that educational

toward Family Obligations among American Adolescents with Asian, Latin American, and European Backgrounds," *Child Development* 70 (1999): 1030–44; Tama Leventhal, Yange Xue, and Jeanne Brooks-Gunn, "Immigrant Differences in School-Age Children's Verbal Trajectories: A Look at Four Racial/Ethnic Groups," *Child Development* 77 (2006): 1359–74.

22 Robert Crosnoe, *Mexican Roots, American Schools: Helping Mexican Immigrant Children Succeed* (Stanford: Stanford University Press, 2006); Jennifer E. Glick, Littisha Bates, and Scott T. Yabiku, "Mother's Age at Arrival in the United States and Early Cognitive Development," *Early Childhood Research Quarterly* 24 (2009): 367–80.

23 Karina Fortuny and Ajay Chaudry, "Children of Immigrants: Immigration Trends" (Urban Institute Fact Sheet No. 1, Urban Institute, Washington, DC, October 2009): 1–5, www.urban.org/publications/901292.html.

24 James W. Collins, Shou-Yien Wu, and Richard J. David, "Differing Intergenerational Birth Weights among the Descendants of US-Born and Foreign-Born Whites and African Americans in Illinois," *American Journal of Epidemiology* 155 (2002): 210–16.

25 Doug Brugge, Mark Woodin, T. J. Schuch, Fatima L. Salas, Acheson Bennett, and Neal-Dra Osgood, "Community-Level Data Suggest that Asthma Prevalence Varies between U.S. and Foreign-Born Black Subpopulations," *Journal of Asthma* 45 (2008): 785–79.

26 Jessica J. De Feyter and Adam Winsler, "The Early Developmental Competencies and School Readiness of Low-Income, Immigrant Children: Influences of Generation, Race/Ethnicity, and National Origins," *Early Childhood Research Quarterly* 24 (2009): 411–31.

27 Philip Kasinitz, John Mollenkopf, Mary Waters, and Jennifer Holdaway, *Inheriting the City: The Children of Immigrants Come of Age* (New York: Russell Sage Foundation, 2008); Xue L. Rong and Frank Brown, "The Effects of Immigrant Generation and Ethnicity on Educational Attainment among Young African and Caribbean Blacks in the United States," *Harvard Educational Review* 71 (2001): 536–66; Kevin J. A. Thomas, "Parental Characteristics and the Schooling Progress of the Children of Im-

progress may occur with age.

Straight-line models of immigrant families' assimilation would predict a gradual decline in the health of immigrant families with increasing time in the host country, as they change their behaviors, language and cultural practices, social networks, and residential context.[28] In this framework of unhealthy acculturation, healthier outcomes among Black immigrant families would fade as immigrants increasingly resemble their native-born peers with comparable residential and socioeconomic conditions. Consistent with this hypothesis, most empirical evidence shows that health advantages are more pronounced among recent immigrants.[29] Studies that examine immigrant-native differences using longitudinal data, however, have not found evidence for convergence between immigrant and native-born youth as they age,[30] suggesting that the children of immigrants may retain some degree of health advantage over time.

Critics of straight-line depictions of assimilation argue that the integration of immigrant families may not be uniform, but may instead follow a degree of segmentation that varies according to parents' levels of education, the quality of children's schooling, the reasons for migration, and phenotype, among other factors.[31] This is particularly relevant for the Black immigrant population, which — regardless of country of origin — experiences a strong degree of residential segregation and racialization. Residential segregation between Blacks and other racial and ethnic groups remains high despite declines in recent decades.[32] Accompanying residential segregation is more restricted access to the highest-quality schools, to employment opportunities, and a closer proximity to health hazards.[33] Foreign-born Blacks, despite possessing greater educational and economic resources than their native-born Black peers, on average, often find it more difficult than their non-Black immigrant peers to avoid lower-resource neighborhoods and to escape racial discrimination.[34] Evidence of weaker academic performance among the children of Black immigrants, therefore, is consistent with "segmented" models of integration,[35] though more favorable educational outcomes later in adolescence suggest that youth may learn to offset a disadvantaged environment with support networks within their families and communities.[36]

migrant and U.S.-Born Blacks," *Demography* 46 (2009): 513–34.

28 E. Arcia, M. Skinner, D. Bailey, and Vivian Correa, "Models of Acculturation and Health Behaviors among Latino Immigrants to the US," *Social Science and Medicine* 53 (2001): 41–53; Milton M. Gordon, *Assimilation in American Life: The Role of Race, Religion, and National Origins* (New York: Oxford University Press, 1964); Maya D. Guendelman, Sapna Cheryan, and Benoît Monin, "Fitting In but Getting Fat: Identity Threat and Dietary Choices among U.S. Immigrants," *Psychological Science* 22(7) (2011): 959-67.

29 Harley and Eskenazi, "Time in the United States, Social Support and Health Behaviors;" Summer S. Hawkins, Kate Lamb, Tim J. Cole, Catherine Law, and the Millennium Cohort Study Child Health Group, "Influence of Moving to the UK on Maternal Health Behaviours: Prospective Cohort Study," *British Medical Journal* 336 (2008): 1052–55.

30 Kelly S. Balistreri and Jennifer Van Hook, "Socioeconomic Status and Body Mass Index among Hispanic Children of Immigrants and Children of Natives," *American Journal of Public Health* 99 (2009): 2238–46; Kathleen M. Harris, Krista M. Perreira, and Dohoon Lee, "Obesity in the Transition to Adulthood: Predictions across Race/Ethnicity, Immigrant Generation, and Sex," *Archives of Pediatrics Adolescent Medicine* 163 (2009): 1022–28; Margot Jackson, "Nativity Differences in Youths' Weight Trajectories: Foreign-Born Integration during the Transition to Adulthood," *Social Science Research* 40(5); 1419–33.

31 Richard Alba and Victor Nee, *Remaking the American Mainstream: Assimilation and Contemporary Immigration* (Cambridge: Harvard University Press, 2003); Min Zhou, "Segmented Assimilation: Issues, Controversies, and Recent Research on the New Second Generation," *International Migration Review* 31 (1997): 975–1008.

32 John R. Logan, Brian J. Stults, and Reynolds Farley, "Segregation of Minorities in the Metropolis: Two Decades of Change," *Demography* 41 (2004): 1–22; Domenico Parisi, Daniel T. Lichter, and Michael C. Taquino, "Multi-Scale Residential Segregation: Black Exceptionalism and America's Changing Color Line," *Social Forces* 89 (2011): 829–52; Rima Wilkes and John Iceland, "Hypersegregation in the Twenty-First Century," *Demography* 41 (2004): 23–36.

33 Ted Mouw, "Job Relocation and the Racial Gap in Unemployment in Detroit and Chicago, 1980 to 1990," *American Sociological Review* 65 (2000): 730–53; David R. Williams and Chiquita Collins, "Racial Residential Segregation: A Fundamental Cause of Racial Disparities in Health," *Public Health Reports* 116 (2001): 404–16.

34 John Iceland and Melissa Scopilliti, "Immigrant Residential Segregation in U.S. Metropolitan Areas, 1990–2000," *Demography* 45 (2008): 79–94; Kasinitz et al., *Inheriting the City*.

35 De Feyter and Winsler, "The Early Developmental Competencies and School Readiness of Low-Income, Immigrant Children."

36 Kasinitz et al., *Inheriting the City*.

D. A Cross-National Consideration

For the most part, research on nativity-based inequalities in child development has been conducted in the United States. This study examines the United States alongside the United Kingdom, which provides a useful comparison for two important reasons.

First, the comparison permits examination of nativity differences in a country with a history of receiving immigrants and a Black foreign-born population comparable to the United States. In 2009 British statistics showed that 11 percent of the population was foreign born; in the same year, 25 percent of children and adolescents were either foreign born or had at least one foreign-born parent.[37] About 22 percent of foreign-born UK adults were born in either the Caribbean (5 percent) or Africa (17 percent). Among immigrants overall, 12 percent self-identified as Black[38] — largely from Africa and the Caribbean — and about 12 percent of the children of immigrants between ages 0 and 18 were Black. In the United States, 23 percent of young children (birth through age 17) have at least one foreign-born parent, and about 8 percent of these children are Black.[39]

A second motivation for extending analysis to the United Kingdom is that existing alongside Black immigrant populations of comparable proportions are notably different health care and social welfare systems, which provide a different context of reception for immigrants and their children. The United Kingdom provides more universal health services than the United States, including health care through the British National Health Service, home visits for new mothers, priority in scheduling medical appointments for children, and child centers with integrated child-care services. Welfare-state policies in the United Kingdom are also more generous than those in the United States with respect to family cash assistance, social housing, and child care.[40] By contrast, the United States provides cash and housing assistance to few low-income families, has a hybrid system of public and private insurance that leaves many low-income children without access to health care, and lacks universal child care except for 3- and 4-year-olds in a handful of states. The multitude of policy differences between the two countries could produce cross-national variation in the integration of the children of Black immigrants. While evidence of similar patterns across countries would be noteworthy, it is difficult to attribute any differences to a particular source.

