Systematic Review

Black Nativity and Health Disparities: A Research Paradigm for Understanding the Social Determinants of Health

Mosi Adesina Ifatunji 1,*, Yanica Faustin 2, Wendy Lee 3 and Deshira Wallace 4

1 Departments of African American Studies and Sociology, College of Letters and Science, University of Wisconsin at Madison, Madison, WI 53706, USA
2 Department of Public Health Studies, College of Arts and Sciences, Elon University, Elon, NC 27244, USA; yfaustin@elon.edu
3 Department of Sociology, College of Letters and Science, University of Wisconsin at Madison, Madison, WI 54706, USA; wklee3@wisc.edu
4 Department of Health Behavior, Gillings School of Public Health, University of North Carolina at Chapel Hill, Chapel Hill, NC 27599, USA; ddwallac@email.unc.edu
* Correspondence: ifatunji@wisc.edu

Abstract: After more than a century of research and debate, the scientific community has yet to reach agreement on the principal causes of racialized disparities in population health. This debate currently centers on the degree to which “race residuals” are a result of unobserved differences in the social context or unobserved differences in population characteristics. The comparative study of native and foreign-born Black populations represents a quasi-experimental design where race is “held constant”. Such studies present a unique opportunity to improve our understanding of the social determinants of population health disparities. Since native and foreign-born Black populations occupy different sociocultural locations, and since populations with greater African ancestry have greater genetic diversity, comparative studies of these populations will advance our understanding of the complex relationship between sociocultural context, population characteristics and health outcomes. Therefore, we offer a conceptual framing for the comparative study of native and foreign-born Blacks along with a review of 208 studies that compare the mental and physical health of these populations. Although there is some complexity, especially with respect to mental health, the overall pattern is that foreign-born Blacks have better health outcomes than native-born Blacks. After reviewing these studies, we conclude with suggestions for future studies in this promising area of social and medical research.

Keywords: Blacks; African Americans; Black immigrants; immigrants; health disparities

1. Introduction

In recent decades, researchers in the social and medical sciences have revisited a longstanding interest in racialized disparities in population health [1–5]. As it stands, after more than a century of research and debate, the scientific community has yet to reach agreement on the principal causes of these multigenerational disparities. We contend that one of the central reasons for stasis rests within the most prominent study design for investigating these disparities—comparing different racial groups on various measures of health status. This design risks confounding between racial group membership and real or perceived differences in social context and/or population characteristics—factors often left unobserved [6]. That is, the debate on how to interpret race residuals (we are referring to the fact that dummy variables for race in regression models often remain statistically significant after controlling for known correlates of a disease) turns on whether these residuals reflect unobserved differences in the social context or unobserved differences in population characteristics [7–9]. Therefore, our understanding of health disparities is
incombered by overarching disagreements as to whether “race” is defined by or rooted in social context, group behaviors or biological endowments.

We join others in suggesting that the presence of a growing and diverse foreign-born population in the United States [10,11] represents an opportunity to improve our understanding of the social determinants of racialized population health disparities [12–17] (we use the term “foreign-born Blacks” to refer to those born outside the country that are either self-identified or legally classified as Black in the United States). To this end, it is important to note that disparities in morbidity and mortality between native-born Blacks and foreign-born Blacks are larger than nativity differences within any other racialized population—e.g., between native and foreign-born Latinx or Asian populations [18–22] (we use the term “native-born Blacks” to refer to all Blacks born in the United States. This term includes Blacks with foreign-born parents and African Americans, or the decedents of American slaves). Therefore, in addition to improving our descriptive understanding of increasing heterogeneity in Black population health, the fact that native- and foreign-born Blacks share the same racial status but often have different health profiles also presents us with a quasi-experimental design for studying factors that might also contribute to racialized disparities in population health [12–17]. That is, since native and foreign-born Blacks share the same racial status while sometimes having different experiences, cultural values and practices [13,23,24], comparative studies of these populations might improve our understanding of the ways in which various race-related sociocultural factors might contribute to disparities in population health between these and other groups [12–17].

While there are a range of possible native/immigrant comparisons, the comparison of native and foreign-born Blacks represents a uniquely useful research paradigm because Black people are the only U.S. population whose racial classification has to do with notions of genetic ancestry [25] and also includes a large immigrant population [10,26]. While “blood quantum” has also been a key determinant of being legally classified as Native American [27], there are no Native American “immigrants” in the United States (we understand that there are many Native Americans that migrate from reservations to other locations in the United States and that this experience may be like the experiences of many foreign-national migrants. While scientists should conduct more research on the ways in which this experience shapes Native American health, we reserve the term “immigrant” to refer to the migration of foreign nationals). Conversely, there are large numbers of Asian and Latinx immigrants, but the Census Bureau legally classifies these populations according to their language and/or national origins, not blood quantum or genetic ancestry. Moreover, the current practice of the U.S. Census conceptualizes Latinx as an ethnic group that is composed of different racial population groups. That is, we continue to debate whether people with proximal ancestry in Latin America constitute their own racial group or an ethnic group that includes different racial categories. Given that this debate remains unsettled, we do not include studies that include “Black” migrants from Latin America [28–30].

It is also important to note that populations with greater amounts of African genetic ancestry tend to have greater genetic variation [31]. This means that we can gain a more fine-grained analysis of the potential interplay between the environment, genomics (including, single nucleotide polymorphisms, methylation and/or gene expression) and population health, especially since there is simultaneously great variation in the health of these populations [18,22].