Despite the established body of research on UK migrant integration,[41] research examining children with immigrant parents has been largely limited because survey data allowing for the identification of these children have only recently become available.[42] Existing research using UK data has established sizeable ethnic disparities in children's health and academic achievement. For example, Black children in families of African or Caribbean descent (without separating children by generational groups) are more likely to have a low birth weight[43] but more likely to be breastfed[44] than white children. Black African and

37 British Office for National Statistics, *Migration Statistics 2008*, Annual Report (Newport, South Wales: United Kingdom Office of National Statistics, 2009).

38 Michael Rendall and John Salt, "The Foreign-Born Population," in *Focus on People and Migration: 2005,* ed., Roma Chappell (London: Palgrave Macmillan, 2005), 132–51.

39 Fortuny and Chaudry, "Children of Immigrants."

40 Janet C. Gornick and Marcia K. Meyers, *Families that Work: Policies for Reconciling Parenthood and Employment* (New York: Russell Sage Foundation, 2005); John Hills, "Ends and Means: The Future Roles of Social Housing in England," *Centre for Analysis of Social Exclusion Report* 34, 2007. London: London School of Economics. http://sticerd.lse.ac.uk/dps/case/cr/CASEreport34.pdf.

41 Michael Marmot, "Changing Places, Changing Risks: The Study of Migrants," *Public Health Reviews* 21 (1993): 185–95.

42 Hawkins et al., "Influence of Moving to the UK on Maternal Health Behaviours;" Lidia Panico, Mel Bartley, Michael Marmot, James Y. Nazroo, Amanda Sacker, and Yvonne J. Kelly, "Ethnic Variation in Childhood Asthma and Wheezing Illnesses: Findings from the Millennium Cohort Study," *International Journal of Epidemiology* 36(5) (2007): 1093-1102.

43 Kelly et al., "Light Drinking in Pregnancy;" Teitler et al., "A Cross-National Comparison of Racial and Ethnic Disparities."

44 Lucy J. Griffiths, A. R. Tate, Carol Dezateux, and the Millennium Cohort Study Child Health Group, "The Contribution of Parental and Community Ethnicity to Breastfeeding Practices: Evidence from the Millennium Cohort Study," *International Journal of Epidemiology* 34 (December 2005): 1378–86.

Caribbean children (again, not separating by generation) also perform more poorly than white children on cognitive assessments.[45]

III. Data

The scarcity of research on children in Black immigrant families can be attributed to the historically small size of this population (which has grown only recently, albeit rapidly). As a result, survey data meant to be representative of the national population have often not included enough children born to Black immigrants to be analyzed as a distinct group.

Data for this research come from the *US Fragile Families and Child Wellbeing Study* (FFS) and the UK *Millennium Cohort Study* (MCS). Both studies represent national populations, contain rich longitudinal information on families' and children's health, and oversample racial and ethnic minority families.

The FFS follows approximately 5,000 children born in large US cities between 1998 and 2000, including a large oversample of children born to unmarried parents. When weighted, these data are representative of births in cities with populations over 200,000. Mothers, and most fathers, were interviewed in the hospital soon after birth, with additional interviews at ages 1, 3, and 5; ninth-year interview data are forthcoming. The MCS is the fourth of Britain's national birth cohort studies. The first wave (2001-02) included 18,818 UK children (in 18,552 families) born between September 2000 and January 2002. Information was first collected from parents when the children were 9 months old, with follow-up interviews with the main caregiver (usually the mother) at ages 3, 5, and 7. Data here are used through age 5 to maximize comparability with the FFS. The sample design included an overrepresentation of families living in areas with high proportions of child poverty or ethnic minority populations.

IV. Measures and Descriptive Findings

A. Nativity, Race, and Ethnicity

Because the FFS and MCS are samples of children born in US and UK hospitals, respectively, they exclude first-generation children — those born outside these countries. This leaves samples of second-generation children (those born in either the United States or United Kingdom with at least one immigrant parent) and of third-generation children (those with parents born in the United States or United Kingdom). In both samples, mothers identify both their region of birth and their race, making identification of Black children of immigrants and Black children of natives possible.

In the United States, this report distinguishes among Black, non-Black Hispanic, and non-Black non-Hispanic foreign-born mothers.[46] In the United Kingdom, it distinguishes among Black (African or Caribbean), South Asian (Indian, Pakistani, Bangladeshi), white, and other foreign-born mothers. Statistical tests that permit comparison between subgroups (Wald and likelihood ratio tests) indicate that Black Africans and Caribbeans in the British sample do not significantly differ in their relationships to the

45 Dearden and Sibieta, "Ethnic Inequalities in Child Outcomes."

46 Small sample sizes prevent further separation by ethnicity; about 60 percent of foreign-born Hispanic mothers identify as Mexican; among other Hispanic ethnicities, Puerto Ricans and Cubans are notable.

outcomes.[47] Overall, racial and ethnic categories among native-born mothers separate non-Hispanic white, non-Black Hispanic, Black, and other mothers in the United States, and Black (African or Caribbean), South Asian (Indian, Pakistani, Bangladeshi), other, and white mothers in the United Kingdom. Nativity categories include foreign-born Black, Hispanic and non-Hispanic mothers in the United States, and foreign-born white, South Asian, Black and other mothers in the United Kingdom. Though the reference category in both samples is made up of (non-Hispanic) white natives, the children of Black immigrants are compared to other racial and ethnic groups.

Table 1 presents weighted (i.e., representative) sample characteristics by nativity. The distribution of foreign-born mothers matches national figures in each survey: 28 percent in the United States (representative of large US cities) and 10 percent in the United Kingdom. The FFS includes about 120 Black immigrant mothers — about 2 percent of the sample; 90 percent of these mothers were born in African or Caribbean countries. About 11 percent of mothers are foreign-born, non-Hispanic (predominantly Asian), and 15 percent are foreign born and Hispanic. The MCS includes about 250 Black African or Caribbean immigrant mothers, about 1 percent of all mothers. Four percent of UK mothers in the sample are white immigrants; 3 percent are South Asian immigrants, and another 1 percent of the sample is foreign born and identifies as another ethnicity. UK white immigrant mothers (who constitute 30 percent of immigrant mothers) mainly come from Western Europe (61 percent), with smaller populations from Eastern Europe (8 percent), Australia, New Zealand, the United States, and Canada (12 percent). The remaining 19 percent come from Asian, African, South American, and Caribbean countries.

47 In the UK Millenium Cohort Study (MCS), nativity and country-of-origin information was obtained at age 3; the sample is therefore limited to mothers present at age 3.

Table 1. Weighted Characteristics of US FFS and UK MCS Samples

	US FFS						UK MCS					
Variable	For. Born Black (N=111)	For. Born, Non-Hisp (N=168)	For Born. Hispanic (N=552)	U.S. Born (N=4,066)	Total (N=4,897)	**Variable**	For. Born Black (N=259)	For. Born White (N=565)	For Born. South As. (N=867)	For. Born Other (N=250).	UK Born (N=13,119)	Total (N=15060)
Nativity	2	11	15	72	100	**Nativity**	1	4	3	2	90	100
Race/Ethnicity						**Race/Ethnicity**						
Hispanic	0	0	100	21	32	Black African or Caribbean	100	0	0	0	2	3
Black	100	22	0	27	23	South Asian (Ind., Pak., Bang.)	0	0	100	0	2	5
NHW	0	16	0	49	37	Other	0	0	0	100	1	2
Other	0	62	0	3	8	White	0	100	0	0	95	90
Child Development						**Child Development**						
Physical Health						*Physical Health*						
Breastfed	91	87	80	60	66	Breastfed	97	88	83	96	72	73
Prenatal Care in 1st Trimester	88	84	82	79	80	Prenatal Care in 1st Trimester	73	81	76	78	78	77
Birthweight	7.264	7.191	7.428	7.227	7.256	Birthweight	7.501	7.567	6.813	7.25	7.443	7.43
Asthma	16	10	10	15	14	Asthma	9	13	11	14	15	14
Mental Health						*Mental Health*						
4 + Warm Parenting Behaviors	40	67	80	79	78	4 + Warm Parenting Behaviors	90	93	71	80	94	93
Spanks Child Sometimes/Often	51	10	9	17	16	Spanks Child Sometimes/Often	32	11	17	19	11	11
Mean Internalizing Z-Score	0.497	-0.22	0.32	-0.039	0.014	Mean Internalizing Z-Score	0.169	-0.056	0.423	0.104	-0.06	-0.047
Mean Externalizing Z-Score	0.287	-0.243	-0.238	-0.002	-0.046	Mean Externalizing Z-Score	0.021	-0.2	0.024	-0.305	-0.055	-0.058
Cognitive Development						*Cognitive Development*						
Mean Reading to Child	5.862	5.157	3.862	5.147	4.973	Mean Reading to Child	4.19	4.3	3.79	4.03	4.28	4.26
Mean PPVT Z-Score	-1.103	0.691	-0.702	0.287	0.137	Mean Naming Z-Score	-0.5	0.231	-0.949	-0.341	0.152	0.117
Parental Resources						**Parental Resources**						
Mother Some College or Higher	33	70	11	45	41	A-levels or Higher Education	50	69	32	54	51	51
HH Poverty Ratio in top 30%, Birth	37	59	13	48	44	HH Poverty Ratio in top 30%, 9 Mon.	22	49	16	27	35	35
HH Poverty Ratio in top 30%, Age 5	41	68	14	46	43	HH Poverty Ratio in top 30%, Age 5	16	49	12	34	37	36
Mother Married to Bio. Father, Birth	40	69	61	56	60	Mother Married to Bio. Father, Birth	46	72	94	78	51	63
Mother Married, Age 5	51	77	56	56	57	Mother Married, Age 5	50	74	92	82	63	65
Child Male	67	55	52	55	55	Child Male	50	51	49	45	51	51
Maternal Age at Birth	27.2	29	27.5	26.7	27	Maternal Age at Birth	31.3	30.8	27.9	30.8	29.2	29.3

Notes: Cells show percentages unless otherwise indicated. NHW=Non-Hispanic White.
Sources: Princeton University, "The Fragile Families and Child Well-Being Study," www.fragilefamilies.princeton.edu/; Centre for Longitudinal Studies, "Millennium Cohort Study," www.cls.ioe.ac.uk/Default.aspx.

B. Child Development

Using both surveys permits examination of two dimensions of children's development at age 5 that have lasting consequences for social and economic attainment later in life: health (physical and mental) and cognitive development. This report also examines indicators of mothers' parenting behaviors that are known to be associated with child well-being in each of these domains, focusing on measures that are comparable across the two data sources.

Measures of ***physical health*** include mothers' breastfeeding initiation (yes/no), early prenatal care (first trimester), as well as children's birth weight (pounds) and asthma history (diagnosed or not). Maternal smoking during pregnancy is not analyzed because, in both surveys, almost no Black immigrant mothers reported smoking. Mothers' breastfeeding behavior and the quality of prenatal medical care are strongly related to children's physical, behavioral, and cognitive development.[48] Although it may seem that the greater likelihood of socioeconomic disadvantage in the FFS would make these mothers more likely than those in the larger population to benefit from prenatal-care assistance, identical findings persist when the sample is weighted to be representative of all births in large US cities.

Measures of ***mental health*** include children's frequency of internalizing and externalizing behavior problems. Particular behaviors were grouped together to create scales of internalizing (withdrawn, sad) and externalizing (aggressive, angry) behaviors. This report also analyzes two parenting measures known to be associated with children's psychological well-being: interviewers' observations of mothers' warmth toward children, and mothers' reported frequency of spanking.[49] In each sample, interviewers recorded whether they observed the following interactions between mothers and children during the interview: positive speaking toward the child; conversing at least twice with the child; answering the child's questions verbally; praising the child spontaneously; and caressing and kissing the child.[50] These are summed up to create a dichotomous measure indicating whether mothers engage in more than three warm behaviors. To measure spanking, an indicator of harsh parenting, in the United States this study uses use mothers' reports of whether and how often they have spanked the child because of misbehaving or acting up. In the United Kingdom, mothers report how often they smack children when they are acting naughty. For both samples mothers who report this behavior sometimes or often are separated from those who report that they spank rarely or never.

Finally, to measure children's ***cognitive development***, children's verbal development, measured by performance on the Peabody Picture Vocabulary Test (PPVT) in the FFS and the British Ability Scales Naming Vocabulary test in the MCS, is analyzed. Both tests measure children's spoken vocabulary, with emphasis on noun identification from pictures, as well as the ability to attach verbal labels to pictures. Scores are standardized to age- and sex-specific reference populations. In order to provide a relative assessment, *z*-scores in both samples of children are analyzed — a *z*-score indicates a child's deviation from the sample average, also referred to as a standard deviation. Finally, a measure of parenting behavior relevant to cognitive development is worth examining: mothers' frequency of reading to children, measured in days per week in the United States (0 to 7) and on a five-point scale in the United Kingdom

48 Greg R. Alexander and Carol C. Korenbrot, "The Role of Prenatal Care in Preventing Low Birth Weight," *The Future of Children* 5 (1995): 103–20; Katriina Heikkilä, Amanda Sacker, Yvonne Kelly, Mary J. Renfrew, and Maria A. Quigley, "Breast Feeding and Child Behaviour in the Millennium Cohort Study," *Archives of Disease in Childhood* 96(7) (2011): 635-43; Sandra J. Kelly, Nancy Day, and Ann P. Streissguth, "Effects of Prenatal Alcohol Exposure on Social Behavior in Humans and Other Species," *Neurotoxicology and Teratology* 22 (2000): 143–49; Wendy H. Oddy, Garth E. Kendall, Eve Blair, Nicholas H. De Klerk, Fiona J. Stanley, Louis I. Landau, S. Silburn, and Stephen Zubrick, "Breast Feeding and Cognitive Development in Childhood: A Prospective Birth Cohort Study," *Paediatric and Perinatal Epidemiology* 17 (2003): 81–90; Lauren S. Wakschlag, Kate E. Pickett, Edwin Cook Jr., Neal L. Benowitz, and Bennett L. Leventhal, "Maternal Smoking during Pregnancy and Severe Antisocial Behavior in Offspring: A Review," *American Journal of Public Health* 92 (2002): 966–74.

49 Using interviewers' observations of mothers' behavior is useful in that it reduces the possibility that mothers' reports of warmth reflect solely cultural norms about appropriate parenting styles.

50 Interviewers' observations are only available at age 3 in the MCS. For this measure the author includes contemporaneous measures of parental resources and sociodemographic factors. Analyzing age-3 warmth measures in the FFS does not change the within- or cross-country findings.

(not at all, a few times/month, a few times/week, several days/week, every day).

Table 1 displays descriptive differences in health and cognitive development between the children of Black immigrants and their peers. With respect to parenting behaviors related to physical health, US Black immigrant mothers are much more likely than US-born mothers to breastfeed (91 percent versus 60 percent), as are immigrant mothers from other ethnic groups. Black UK immigrant mothers are also more likely to breastfeed than UK-born mothers and than their white and South Asian immigrant peers. In both countries there are very small differences in immigrant versus native-born mothers' use of early prenatal care, suggesting that the United States largely succeeds at providing health-care access to pregnant mothers and children, despite a health-care system that offers less universal access than in the United Kingdom. These advantageous parenting behaviors, however, do not necessarily produce healthier physical health outcomes.

In both countries, the children of Black immigrants have a healthy birth weight, on average, but in the United States they are as likely as their native-born peers to have been diagnosed with asthma by age 5. The children of Black UK immigrants are slightly less likely than the children of natives to have asthma by age 5 (9 percent versus 15 percent). With respect to parenting and development related to mental health, in both countries the children of Black immigrants demonstrate above-average numbers of internalizing (anxious, depressed) and externalizing (aggressive) behaviors, respectively. In both countries there is also descriptive evidence of more frequent spanking in Black immigrant families, and in the United States, fewer warm parenting behaviors among this group.

In both countries, the children of Black immigrants have a healthy birth weight, on average.

With respect to cognitive development, the children of Black immigrants are at a clear disadvantage in both countries. Though Black immigrant mothers read to their children most days of the week, on average, their children perform substantially lower than their peers on verbal achievement assessments. This disadvantage is over a full standard deviation below average in the United States, and a half of a standard deviation in the United Kingdom. Large standard deviations indicate a sizeable difference from the average child in the sample. In contrast, the children of native-born mothers have above-average performance in both countries, as do the children of some immigrant groups, including US non-Hispanic (largely East Asian) and UK white immigrants.

C. Sociodemographic Characteristics

Several characteristics related to both nativity and mothers' behaviors are examined here. In the United States, ***maternal education*** separates mothers with less than a high school education or a high school diploma from those with some college or a college diploma/higher. In the United Kingdom a comparable measure can be used, separating mothers with no qualifications from those completing A-level college entrance exams and vocational equivalents, or with a university degree. ***Family income*** is measured using household poverty ratios (adjusted for household size and the number of children) — in each sample a distinction is made between ratios in the top 30 percent versus below. ***Family structure*** measures differentiate between two groups of mothers — those married to the biological father versus those who are single, cohabiting with the biological father, or coresiding (married or cohabiting) with a nonbiological father. Mothers' age at birth and children's sex are also measured.