We advance the argument for the comparative study of native and foreign-born Blacks in four ways. First, we review differences between these populations vis-à-vis the most prominently studied determinants of population health (i.e., health behaviors, socioeconomic status, environmental factors and population genetics), arguing that since these populations have different social and cultural locations and practices, comparative studies of these populations might yield important insights into the social determinants of population health. Second, we argue that, since native and foreign-born Blacks experience and interpret race differently in the U.S. [24,32–36], the comparative study of these populations...
will also advance our understanding of the role of racialized bias and discrimination in population health disparities. Third, we suggest that, since these populations share the same racial status, and since populations with greater amounts of African ancestry have greater genetic diversity [31], the comparative study of these populations will improve our understanding of the complex interplay between sociocultural context, population genetics and health outcomes in a way that avoids debates having to do with the nature of racial classification (e.g., [37,38]). Fourth, we encourage the comparative study of native and foreign-born Black health by offering a summary review of 208 existing studies that compare the health of these populations, including potential data sources for further investigation. This is the first review of its kind and offers the current state of knowledge on patterned health differences between native and foreign-born Blacks. We conclude our review with our thoughts on potential future directions within this research paradigm.

2. Descriptive Benefits

Most studies of health disparities between White and Black (read native-born Black or African American) populations in the United States have an implied interest in the relative health of native-born Whites and the decedents of enslaved Africans in the United States. However, over the last five or six decades, the country of origin of the U.S. Black population has diversified. Between 1960 and 2005, a 22-fold increase in the number of foreign-born Black people living in the United States occurred (from 125,000 to 2,815,000; [10]). Since 1990, this rapid increase in the size of the foreign-born Black population has been met with increasing diversity in the regions and countries from which immigrants originate. While foreign-born Blacks from the Caribbean have been migrating to the U.S. since the early 1900s [26], between 2000 and 2005, more foreign-born Blacks entered the U.S. from Africa than the Caribbean [10]. Moreover, there is greater diversity in the reasons for migration, especially from African countries—more enter as refugees, asylees or on diversity visas [10]. Black people also migrate to the U.S. from non-majority Black countries throughout Europe [17]. Increases in the size and diversity of the foreign-born Black population in recent decades complicates our understanding of the U.S. Black population [10,24]. That is, increasing portions of Blacks in the United States do not have ancestry in American slavery and are therefore not part of the traditional perspective on multigenerational Black–White inequality in the U.S.

Although these population trends have resulted in greater diversification in the Black population, most research into population health overlooks this diversity. This practice obscures our ability to analyze and understand the increasing variation in the health status of this rapidly diversifying population. Indeed, disparities between native and foreign-born Blacks are wider than those between other native and foreign-born populations within other racialized groups [18,22]. As our review of the literature shows, there are a range of health differences between native and foreign-born Blacks, but most studies show that foreign-born Blacks have better health profiles than native-born Blacks. This means that, in addition to not having a good understanding of the health status of an increasingly diverse Black population, it is likely that studies that do not account for this heterogeneity are underestimating and potentially misunderstanding the basic nature of population health differences between Blacks and Whites. Parsing the Black population will therefore improve our understanding of the nature of Black population health and Black–White health disparities in the United States.

3. Perspectives on Black Ethnicity and Population Health

While most are interested in the health of the decedents of American slavery, there is also a longstanding interest in the comparative study of different Black populations as part of a larger effort to understand and unpack the nature of Black–White racial disparities across a range of life domains. These began with distinctions between Blacks, both “slave” and “free” [23,39], but also included distinctions between native and foreign-born Blacks [23,40]. The more recent of these studies show that these populations have different
levels and kinds of education [41,42], hold different kinds of jobs [43], attain different levels of success in the labor market [44,45] and often live in different neighborhoods, experiencing different levels of housing segregation from Whites [46,47]. Therefore, while they might share a similar multivariate distribution of skin color, hair texture and craniofacial bone structure, these populations experience the U.S. racialized social system [48] differently [24,32–35,49–55]. Differences in sociocultural context and practice matched with similarities in markers that are widely associated with “racial status” mean that the comparative study of these populations presents a quasi-experimental study design whereby racial status is “held constant” while allowing various factors that are associated with the “social determinants of health” to vary [12–17].

Population health researchers have previously described the basic advantages of this study design. For instance, in 1992, Richard Davis argued that, given social and cultural differences between native and foreign-born Blacks, there might be great scientific benefit to model stratification across these populations. He argued that “… it stands to reason that the assimilation patterns of native and foreign-born Blacks may be fairly different; if for no other reason than that they often speak a different language … Foreign-born bilingual or non-English speaking Blacks may find it more convenient to coalesce among themselves … these factors suggest the possibility of a very different pattern of assimilation for Black ethnics” [13].

About a decade later, James Jackson and colleagues suggested that comparisons between native and foreign-born Blacks would help refine our understanding of “… the types and amounts of racial and non-racial factors that affect the differential distribution of mental disorders within race and ethnic groups can be identified, leading to possible explications of how race and ethnic group memberships combine with different types of stressors to affect mental health” [16] and that, “… differential immigration experiences among [foreign-born Blacks] will contribute to understanding the mental health implications of racial/ethnic identity and acculturation strategies” [16]. They then suggest that this “… will result in a better understanding of the nature of racial and ethnic differences in the distribution of serious mental disorders” [16].

Shortly thereafter, Carlotta Arthur and Edward Katkin argued that comparative studies of native and foreign-born Blacks will “… raise awareness of the issue of ethnicity among Black populations and to bring attention to new ways to think about health disparities research and the promise that such explorations hold for finding new avenues through which to intervene” [12], including “… in-depth knowledge of the ways in which ethnicity and culture interact with health-related issues in Black populations in the U.S” [13].