Table 1 shows that nativity groups vary dramatically in terms of parental education and family income. Thirty-three percent of US Black immigrant mothers have completed at least some college at the time

of children's birth, compared to 70 percent of other non-Hispanic immigrant mothers, 41 percent of the total sample and just 11 percent of Hispanic immigrant mothers. Black immigrant families are also slightly less likely to have a household poverty ratio in the top 30 percent (37 percent) than native-born families (48 percent) when children are born, but more likely than Hispanic immigrant families (13 percent). In the United Kingdom, Black immigrant mothers are about as likely to have postsecondary education as their native-born peers (50 percent versus 51 percent), but less likely than white immigrant mothers (69 percent). South Asian immigrant mothers are disproportionately poorly educated, with only 32 percent having some postsecondary schooling. However, these mothers are only slightly less likely to live in high earning households than Black immigrant mothers. Finally, in both countries Black immigrant mothers are the least likely to be married to their child's biological father around the time of birth — a troubling finding given a vast literature in both countries documenting the disadvantages faced by children who grow up in households without continuously married parents because of a decline in the quantity and quality of resources available to children.[51]

V. Multivariate Findings

Taken together, the descriptive findings indicate, first, that the children of Black immigrants are more likely than their peers to be exposed to physically healthy parenting behaviors (especially in the United States), but also more likely to be exposed to harsh parenting in the form of spanking; and that they experience a clear disadvantage in cognitive development when compared to their peers. Moreover, it appears that these patterns are largely similar across the United States and United Kingdom. To examine these patterns more rigorously, this analysis uses ordinary least squares and binary logistic regression models to predict children's outcomes and mothers' parenting behaviors around birth and age 5, controlling for the sociodemographic factors described above. To ease interpretation, the author calculates adjusted predicted values from the estimates to compare across nativity groups, ethnic groups, and countries.

The children of Black immigrants are more likely than their peers to be exposed to physically healthy parenting behaviors.

A. Parenting Behavior

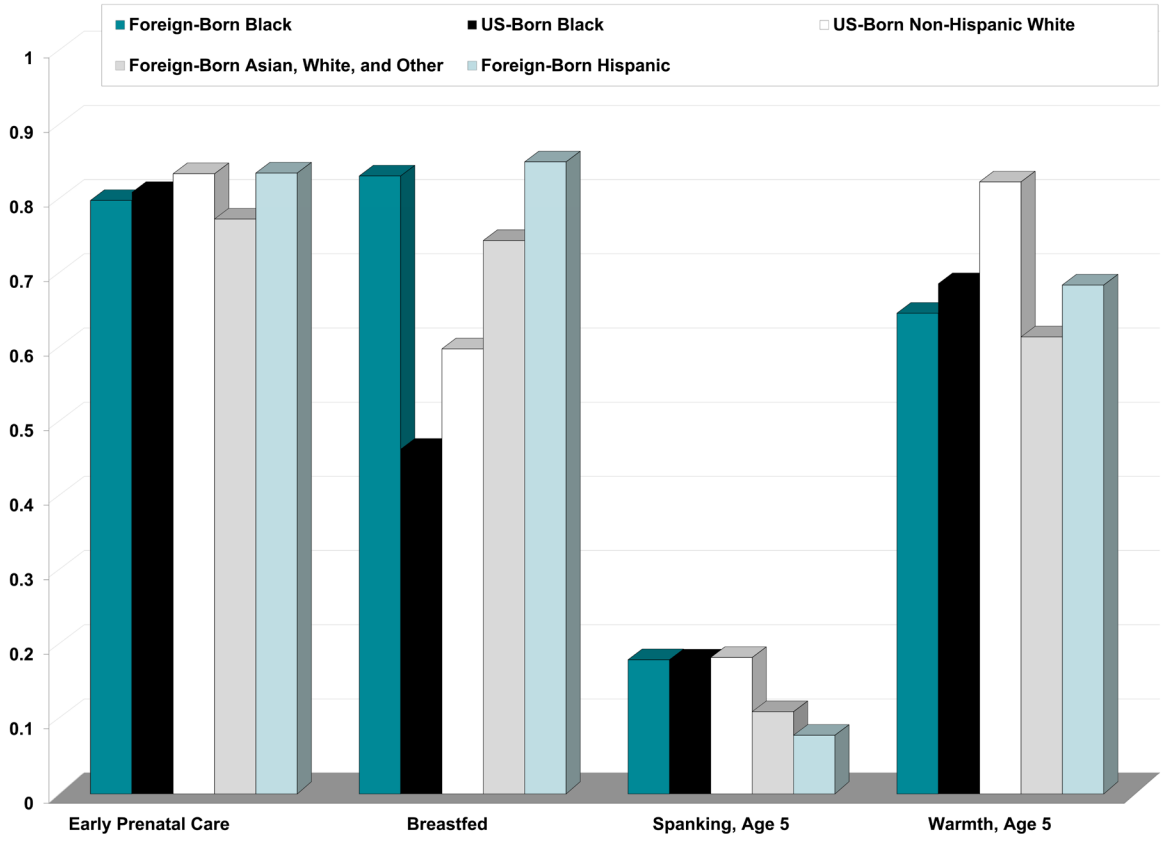
Tables A-1 and A-2 (see Appendices) show estimates from multivariate regression models of nativity differences in parenting behaviors related to children's physical health, mental health, and cognitive development, adjusted for sociodemographic factors. Multivariate regression models provide a way of controlling for differences between children that may be related to their parents' immigration status, such as education, income, and household composition. One type of multivariate model is the logistic regression model, which expresses relationships in the form of odds ratios. An odds ratio larger than 1

51 For example, Kathleen Kiernan and John Hobcraft, "Parental Divorce during Childhood: Age at First Intercourse, Partnership and Parenthood," *Population Studies* 51 (1997): 41-55; Wendy Sigle-Rushton and Sara McLanahan, "Father Absence and Child Wellbeing: A Critical Review," in *The Future of the Family*, eds., Daniel P. Moynihan, Lee Rainwater, and Timothy Smeeding (New York: Russell Sage Foundation, 2004).

indicates a greater chance of the outcome, whereas an odds ratio smaller than 1 indicates a lower chance of the outcome. An odds ratio of 1 indicates no difference in the outcome between people with and without a particular characteristic.

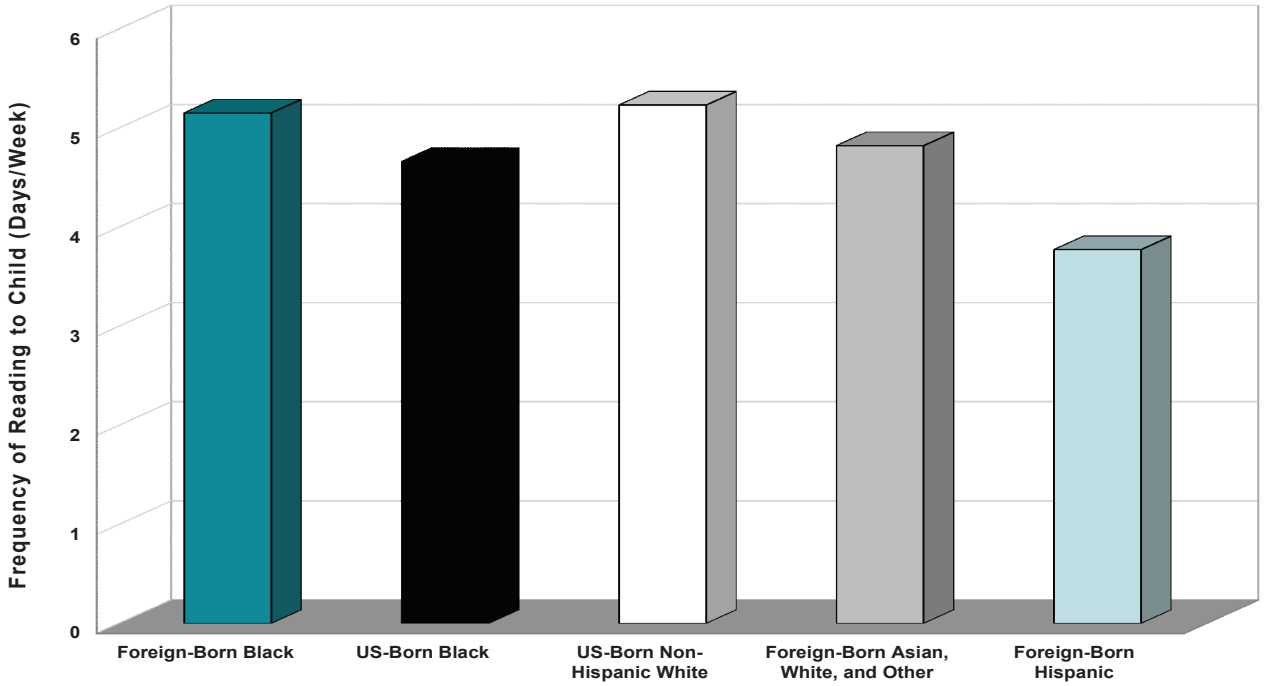
Table A-1 displays the US findings from the FFS. Each column contains estimates for a different outcome and each table describes differences between the children of Black immigrants and several comparison groups: native-born whites (the reference category), native-born Blacks, foreign-born Hispanics, and other foreign-born non-Hispanics (who are largely East Asian). Consistent with the descriptive evidence presented in Table 1, there are few differences in mothers' receipt of prenatal care. Black immigrant mothers are not significantly more or less likely to use early prenatal care than native-born whites, native-born Blacks, or their immigrant peers in other racial and ethnic groups. However, they are significantly more likely to breastfeed than native-born whites, Blacks, and Hispanics. The odds of breastfeeding are almost six times higher among Black immigrant mothers than among non-Hispanic white natives, after adjusting for social and demographic differences between these groups. Black immigrant mothers are also significantly more likely than native-born Blacks to breastfeed, as shown in the test at the bottom of Table A-1. There is no meaningful difference between the breastfeeding behavior of immigrant Blacks and their Hispanic or other non-Hispanic counterparts. These differences are better understood graphically: Figure 1 displays the probability of early prenatal care and breastfeeding in the United States for each foreign-born and native-born ethnic group, adjusted for social and demographic differences between children. The graph shows few differences in mothers' use of prenatal care, but sharp differences in breastfeeding behavior between Black immigrant mothers and their native-born Black and non-Hispanic white peers.