While these scholars have done well to describe the ways in which the comparative study of native and foreign-born Blacks will allow for insights into the role of “race and culture” in population health, we develop this perspective further, offering a more detailed consideration of how such studies might improve our understanding of population health disparities. That is, the previously proposed distinctions focus on “race”, “ethnicity” and “culture”, broadly speaking. We offer a more detailed assessment, parsing these broad distinctions into four principal causes of population health: health behaviors, socioeconomic status, environmental stressors and population genetics [15,56]. Since we believe that earlier efforts were an attempt to say that the comparative study of native and foreign-born Black health might allow for a greater understanding of the relative role of these principal causes, we illustrate the utility of this comparative approach by reviewing differences between these populations across the principal causes of health disparities.

3.1. Health Behaviors

Most health scientists agree that diet, nutrition and exercise matter for individual health outcomes, but there are still questions concerning the relative importance of health behaviors in explaining racialized differences in population health. Some researchers have speculated that “unexplained differences reflect unmeasured factors that are associated with both race/ethnicity and the specified outcome but are not related to either discrimination or
socioeconomic position, [including] culturally shaped patterns of food consumption” [57]. Indeed, studies show that foreign-born Blacks report what some may classify as better health behaviors than native-born Blacks, suggesting that this unobserved “cultural” factor might contribute to health differences between these populations. For instance, native-born Blacks are more likely to smoke than foreign-born Blacks [19,58,59]. Native-born Blacks are also more likely to drink and use drugs than foreign-born Blacks [59,60]. Foreign-born Blacks are more likely than native-born Blacks to report “at least some physical activity” [59], and they have more healthful diets than native-born Blacks [61]. Since these populations have known differences in health behaviors, their health differences might stem from different health behaviors.

3.2. Socioeconomic Status

One of the central arguments in studies that focus on the social determinants of health is that socioeconomic status plays a central, if not fundamental, role in shaping population health [62]. Native and foreign-born Blacks also have known differences in socioeconomic status and resources. Foreign-born Blacks have greater educational attainment than native-born Blacks [44] and are also more likely to attend more selective colleges and universities [42]. Although newly arriving foreign-born Blacks often have lower annual earnings than native-born Blacks, their earnings often match or exceed the earnings of native-born Blacks after being in the labor market for about 15 years [44,63,64]. Foreign-born Blacks also have a greater occupational status than native-born Blacks [43]. Since socioeconomic status and resources play a key role in population health disparities and foreign-born Blacks have greater socioeconomic status profiles than native-born Blacks, health differences between these populations might result from differences in socioeconomic status.

3.3. Environment

The environmental factors that contribute to health outcomes range from psychosocial stressors to the physical ecology of the built environment. Studies that assess housing segregation between native and foreign-born Blacks show that, while not as pronounced as Black–White segregation, these populations often live in different areas [47,65]. Therefore, there may be some differences in their physical ecology. Although these populations experience similar levels of racial discrimination [34], the nature of these racialized experiences may be different [32,53], and/or they may process or cope with relatively similar experiences differently [24,66,67]. Unlike native-born Blacks, foreign-born Blacks experience various forms of stress associated with the process of immigrant assimilation [32,55], and they enter the United States from both majority-White and majority-Black sending countries [17], which means Black populations in the United States might have historical differences in racial context at different stages of the life course [14,68,69]. Since these populations often live in different neighborhoods and experience different psychosocial stressors (differently), comparative studies might allow for improvements in our understanding of how the social and physical environment contributes to disparities in population health.

3.4. Genetics

In recent years, medical scientists have made tremendous headway in furthering our understanding of the links between genetics and individual health outcomes, but the relationship between genetics and health disparities between population groups remains less clear [70–72]. Still, some interpret race residuals as offering evidence of the role of unobserved differences in population genetics, which, when comparing Whites and Blacks, may, knowingly or unknowingly, lend credence to arguments for the genetic determinants of racial difference [73] (these scientists are often much less clear or forthcoming about what these genetic differences might be and how they might contribute to differences in health between populations with different racial statuses). Notwithstanding the fact that native and foreign-born Blacks share the same racial status and similar distributions of African genetic ancestry while occupying different sociocultural contexts, comparative studies avoid contentious debates on the genetic
basis of racial difference and the potential role of such genetic differences in population health disparities. However, scientists can still further investigate the potential role of genetics in population health (e.g., single-nucleotide polymorphisms, genetic methylation and gene expression; [37,38,74]). For instance, while native and foreign-born Blacks have similar physical features that are widely associated with Blackness (i.e., skin color, hair texture and craniofacial bone structure; [75]), it is entirely possible that these populations have other important biological differences. Indeed, there is more genetic variation in populations with greater African ancestry, which might further advance our understandings of complex interactions between genes, the environment and health. For example, such studies might consider differences in DNA methylation and/or gene expression [76] and how such differences might be related to differences in historical traumas [77,78].