Figure 1. Probability of Maternal Behaviors: United States



Note: All other variables are held constant at their means.
Source: Princeton University, "The Fragile Families and Child Well-Being Study."

Figure 2. Frequency of Reading to Child, Age 5: United States

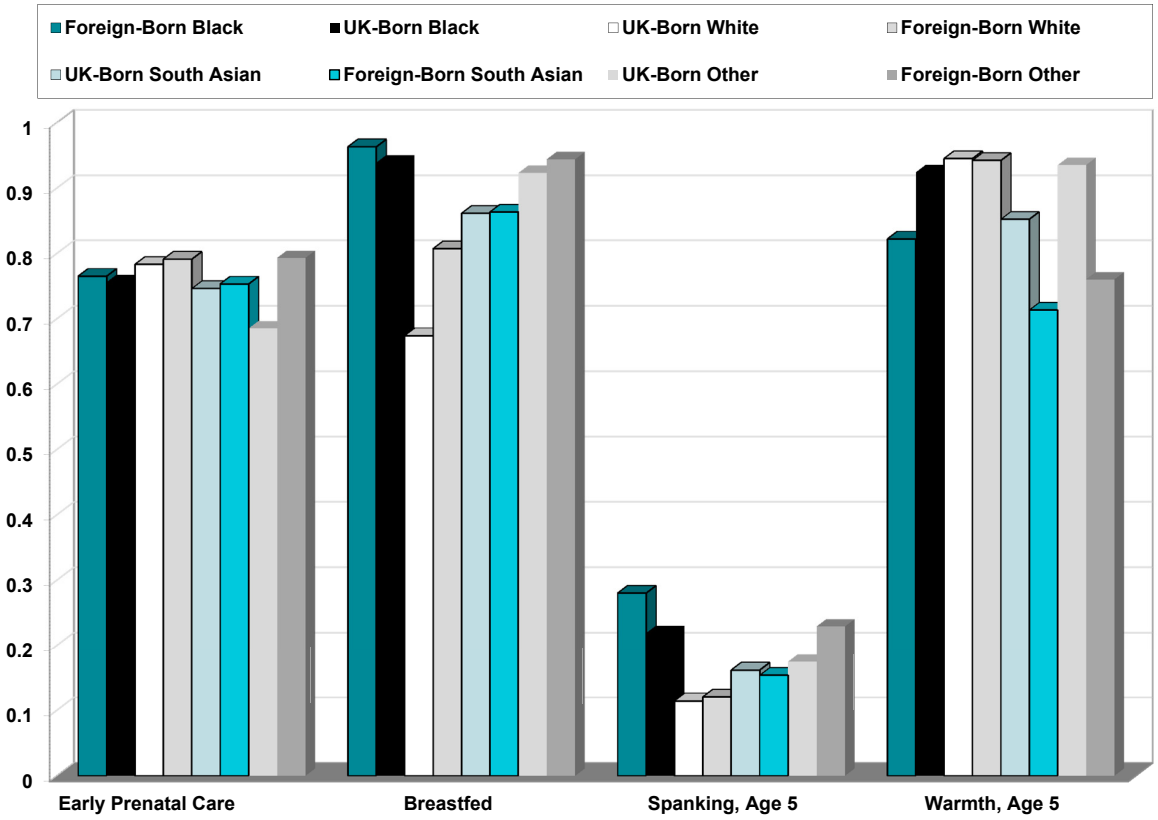


Note: All other variables are held constant at their means.
Source: Princeton University, "The Fragile Families and Child Well-Being Study."

Turning to parenting behaviors related to mental health, there is little evidence of differences between Black immigrant mothers and their peers. After adjusting for differences in parents' socioeconomic resources and family structure, Black immigrant mothers are no more likely to spank their children regularly than their peers in other ethnic and nativity groups. Nor are they less likely to demonstrate a high frequency of warm parenting behaviors — though non-Hispanic white native mothers are the most likely to practice regular warm parenting, this finding is not statistically different from that observed in other groups. Caution should be exercised in interpreting these findings, as the small number of Black immigrant mothers with a positive value on the spanking and warmth variables (N~20) reduces the precision of estimates. Finally, with respect to mothers' frequency of reading to children, most mothers read often to their children, regardless of nativity or ethnicity. Figure 2 shows that an average Black immigrant mother is predicted to read to her children about the same amount as an average non-Hispanic white, native-born mother (five days a week), and slightly more than an average native-born Black mother.

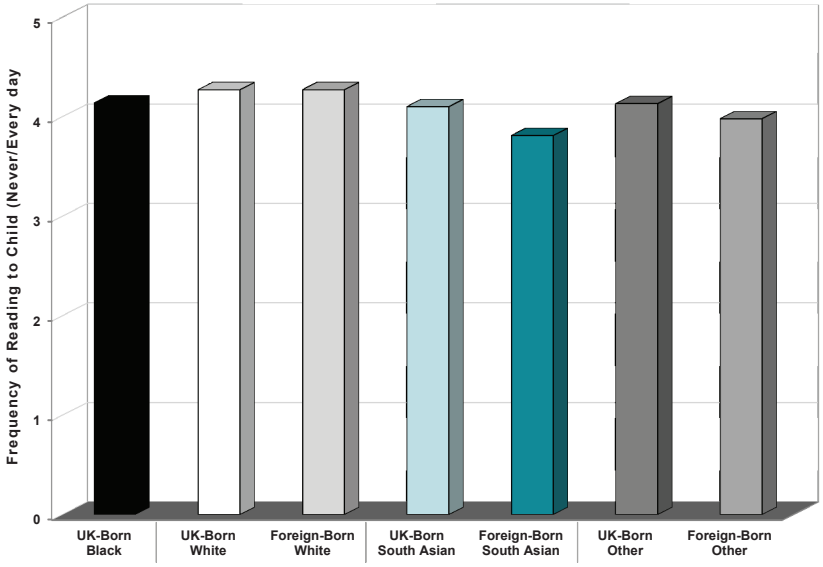
Table A-2 reveals both similarities and differences among UK mothers. Black immigrant mothers are more likely to breastfeed than white natives, or than white immigrant mothers and UK-born Blacks. As in the United States, there is little evidence of immigrant-native differences in early prenatal care. These patterns are reinforced in Figure 3, which shows that Black immigrant mothers are 30 percent more likely to breastfeed than UK-born whites. Also in line with the US findings, examining spanking reveals no meaningful differences in mothers' behavior. In contrast to US patterns, however, Black immigrant mothers are significantly less likely to engage in frequent warm parenting behaviors than both native whites and Blacks. Immigrant mothers in ethnic groups are also less likely to practice warm parenting, as shown graphically in Figure 3.

Figure 3. Probability of Maternal Behaviors: United Kingdom



Note: All other variables are held constant at their means.
Source: Centre for Longitudinal Studies, "Millennium Cohort Study."

Figure 4. Frequency of Reading to Child, Age 5: United Kingdom



Note: All other variables are held constant at their means.
Source: Princeton University, "The Fragile Families and Child Well-Being Study."

Finally, Black immigrant mothers read to their children significantly less than native-born white and Black mothers, on average, as do all other foreign-born mothers except for whites. Figure 4 compares the predicted reading frequency for all UK mothers. There is little cross-national variation in Black immigrant mothers' reading behavior, with mothers in both countries reading to their children most days of the week, on average.

Overall, examining differences in parenting behavior in Black immigrant families reveals both advantages and disadvantages relative to other groups, as well as some variation across settings. In both countries, there is clear evidence of favorable breastfeeding patterns among Black immigrant

mothers, and high usage of early prenatal care among all mothers. Patterns for spanking and warm parenting are less clear, with little multivariate evidence of group differences in the United States — and, in fact, some evidence of warmer parenting among Black immigrant families than among Black natives — but a lower likelihood of warm parenting among Black UK immigrant families, as well as among other immigrant mothers.

B. Children's Health and Cognitive Development

Tables A-3 and A-4 (see Appendices) examine whether the findings observed for parenting behavior extend to children's physical health (asthma), mental health (internalizing and externalizing behaviors), and cognitive development (verbal development). Table A-3, which displays the US findings, shows that children of Black immigrant mothers have a slightly higher birth weight than both native-born Blacks and non-Hispanic whites. Table A-5 shows that this difference is relatively large — almost 0.5 pounds — compared to the predicted birth weight of an average child in a native-born Black family. Later in childhood, at age 5, there is no evidence of an asthma advantage among children in Black immigrant families, in contrast to the substantially lower asthma risk experienced by white and Hispanic children, regardless of parental nativity. There is also little evidence of meaningful differences in children's mental health, as measured by the frequency of internalizing and externalizing behaviors. Finally, Table A-3 and Figure A-1A (see Appendices) show that children in all Black families lag substantially behind children in white families in cognitive development. There is marginally statistically significant evidence that this disadvantage is stronger for children in Black immigrant families than those in native-born families. Children in Hispanic immigrant families experience the largest cognitive disadvantage, which is only slightly reduced after controlling for mothers' English language ability.

Turning to children's physical health in the United Kingdom, Tables A-4 and A-5 show that UK children in Black immigrant families also have a birth weight equivalent to or higher than their peers in native-born families and in other ethnic groups, on average. The US asthma disadvantage, however, is not observed — instead, UK children in Black immigrant families are significantly less likely to have asthma by age 5 than children in all other nativity and ethnic groups. Table A-5 demonstrates this difference: the probability of an asthma diagnosis by age 5 is about 1 percent for the children of Black immigrants, compared to almost 18 percent and 15 percent for the children of UK-born Blacks and whites, respectively. There are few strong differences in the frequency of children's behaviors related to anxiety, depression, and aggression. As in the United States, there is a pattern of more frequent internalizing behaviors among children in Black immigrant families, but this is not statistically significant.

There is a clear disadvantage in Black children's cognitive development in the United Kingdom.

Finally, there is a clear disadvantage in Black children's cognitive development in the United Kingdom, and this disadvantage is stronger among children whose mothers are immigrants. Black children with foreign-born mothers have significantly poorer verbal development than children of native-born whites — Figure A-1B shows that this predicted disadvantage is about 0.7 of a standard deviation for an average child, and that children in Black immigrant families are also predicted to perform about 0.3 of a standard deviation lower than Black children of native-born mothers. The greatest gap in verbal development, however, is between children of Asian immigrant parents and native-born whites: over a full standard deviation. Controlling for the primary use of a language other than English in the home reduces the gap in cognitive development between Black immigrants' children and the children of native-born whites by only about 5 percent.

VI. Conclusions

Identifying, explaining, and addressing nativity-based inequalities in child development at an early age are essential for ensuring the smooth social integration of children from immigrant families. It is difficult to predict whether the children of Black immigrants, who constitute an increasingly large fraction of the children of immigrants in the United States, will integrate toward the mainstream of non-Hispanic white America or whether their development will more closely resemble that of Black children with native-born parents.[52] On the one hand, some research has established favorable health outcomes and academic achievement for children of immigrants from Latin America and Asia, suggesting that the cultural and environmental circumstances of some immigrant families are protective for children. On the other hand, racial inequalities in children's development are large and persistent: Black children experience a disproportionate burden of chronic illness and perform more poorly on cognitive assessments than their peers, on average. Black children are also more likely to live in highly segregated neighborhoods, and are therefore more likely to attend under-resourced schools and to be exposed to health hazards and crime.

The analyses in this report are intended to describe the integration of children in Black immigrant families across two developmental domains — health (physical and mental) and cognitive. A primary goal of the report is to study children in both the United States and the United Kingdom, where there are large Black immigrant populations but notably different contexts with respect to immigration policy, health care, and social welfare provision. Using two national samples of mothers and children, this analysis compares children in Black immigrant families to the mainstream of non-Hispanic whites, as well as to Black children of native-born mothers and to children of other immigrant families.

Identifying, explaining, and addressing nativity-based inequalities in child development at an early age are essential for ensuring the smooth social integration of children from immigrant families.

The findings presented here should be interpreted cautiously in light of the small sample sizes available in the data sources analyzed. Though the Black immigrant population has grown rapidly in both the United States and United Kingdom, and both surveys oversample ethnic minority samples, the data include a total of about 120 US children in Black immigrant families, and about 250 UK children. This limits the scope of health markers that can be studied, the ability to separately analyze diverse Black ethnic groups, and the precision with which multivariate regression models can be estimated. For example, in the US data there are too few Black immigrant mothers who smoke while pregnant to analyze disparities in this outcome using multivariate techniques. Similarly, this analysis is forced to combine families from disparate regions of the world — Africa and the Caribbean — despite the possibility that families' behaviors and children's development varies greatly not only by race, but also by region and country of origin.

The limitations imposed by small sample sizes, however, should be balanced against the benefits of using data sources that are representative of national populations, as well as by the cross-national perspective afforded by using two samples. The findings suggest that the development of children in Black immigrant families exhibits both favorable and disadvantaged patterns, depending on the marker

52 Demographic projections suggest that the non-Hispanic white population in the United States is growing at the slowest rate, suggesting that the definition of mainstream will evolve.

under consideration. In both countries, there is clear evidence of favorable breastfeeding patterns among Black immigrant mothers, and high usage of early prenatal care among all mothers. Black immigrant mothers' healthy parenting behavior is paralleled by the healthy birth weight of their children and, in the United Kingdom, by their lower asthma risk at age 5. There is little multivariate evidence of differences in parenting and outcomes related to children's mental health. There is some evidence of warmer parenting among US Black immigrant families than among Black natives, but a lower likelihood of warm parenting among Black UK immigrant families, as well as among other UK immigrant families. These differences do not translate into large disparities in the frequency of children's internalizing and externalizing behaviors, however. In both countries, children of Black immigrant families have more frequent internalizing behaviors than those of white families, though these patterns are not statistically significant. Finally, Black children perform more poorly on cognitive assessments of verbal development, and in the United Kingdom, this disadvantage is particularly pronounced among children whose mothers are immigrants.

The findings suggest that the development of children in Black immigrant families exhibits both favorable and disadvantaged patterns.

The direction and magnitude of parenting and developmental differences between Black children in immigrant families and their peers is largely similar across policy contexts. These similarities are notable: policies related to immigration, health care, parenting support, and social services would suggest that there should be substantial cross-country variation related to the differential context of reception. For example, the availability of federally funded health visits for new mothers in the United Kingdom would suggest that there should be fewer differences in parenting behaviors in that context than in the United States. There are some important exceptions to the fairly similar patterns across countries, however. In the United Kingdom, children of Black immigrant families have a particularly strong cognitive disadvantage (even after controlling for the language spoken at home), though the direction of this relationship is similar in the United States. At the same time, however, these children are less likely to have asthma than their peers in other ethnic and nativity groups. One interpretation is that children in Black UK immigrant families are less likely to be diagnosed than their peers, but no less likely to have asthma. Though there is evidence of racial and ethnic disparities in health-care usage and diagnosis patterns, this possibility would seem more plausible in the United States, where health care is less accessible than in the United Kingdom. A policy-driven interpretation would suggest that Black immigrant families in the United Kingdom are better able to access preventive health care for their children, and better able to afford housing that does not expose children to health risks. The potential benefit of social housing policy does not extend to children's cognitive development, however, and differences in mothers' reading behavior do not explain the lower performance of children in Black immigrant families.

Though it is tempting to explain differences between immigrant and native families by the context of reception, there is a potentially equally important role played by selective migration. In many countries, some people are more likely to migrate than others, producing differences in the host country that reflect not only new circumstances, but also preexisting characteristics and resources. Existing research, for example, suggests that the average immigrant to the United States has a higher education than an average member of his or her population of origin,[53] and that migrants from some countries are the healthiest of their native population.[54] This selection pattern may be particularly pronounced among the Black

53 Cynthia Feliciano, "Educational Selectivity in U.S. Immigration: How Do Immigrants Compare to those Left Behind?" *Demography* 42 (2005): 131–52.

54 Landale, Oropesa, and Gorman, "Migration and Infant Death;" Luis N. Rubalcava, Graciela M. Teruel, Duncan Thomas, and Noreen Goldman, "The Healthy Migrant Effect: New Findings from the Mexican Family Life Survey," *American Journal of Public Health* 98 (2008): 78–84.

immigrant population, which is highly educated relative to the populations in their countries of origin.[55] Variation in migrants' characteristics may contribute to cross-national differences in parents' behaviors and children's development. This variation may also help to explain the *similarity* of many patterns across countries, such as the fairly universal pattern of prevalent breastfeeding and healthy birth weight among Black immigrant families, if parents import healthy behavioral norms from their native countries.