4. Methods
Since we believed that, compared to the study of other native and immigrant populations, there were few studies of native and foreign-born Black populations, we began with an effort to find all existing studies that compared the health of these populations. The initial timeframe for our review took place between August 2017 and May 2018. We began by searching the MEDLINE/PubMed database using the keyword “Black immigrant”. Given our larger argument, we only retained studies that included a comparison with native and foreign-born Blacks. We excluded studies that only included foreign-born Blacks because they do not allow for direct comparisons with native-born Blacks. This search resulted in 29 “seed studies”. We then reviewed the citations included at the end of these studies and used the “cited by” feature on Google Scholar to find studies that cited any of the seed studies. We repeated this process for each study that we found until we no longer found additional studies (i.e., checking the references at the end of studies for more studies and finding all known citations of each study that we identified, using Google Scholar). This process identified 139 studies. We then re-ran this process again in April 2022. We reviewed all the 139 previous identified studies and used the “cited by” feature of Google Scholar to identify recently published studies that cited any of our 139 previously identified studies. As we identified more recently published studies, we then checked their references for previously unidentified studies. This process resulted in a total of 208 studies of health disparities between native and foreign-born Blacks. As the focus was on health outcomes, we excluded studies that focused on health-seeking behaviors and the use of health services. While some studies also controlled for health status co-morbidity, we did not specify this in our tables, as health status did not fit within our set of principal causes for population health.