Surely, Black migrants' cultural practices, the resources they bring with them, and the policies available to them contribute to the extent to which they mirror or contrast with their peers in the host country. In the absence of additional data, it is not possible to go beyond speculation in understanding what drives the relative advantages and disadvantages faced by Black immigrant families. These analyses provide a first and necessary step toward that larger question by describing group differences. The findings suggest that Black immigrant families' behaviors are both beneficial and detrimental to their children's development, and that children's integration is neither wholly toward the non-Hispanic white "mainstream" nor "segmented" toward the patterns of Black children in native-born families. An important next step will be to understand how nativity-based inequalities in child development evolve over time, and how the shape and magnitude of children's developmental trajectories are sensitive to positive and negative changes in their families' social resources and relationships. It is clear that neither children's adaptation to their parents' new society, nor the extent to which parents can use their resources to facilitate smooth developmental pathways, is unidimensional. Philip Kasinitz et al.[56] in their study of several ethnic groups of second-generation youth in New York City (including those in Black immigrant families) argue that youth selectively adopt behaviors and norms of both their country and their parents' country, and that this selective adaptation ultimately increases their ability to achieve productive lives. In this vein, in future work it will be important to understand the changing family, neighborhood, social, and economic arrangements experienced by immigrant children over time, in order to understand whether and how parents and children are able to maximize the favorable aspects of their environments, and minimize those that may be risk inducing.

The findings suggest that Black immigrant families' behaviors are both beneficial and detrimental to their children's development.

55 Randy Capps, Kristen McCabe, and Michael Fix, *New Streams: Black African Migration to the United States* (Washington, DC: Migration Policy Institute, 2011), www.migrationpolicy.org/pubs/AfricanMigrationUS.pdf.

56 Kasinitz et al., *Inheriting the City*.

Appendices

Table A-1. Regression of Nativity and Ethnic Differences in Maternal Behaviors, US

	Physical Health		Mental Health		Cognitive Development
	Early Prenatal Care	Breastfeeding	Spanking	Warmth	Reading to Child
Foreign Born	-0.304	0.918**	-0.588	-0.677	-0.128
Black	-0.161	-0.560**	-0.012	-0.738**	-0.563**
Black, Foreign Born	0.23	0.822*	0.583	0.499	0.619†
Hispanic	-0.308*	-0.199†	-0.543**	-0.411†	-0.433**
Hispanic, Foreign Born	-0.710*	0.866*	0.158	0.716	-0.614*
Mother more than HS	0.489**	0.886**	-0.007	0.159	0.240**
High HH Poverty Ratio	0.626**	0.185*	-0.045	0.385**	0.126
Married at Birth	0.760**	0.618**	0.082	0.239	0.0241
Cohabiting at Birth	0.272*	0.131†	-0.129	0.143	-0.163*
Child Male	0.129†	-0.0489	0.270**	-0.087	-0.086
Intercept	0.954**	0.202	-0.352	0.583*	5.509**
Tests of Coefficient Equality					
FB Black vs. NB Black					
x2 (1)	0.89	8.36	1.29	3.86	10.18
p > x^2	0.35	0	0.26	0.05	0
FB Black vs. FB Hispanic					
x2 (1)	2.63	0.02	1.19	0.34	20.31
p > x^2	0.1	0.88	0.28	0.56	0
FB Black vs. FB Non-Hispanic					
x2 (1)	0.73	0.02	1.99	1.31	1.82
p > x^2	0.39	0.89	0.16	0.25	0.17
Model Type	L	L	L	L	OLS
N	4,897	4,897	4,139	3,023	4,139

Notes: All covariates measured contemporaneously. Models also mother's age at birth. Reference categories are as follows: for nativity, native-born non-Hispanics; for race/ethnicity, non-Hispanic white, mother HS or less, HH poverty ratio not in top 30 percent. FB = foreign born; HH = household; HS = high school education; L = binary logit regression; NB = native born;
OLS = ordinary least squares regression.
† <.10; * p<.05 ; ** p <.01.
Source: Princeton University, "The Fragile Families and Child Well-Being Study."

Table A-2. Regression of Nativity and Ethnic Differences in Maternal Behaviors, UK

	Physical Health		Mental Health		Cognitive Development
	Early Prenatal Care	Breastfeeding	Spanking	Warmth	Reading to Child
Foreign Born	0.0947	0.734**	0.137	-0.359*	-0.0207
Black	-0.247	2.063**	0.789**	-0.505*	-0.167**
Black, Foreign Born	0.0603	0.141	0.0145	-1.104**	-0.227**
South Asian	-0.012	1.007**	0.424**	-1.168**	-0.230**
South Asian, Foreign Born	-0.0112	-0.671**	-0.145	-0.482*	-0.262**
Other	-0.502*	1.778**	0.573*	-0.203	-0.0923
Other, Foreign Born	0.531	-0.381	-0.0599	-1.561**	-0.276*
More than HS	0.075†	0.976**	-0.0549	0.621**	0.272**
HH Poverty Ratio Top 30%	0.179**	0.539**	-0.214**	0.282**	0.151**
Child Male	0.051	-0.058	-0.363**	0.0773	0.031†
Married at Birth	0.552**	0.600**	0.247**	0.447**	0.074**
Cohabiting at Birth	0.362**	0.432**	0.298**	0.334**	-0.061*
Intercept	0.571**	-1.165**	-0.962**	0.944**	4.122**
Tests of Coefficient Equality					
FB Black vs. NB Black					
$\chi 2$ (1)	0.15	17.48	3.62	0.7	0.07
$p > \chi^2$	0.7	0	0.05	0.4	0.79
FB Black vs. FB white					
$\chi 2$ (1)	1.17	27.51	8.4	0.16	3.49
$p > \chi^2$	0.28	0	0	0.69	0.06
Model type	L	L	L	L	OLS
N	15,060	15,060	13,381	13,381	13,381

Note: All covariates measured contemporaneously. Models also control for mother's age at birth. Reference categories are as follows: native-born white, mother no qualifications or O-levels only, HH poverty ratio not in top 30%. FB = foreign born; HH = household; HS = high school education; L = binary logit regression; NB = native born; OLS = ordinary least squares regression.
† <.10; * p<.05 ; ** p <.01.
Source: Centre for Longitudinal Studies, "Millennium Cohort Study."

Table A-3. Regression of Nativity and Ethnic Differences in Child Development, Age 5, US

	Physical Health		Mental Health		Cognitive Development
	Birthweight (lbs.)	Asthma	Externalizing Behaviors	Internalizing Behaviors	PPVT Z-Score
Foreign Born	-0.215	-0.473	-0.189	-0.032	-0.0561
Black	-0.398**	0.540**	-0.121*	-0.134**	-0.557**
Black, Foreign Born	0.636**	0.506	0.014	0.245	-0.0693
Hispanic	-0.03	0.678**	-0.101	0.088	-0.511**
Hispanic, Foreign Born	0.508**	-0.224	-0.022	0.201	-0.445**
Mother more than HS	0.151**	0.056	-0.137**	-0.199**	0.423**
High HH Poverty Ratio	0.051	-0.248**	-0.154**	-0.161**	0.247**
Married at Birth	0.304**	-0.430**	-0.235**	-0.182**	0.0576
Child Male	0.203**	0.438**	0.122**	0.042	-0.127**
Intercept	7.135**	-1.764**	0.400**	0.212*	0.289**
Tests of Coefficient Equality					
FB Black vs. NB Black					
x2 (1)	23.58	0	0.38	3	2.65
$p > x^2$	0	0.95	0.55	0.08	0.09
FB Black vs. FB Hisp.					
x2 (1)	0.68	4.72	0.05	0.08	3.27
$p > x^2$	0.41	0.03	0.83	0.78	0.07
FB Black vs. FB non-Hisp.					
x2 (1)	7.25	1.44	0.38	0.67	0
$p > x^2$	0	0.23	0.54	0.41	0.97
Model type	OLS	L	L	L	OLS
N	4,987	4,139	3,023	3,023	3,023

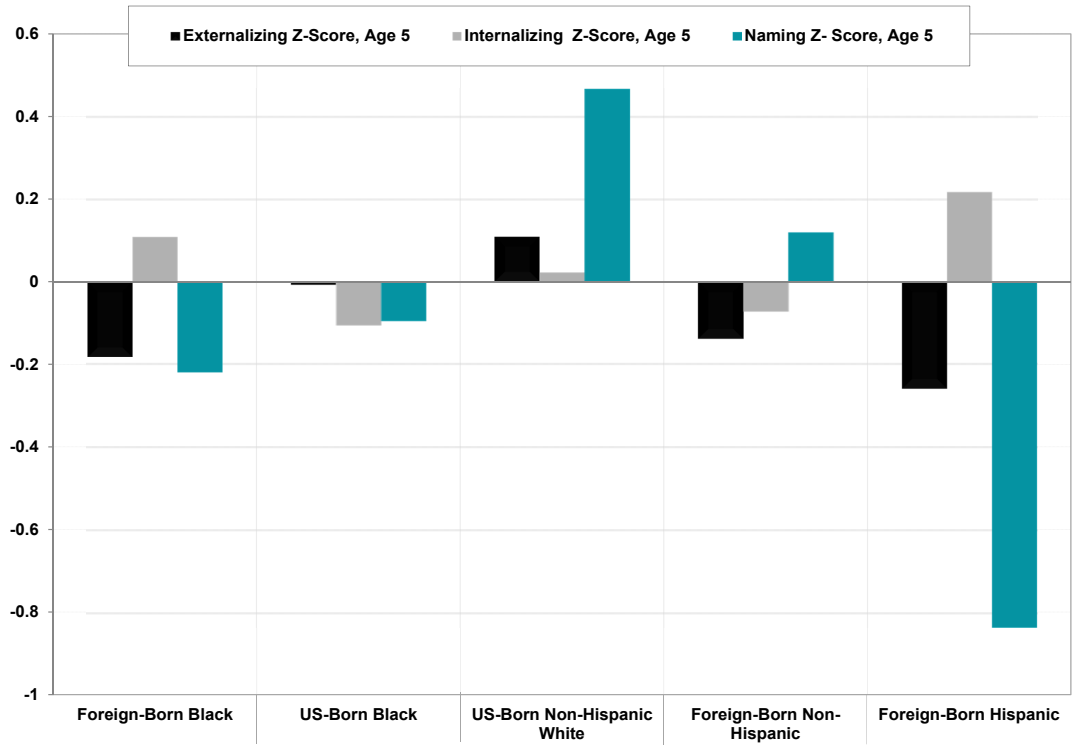
Notes: All covariates measured contemporaneously. Models also control for mother's age at birth. Reference categories are as follows: for nativity, native-born non-Hispanics; for race/ethnicity, non-Hispanic white, mother HS or less, HH poverty ratio not in top 30%. FB = foreign born; HH =household; HS = high school education; L = binary logit regression; NB = native born; OLS = ordinary least squares regression.
† <.10; * p<.05 ; ** p <.01
Source: Princeton University, "The Fragile Families and Child Well-Being Study."

Table A-4. Regression of Nativity and Ethnic Differences in Child Development, Age 5, UK

	Physical Health		Mental Health		Cognitive Development
	Birthweight (lbs.)	Asthma	Externalizing Behaviors	Internalizing Behaviors	Naming Score
Foreign Born	0.087	-0.0805	0.035	0.164*	-0.0857†
Black	-0.375**	0.366*	0.0784	0.005	-0.402**
Black, Foreign Born	0.199	-0.839**	-0.247	0.122	-0.318*
South Asian	-0.780**	0.0785	0.199	0.263**	-0.785**
South Asian, Foreign Born	0.01	-0.367*	-0.0939	0.189	-0.256**
Other	-0.569**	-1.154*	0.0091	0.115	-0.449**
Other, Foreign Born	0.011	1.304	-0.0389	0.0729	-0.228
Mother A-level or Higher	0.127**	-0.200**	-0.786**	-0.204**	0.315**
High HH Poverty Ratio	0.04	-0.234**	-0.462**	-0.123**	0.225**
Child Male	-0.271**	-0.401**	-0.291**	-0.044*	0.0563**
Married at Birth	0.271**	-0.194**	-0.298**	-0.231**	0.127**
Intercept	7.576**	-0.224	1.170**	0.517**	-0.423**
Tests of Coefficient Equality					
FB Black vs. NB Black					
x2 (1)	5.32	7.49	0.44	0.06	0.23
p x^2	0.02	0.01	0.51	0.8	0.63
FB Black vs. FB White					
x2 (1)	15.39	3.49	0	0.06	14.27
p > x^2	0	0.06	0.98	0.82	0
Model Type	OLS	L	OLS	OLS	OLS
N	13,381	13,381	13,381	13,381	13,381

Notes: All covariates measured contemporaneously. Models also control for mother's age at birth. Reference categories are as follows: native-born white, mother no qualifications or O-levels only, HH poverty ratio not in top 30%. FB = foreign born; HH = household; HS = high school education; L = binary logit regression; NB = native born; OLS = ordinary least squares regression.
† <.10; * p<.05 ; ** p <.01
Source: Centre for Longitudinal Studies, "Millennium Cohort Study."

Figure A-1A. Predicted Z-Scores: United States



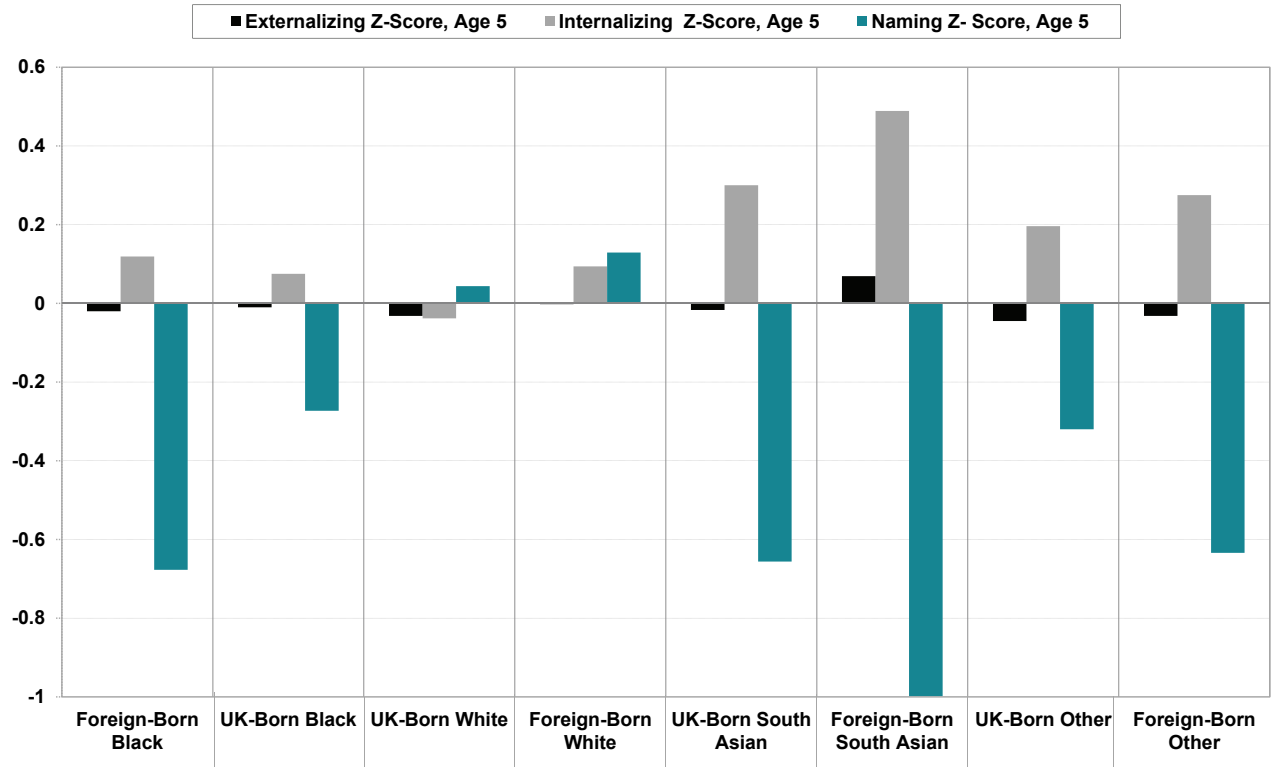
Note: All other variables in Table 4 are held constant at their means.
Source: Princeton University, "The Fragile Families and Child Well-Being Study."

Table A-5. Predicted Child Outcomes, by Nativity and Race/Ethnicity, US and UK*

US	Birth Weight (lbs.)	Asthma
US-Born, Black	6.854	0.226
Foreign Born, Black	7.274	0.231
US Born, Non-Hispanic White	7.257	0.144
Foreign Born, Non-Hispanic	6.847	0.121
Foreign Born, Hispanic	7.325	0.178
UK	**Birth Weight (lbs.)**	**Asthma**
UK Born, Black	7.085	0.189
Foreign Born, Black	7.371	0.01
UK Born, White	7.461	0.145
Foreign Born, White	7.548	0.145
UK Born, South Asian	6.681	0.15
Foreign Born, South Asian	6.777	0.101
UK Born, Other	6.892	0.048
Foreign Born, Other	6.989	0.2

Note: *Probabilities computed from parameters shown in Tables A-3 and A-4. All other covariates held constant at their means.
Source: Princeton University, "The Fragile Families and Child Well-Being Study;" Centre for Longitudinal Studies, "Millennium Cohort Study."

Figure A-1B. Predicted Z-Scores, United Kingdom



Note: All other variables are held constant at their means.
Source: Centre for Longitudinal Studies, "Millennium Cohort Study."

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About the Author

Margot Jackson is an Assistant Professor of Sociology at Brown University, where she studies life-course and intergenerational aspects of the relationship between social circumstances and health, with a focus on the early life-cycle reproduction of social inequality and the role of child health in the production of social inequality.

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She is currently working on two projects. First, using longitudinal data from the United States and the United Kingdom, she is studying the dynamics of child health and socioeconomic attainment — specifically, whether child health is a source of compounding disadvantage in academic achievement during the school years, as well as whether the shape and size of poor health's changing influence depends on its timing and persistence. In a second project she is examining health among children with migration backgrounds, among whom potentially divergent patterns of economic status and health with time in the United States complicate understanding of the socioeconomic gradient in health.

For more on MPI's Young Children of Black Immigrants initiative, please visit:
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