5. Results
We organized the studies that we identified in Table 1 according to the Institutes of the National Institutes of Health. Most of the studies controlled for differences in socioeconomic status (194), followed by environment (55) and health behaviors (60), while very few considered genetics (6). The majority of national studies used data from the National Survey of American Life (NSAL, 45; [79]), followed by the National Health Interview Survey (NHIS, 34), the National Health and Nutrition Examination Study (NHANES, 11) and the U.S. Census (10). The remaining studies included small non-probability samples from specific community locations. Figure 1 shows the overall trend in the number of studies. The first study appeared in 1985. Since then, there has been a general increase in the rate of publications, but this increase has tapered off in recent years. Figure 2a,b shows that most studies, both bi-variate (or descriptive) and multivariate (or adjusted), report better health among foreign-born Blacks. We use the term “positive” to infer that our basic hypothesis holds true in these cases—i.e., foreign-born Blacks have better health than native-born Blacks. We use the term “negative” to denote the opposite and “mixed” when multiple outcomes had different “directions.” Although these populations are sometimes different on measures of health behavior, socioeconomic status and environment, our summary of the multivariate figures suggests that studies that account for these factors often do not provide a full accounting for health disparities between these populations.
| Mental health | Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|---------------|--------------|----------------------|--------|------------------|-----------|--------------|
|               | Cohen, 1997  | African American adults (135) Caribbean-born Black adults (91) | New York City, NY | Mental health disorder: Medical chart review | Negative | Negative |
|               | Miranda, 2005 | African American women (7965) African-born Black women (913) Caribbean-born Black women (273) | Washington, DC | Depressive symptoms: Prime-MD assessed | Positive | Positive |
|               | Joe, 2006    | African American adults (3570) Black Caribbean adults (1621) | National (NSAL) | Lifetime suicide ideation: self-reported | Negative | Mixed |
|               | Jackson, 2007 | African American adults (3570) Black Caribbean adults (1621) | National (NSAL) | Mental disorders (DSM-IV): WMH-CIDI assessed | Negative | Negative |
|               | Williams, 2007 | African American adults (3570) Black Caribbean adults (1621) | National (NSAL) | Major depressive disorder (DSM-IV): WMH-CIDI assessed | Positive | Negative |
|               | Williams, 2007 | African American adults (3570) Black Caribbean adults (1621) | National (NSAL) | Psychiatric disorders (DSM-IV): WHM-CIDI assessed | Mixed | Positive |
|               | Taylor, 2007  | African American adults (3570) Black Caribbean adults (1621) African American adolescents (810) Black Caribbean adolescents (360) | National (NSAL) | Psychiatric disorders (DSM-IV): WMH-CIDI | Not applicable | Positive |
|               | Himle, 2008  | African American adults (3570) Black Caribbean adults (1621) | National (NSAL) | Obsessive Compulsive Disorder (DSM-IV): WMH-CIDI assessed | Negative | Negative |
|               | Himle, 2009  | African American adults (3431) Black Caribbean adults (1585) Non-Hispanic white adults (6696) | National (NSAL; NCSR) | Psychiatric disorders (12-month; DSM-IV); WHM-CIDI assessed Psychiatric disorders (lifetime; DSM-IV); WHM-CIDI assessed | Negative | Negative |
|               | Lincoln, 2010 | African American adults (837) Black Caribbean adults (304) | National (NSAL) | Self-rated mental health: One-item, self-reported Depressive symptoms: CESD-12 scale | Not applicable | Positive |
|               | Boyd, 2011   | African American women (2019) Black Caribbean women (799) Non-Hispanic white women (400) | National (NSAL) | Lifetime mood disorder (DSM-IV): WHM-CIDI assessed | Mixed | Positive |
|               | Soto, 2011   | African American adults (3570) Black Caribbean adults (1438) | National (NSAL) | Generalized anxiety disorder (DSM-IV): WHM-CIDI assessed | Positive | Positive |
|               | Taylor, 2011 | African American adults (3570) Caribbean Black adults (1621) | National (NSAL) | Suicidal behavior (DSM-IV): WHM-CIDI assessed | Positive | Positive |
| Author, Year     | Study Population (N)                                                                 | Sample                      | Measured Outcome                                                                                                           | Bivariate | Multivariate |
|------------------|-------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------|--------------|
| Mental health    | Aranda, 2012 [93]                                                                    | National (NSAL)             | Major depressive disorder (lifetime; DSM-IV): WMH-CIDI assessed Major depressive disorder (12-month; DSM-IV): WMH-CIDI assessed | Negative  | Negative      |
| Mental health    | Doyle, 2012 [94]                                                                     | National (NSAL)             | Mental illness (DSM-IV): WMH-CIDI assessed Mental health severity: Sheehan disability scale                                  | Positive  | Positive      |
| Mental health    | Goosby, 2012 [95]                                                                   | National (NSAL)             | Depressive symptoms: CESD-12 scale Adolescent stress appraisal: Cohen’s perceived scale Parent stress appraisal: one-time, self-report | Mixed     | Mixed         |
| Mental health    | Ida, 2012 [96]                                                                       | National (NSAL)             | Depressive symptoms: CESD-12 scale                                                                                        | Positive  | Positive      |
| Mental health    | Lincoln, 2010 [89]                                                                   | National (NSAL)             | Major depressive disorder (DSM-IV): WMH-CIDI assessed                                                                      | Negative  | Negative      |
| Mental health    | Lincoln, 2012 [97]                                                                   | National (NSAL)             | Suicide ideation: self-reported Suicide attempts: self-reported                                                              | Negative  | Negative      |
| Mental health    | Woodward, 2012 [98]                                                                  | National (NSAL; NCSR, NLAAS)| Lifetime affective disorders (DSM-IV): WMH-CIDI assessed Anxiety disorder (DSM-IV): WMH-CIDI assessed                     | Mixed     | Negative      |
| Mental health    | Assari, 2013 [99]                                                                    | National (NSAL)             | Psychiatric disorders (DSM-IV): WMH-CIDI assessed Lifetime serious suicide ideation: Self-reported                           | Positive  | Positive      |
| Mental health    | Gibbs, 2013 [100]                                                                    | National (NESARC)           | Psychiatric disorders (DSM-IV): WMH-CIDI assessed Lifetime major depressive disorder: Self-reported                           | Positive  | Positive      |
| Mental health    | Henning-Smith, 2013 [101]                                                           | Minnesota                   | Mental health: Self-reported emotional health                                                                               | Positive  | Positive      |
| Mental health    | Levine, 2013 [102]                                                                   | National (NSAL; NCSR)       | Panic disorder (lifetime; DSM-IV): WMH-CIDI assessed Panic disorder 12-month; DSM-IV: WMH-CIDI assessed                       | Negative  | Mixed         |
| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|--------------|----------------------|--------|-----------------|-----------|--------------|
| Mental health Marshall, 2013 [103] | African American adults (837) Caribbean Black adults (271) | National (NSAL) | Depressive symptoms: CESD-12 scale | Not applicable | Mixed |
| Mental health Woodward, 2013 [104] | African American adults (1135) Caribbean black adults (426) Non-Hispanic white adults (389) | National (NSAL) | Major depressive disorder (lifetime; DSM-IV): WMH-CIDI assessed Major depressive disorder (12-month; DSM-IV): WMH-CIDI assessed | Not applicable | Mixed |
| Mental health Levine, 2014 [105] | African American adults (3570) Caribbean-born Black adults (1621) | National (NSAL) | Social anxiety disorder (DSM-IV): WMH-CIDI assessed | Positive | Mixed |
| Mental health Brewton-Tiayon, 2015 [106] | African American adults (3434) US-born Caribbean adults (432) Caribbean-born Black adults (1141) | National (NSAL) | Major depressive disorder (lifetime; DSM-IV): WMH-CIDI assessed Major depressive episode (lifetime; DSM-IV): WMH-CIDI assessed Depressive symptoms: CESD-12 scale | Mixed | Not applicable |
| Mental health Lankarani, 2015 [107] | African American adults (396) Caribbean Black adults (131) non-Hispanic white adults (75) | National (NSAL) | Major depressive disorder (lifetime; DSM-IV): WMH-CIDI assessed Major depressive disorder (12-month; DSM-IV): WMH-CIDI assessed Chronic medical conditions: Self-reported | Positive | Positive |
| Mental health Taylor, 2015 [108] | African American adults (3570) Caribbean-born Black adults (1621) | National (NSAL) | Major depressive disorder (lifetime; DSM-IV): WMH-CIDI assessed Major depressive disorder (12-month; DSM-IV): WMH-CIDI assessed Psychological distress: Kessler-6 scale | Mixed | Mixed |
| Mental health Assari, 2016 [109] | African American adults (3570) Caribbean-born Black adults (1621) | National (NSAL) | Mental health: Self-rated | Mixed | Mixed |
| Mental health Assari, 2013 [99] | African American adults (3570) Caribbean-born Black adults (1621) | National (NSAL) | Suicide ideation: Single-item self-report | Not applicable | Mixed |
| Mental health Mereish, 2016 [110] | African American men (1201) Caribbean-descendent Black men (545) | National (NSAL) | Depressive symptoms: CESD-12 scale | Positive | Positive |
| Mental health Molina, 2016 [111] | African American adults (3570) Caribbean-born Black adults (1418) | National (NSAL) | Major depressive disorder (12-month; DSM-IV): WMH-CIDI assessed | Mixed | Positive |
| Mental health Blostein, 2017 [112] | African American adults (3570) Caribbean-born Black adults (1621) | National (NSAL) | Lifetime binge eating (DSM-IV): WMH-CIDI assessed | Not applicable | Negative |
| Mental health Mouzon, 2017 [113] | African American adults (3570) Caribbean-born Black adults (1438) | National (NSAL) | Depressive symptoms: CESD-12 scale Psychological distress: Kessler-6 scale | Not applicable | Positive |
| Mental health | Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|---------------|--------------|----------------------|--------|----------------|-----------|-------------|
| Mental health | Moon, 2019 [114] | US born Black adults (1535) Foreign born Black adults (125) US and foreign-born White; Latino populations | National (NHATS) | Dementia: proxy report, AD8 score, and cognitive testing | Positive | Positive |
| Mental health | Erving, 2019 [115] | African Americans (1616) Caribbean Blacks (601) | National (NSAL) | Depressive symptoms: CESD-12 scale | Not applicable | Not applicable |
| Mental health | Ikonte, 2020 [116] | US born Black adults (10,959) Foreign born Black adults (6605) US and foreign-born White; Latino populations | National (NHIS) | Psychological distress: Kessler-6 scale | Positive | Positive |
| Mental health | Erving, 2021 [117] | African-American women (2084) U.S. born Afro-Caribbean women (250) Foreign-born Afro-Caribbean women (631) | National (NSAL) | Depressive symptoms: CESD-12 scale | Positive | Positive |
| Maternal | Cabral, 1990 [118] | African-American women (616) Foreign-born Black women (201) | Massachusetts | Intrauterine growth: Clinically derived Duration of gestation: Clinically derived Birthweight: Clinically derived | Positive | Positive |
| Maternal | Friedman, 1993 [119] | African-American women (n/r) Foreign-born Black women (n/r) | Massachusetts | Birthweight: Birth certificate tapes | Positive | Positive |
| Maternal | Wasse, 1994 [120] | African American women (526) Ethiopian-born Black women (264) | Washington State | Birthweight: Birth certificate tapes | Positive | Positive |
| Maternal | David, 1997 [121] | African-American women (43,322) African-born Black women (3135) | Illinois | Birthweight: Birth certificate tapes | Positive | Positive |
| Maternal | Hummer, 1999 [18] | African-American women (n/r) Foreign-born Black women (n/r) | National (NCHS) | Infant mortality: infant born alive survived to first birthday | Positive | Positive |
| Maternal | Fang, 1999 [122] | U.S. born (Southern) Black women (17,968) U.S.-born (Northeastern) Black women (155,101) African-born Black women (9362) Caribbean-born Black women (76,426) South America born Black women (11,006) | New York City, NY | Preterm Birth Risk: Birth records | Positive | Positive |
| Maternal | Pallotto, 2000 [123] | African-American women (67,357) Caribbean-born Black women (2265) | Illinois | Low birth weight: Clinically derived | Positive | Positive |
Table 1. Cont.

| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|--------------|----------------------|--------|------------------|-----------|--------------|
| Maternal     | Collins, 2002 [124]  | African-American Grandmothers (31,699) African/Caribbean-born Black Grandmothers (104) Illinois | Low birth weight: Clinically derived | Positive | Positive |
| Maternal     | Rosenberg, 2002 [125]| African-American women (130,681) Foreign-born Black women (72,293) New York City, NY | Low birth weight: Clinically derived Infant mortality: State records | Positive | Positive |
| Maternal     | Acevedo-Garcia, 2005 [126]| African-American women (322,510) Foreign-born Black women (40,213) National (Detail Natality) | Low birth weight: Clinically derived | Positive | Positive |
| Maternal     | Howard, 2006 [69]    | African-American women (88,966) West-Indian/Brazilian Black women (47,050) South/Central American Black women (15,234) African-born Black women (10,875) Puerto Rican Black women (3948) European Black women (1028) Asian Black women (747) Cuban Black women (191) New York City, NY | Low birth weight: Clinically derived Preterm delivery: Clinically derived | Positive | Positive |
| Maternal     | Grady, 2007 [127]    | African-American women (17,938) Foreign-born Black women (18,459) New York City, NY | Birthweight risk: Geocoded | Positive | Positive |
| Maternal     | Dominguez, 2009 [128]| African-American women (185) Foreign-born Black women (114) Boston, MA | Preterm delivery: Clinically derived Low birthweight: Clinically derived Infant mortality: Clinically derived | Positive | Positive |
| Maternal     | Elo, 2010 [60]       | African-American Pregnant women (2816) Caribbean-born Pregnant women (179) Philadelphia, PA | Smoking: Self-report, 12 months prior to pregnancy Alcohol use: Self-report, 12 months prior to pregnancy Marijuana use: Seld-report, 12 months prior to pregnancy | Positive | Positive |
| Maternal     | Mason, 2010 [129]    | African-American women (141,969) Caribbean-born Black women (87,026) African-born Black women (21,088) New York City, NY | Preterm Birth Risk: Birth records | Positive | Positive |
| Maternal     | Bloch, 2011 [130]    | African-American women (24,165) Foreign-born Black women (6136) Philadelphia, PA | Preterm delivery rate: Geospatial | Negative | Negative |
| Maternal     | Elo, 2014 [131]      | African-American women (296,787) Foreign-born Black women (47,334) 27 States | Rates of Prematurity: Clinically estimated gestational age (20-37 weeks) Small for Gestational Age: weight <10th percentile given gestational week | Positive | Positive |
| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|-------------|----------------------|--------|-----------------|-----------|--------------|
| Maternal Hendi, 2015 [132] | African American women (34,371) African-born women (4146) Caribbean-born women (3151) | National (NHIS) | Childhood health: self-report | Positive | Positive |
| Maternal DeSisto, 2018 [133] | US born Black women (337,141) Foreign born Black women (63,493) | National (Detail Natality) | Preterm Birth Risk: Birth records | Positive | Positive |
| Maternal Singh, 2018 [19] | US born Black women (1,004,997) Foreign born Black women (177,299) US and foreign-born White; Asian populations | National (Detail Natality) | Maternal Hypertension Risk: Birth records | Positive | Positive |
| Maternal Oliver, 2018 [134] | US born Black women (303,028) African born Black women (10,966) Somalia-born women (8480) | Ohio | Preterm delivery rate: Clinically derived | Mixed | Mixed |
| Maternal Kirby, 2019 [135] | US born Black women (1,561,600) Foreign born Black women (254,052) US and foreign-born White; Latino populations | National (Detail Natality) | Birth Defect Risk: Birth records | Positive | Positive |
| Maternal Elsayed, 2019 [136] | US born Black women (340) Foreign born Black women (107) | Newark, NJ | Preterm Birth Risk: Clinically derived | Positive | Positive |
| Maternal Singh, 2019 [137] | US born Black women (n/r) Foreign born Black women (n/r) US and foreign-born White; Asian; Latino populations | National (Detail Natality) | Pre-pregnancy Obesity: Self-reported | Positive | Positive |
| Maternal Scott, 2020 [138] | US born Black women (7222) Foreign born Black women (1387) | California | Gestational Diabetes Risk: Clinically derived Preterm Birth Risk: Clinically derived | Positive | Positive |
| Maternal Araneta, 2020 [139] | US born Black women (6673) Foreign born Black women (2083) US and foreign-born White; Asian; Latino populations | San Diego, CA | Preterm delivery: Clinically derived | Positive | Positive |
| Maternal Hoyt, 2020 [140] | US born Black women (1101) Foreign born Black women (151) | National (NBDPS) | Birth Defect Risk: Birth records | Positive | Positive |
| Maternal Boakye, 2021 [141] | US born Black women (1607) Foreign born Black women (1092) US and foreign-born White; Latino populations | Boston, MA | Preeclampsia Risk: Clinically derived | Positive | Positive |
| Maternal Hong, 2021 [142] | African-American (275) Foreign born Haitian women (151) | Boston, MA | Preeclampsia Risk: Clinically derived | Negative | Positive |
Table 1. Cont.

| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|--------------|----------------------|--------|------------------|-----------|--------------|
| Maternal     | McKenzie-Sampson, 2021 [143] | US born Black women (129,775) Foreign born Black women (16,896) | California | Preterm Birth Risk: Clinically derived  | Positive | Positive |
| Maternal     | Adegoke, 2021 [144] | US born Black women (1722) Foreign born Black women (2994) US and foreign-born White; Latino populations | Boston, MA | Preterm Birth Risk: Clinically derived Hypertensive disorders: Clinically derived Low birthweight: Clinically derived Intrauterine fetal demise: Clinically derived | Positive | Positive |
| Maternal     | Boakye, 2021 [141] | US born Black women (1605) Foreign born Black women (1093) US and foreign-born White; Latino populations | Boston, MA | Preeclampsia Risk: Clinically derived | Positive | Positive |
| Maternal     | Andrasfay, 2021 [145] | US born Black women (47,324) Foreign born Black women (1157) US and foreign-born White; Asian; Latino populations | California | Low birthweight (less than 2500 g): Clinically derived Preterm Birth Risk: Clinically derived | Positive | Positive |
| Maternal     | Green, 2021 [146] | US born Black women (n/r) Foreign born Black women (n/r) US and foreign-born White; Asian; Latino populations | National (ECLS-B) | Pregnancy-related obesity: Self-reported | Positive | Mixed |
| Maternal     | Park, 2021 [147] | US born Black women (1849) Foreign born Black women (1849) US and foreign-born White; Latino populations | Boston, MA | Tobacco use: Self-reported Alcohol use: Self-reported Postnatal CMDs: Self-reported | Positive | Positive |
| Maternal     | Blebu, 2021 [148] | US born Black women (83,169) African born Black women (7151) Caribbean-born Black women (943) | California | Preterm delivery: Clinically derived | Positive | Mixed |
| Maternal     | Kwapong, 2022 [149] | US born Black women (1607) Foreign born Black women (1092) US and foreign-born White; Latino populations | Boston, MA | Preterm delivery: Clinically derived | Positive | Positive |
| Maternal     | Minhas, 2022 [150] | US born Black women (1607) Foreign born Black women (1092) | Boston, MA | Preterm delivery: Clinically derived | Positive | Positive |
| Maternal     | Maiyegun, 2022 [151] | US born Black women (1,746,740) Foreign born Black women (332,422) US and foreign-born White; Latino populations | National (Detail Natality) | Stillbirth Risk: Birth records | Positive | Positive |
Table 1. Cont.

| Author, Year  | Study Population (N)                                                                 | Sample               | Measured Outcome                          | Bivariate | Multivariate |
|---------------|--------------------------------------------------------------------------------------|----------------------|-------------------------------------------|-----------|--------------|
| Maternal      |                                                                                      |                      | Preterm delivery: Clinically derived      | Positive  | Positive      |
| Maternal      | US born Black women (61,589) Foreign born Black women (7348) US and foreign-born White; Asian; Latino populations | Philadelphia, PA     | Gestational Diabetes Risk: Clinically derived | Negative  | Mixed         |
| Maternal      | US born Black women (12,292) Foreign born Black women (14,356)                       | Central Massachusetts| Preterm delivery: Clinically derived      | Positive  | Mixed         |
| Maternal      | US born Black women (4134) Foreign born Black women (1402) US and foreign-born White; Latino populations | Houston, TX          | Chlamydia, Gonorrhea, and Syphilis Risk: Clinically derived | Positive  | Mixed         |
| CVD           | African American adults (22) African-born adults (22)                                 | Independent         | Hypertension: Diurnal blood pressure      | Positive  | Positive      |
| CVD           | African American adults (Northern) (1,008,677) Black Caribbean adults (309,380)     | New York City, NY   | Hypertension: Mortality records           | Positive  | Positive      |
| CVD           | African American adults (1518) Caribbean Black adults (2722) African Black adults (4862) | National (ICSHB)    | Hypertension: Clinical assessment Obesity: Clinical assessment | Positive  | Negative       |
| CVD           | African American adults (31) African-born adults (27)                                | Ohio                | Hypertension: Measured systolic/diastolic blood pressure | Negative  | Negative       |
| CVD           | African American adults (95) African-born adults (87)                                | Independent         | Hypertension                              | Positive  | Positive      |
| CVD           | African American adults (99) African-born adults (86)                                | Houston, TX         | Hypertension: Mercury sphygmonomanometer  | Negative  | Positive      |
| CVD           | African American adults (Northern) (1403) African American adults (Southern) (1751) | National (NHANES)   | Hypertension: self-reported uncontrolled or target-organ damage | Positive  | Positive      |
| CVD           | African American adults (16,891) Foreign-born Black adults (2015)                    | National (NHIS)     | Activation limitation attributed to hypertension: self-reported | Positive  | Positive      |
| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|-------------|----------------------|--------|-----------------|-----------|-------------|
| CVD Lancaster, 2006 | African American adults (2062) Foreign-born Black adults (241) Foreign-born, Hispanic Black adults (4) US-born, Hispanic Black adults (21) | National (NHANES) | Coronary heart disease risk profile | Positive | Positive |
| CVD Ryan, 2006 | African American adults (78) Foreign-born Black adults (112) | New Hampshire | Hypertension: Measured blood pressure Physical health: Self-reported health, SF-12 | Negative | Negative |
| CVD Davis, 2007 | African American adults (61) US-born, Black Caribbeans (62) Foreign-born Black Caribbeans (66) | South Florida | Hypertension: measured blood pressure Diabetes: fasting blood glucose Cholestrol: measured LDL | Positive | Positive |
| CVD Borrell, 2008 | African American adults (36,358) Foreign-born Black adults (3376) | National (NHIS) | Hypertension: self-reported doctor diagnosed | Positive | Positive |
| CVD White, 2011 | African American adults (2985) Foreign-born Black adults (1514) | New York City, NY | Hypertension: self-reported doctor diagnosed | Positive | Positive |
| CVD Baltimore, 2012 | African American adults (125) Caribbean-born Black adults (150) | New York | Myocardial infarction: self-reported Hypertension: self-reported | Negative | Not applicable |
| CVD Sellers, 2012 | African American adults (3570) Caribbean Black adults (445) Non-Hispanic white adults (891) | National (NSAL) | Hypertension: self-reported Obesity: BMI derived from height/weight Count of physical health problems: self-reported Self-rated health: self-reported | Negative | Negative |
| CVD Yu, 2013 | African American men (75) African-born men (80) | Washington, DC | Cardiometabolic diseases: self-reported (prediabetes, diabetes, insulin resistance, metabolic triad) | Mixed | Not applicable |
| CVD Dagadu, 2014 | African American adults (1588) Caribbean Black adults (549) | National (NSAL) | Heart trouble: Self-reported | Mixed | Mixed |
| CVD O'Connor, 2014 | African American adults (76) Foreign-born Black adults (138) | Washington, DC | Hypertension: measured blood pressure Type 2 diabetes: fasting glucose; 2-h glucose Visceral Adipose Tissue: Computerized tomographic scans | Negative | Negative |
| CVD Brown, 2017 | African American adults (4249) Foreign-born Black adults (519) | National (NHANES) | Hypertension: self-reported doctor diagnosed or measured blood pressure | Positive | Positive |
| CVD Cole, 2017 | African American men (817) Foreign-born Black men (310) | New York City, NY | Hypertension: measured blood pressure Hypertension awareness: self-reported hypertension | Positive | Positive |
Table 1. Cont.

| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|--------------|----------------------|--------|------------------|-----------|--------------|
| CVD | Commodore-Mensah, 2017 [173] | African American adults (40,838) African-Born Black adults (36,881) Caribbean-Born Black adults (1660) | National (NHIS) | Hypertension: self-reported doctor diagnosed | Positive | Positive |
| CVD | Cole, 2018 [174] | US born Black men (829) Foreign born Black men (311) | New York City, NY | Hypertension awareness: self-reported hypertension | Negative | Negative |
| CVD | Fang, 2018 [175] | US born Black adults (n/r) Foreign born Black adults (n/r) US and foreign-born White; Asian; Latino populations | National (NHIS) | Coronary heart disease risk profile | Not applicable | Negative |
| CVD | Turkson-Ocran, 2020 [176] | African-Americans (27,749) African immigrants (1345) | National (NHIS) | Coronary heart disease risk profile | Negative | Negative |
| CVD | Whaley, 2020 [177] | African-Americans (3570) African immigrants (1411) | National (NSAL) | Coronary heart disease risk profile | Negative | Negative |
| CVD | Doamekpor, 2021 [178] | US born Black adults (4693) Foreign born Black adults (2968) | National (NHANES) | Coronary heart disease risk profile | Mixed | Negative |
| Metabolic Conditions | Hicks, 2003 [161] | African American adults (Northern) (1403) African American adults (Southern) (1751) Foreign-born adults (215) | National (NHANES) | Type 2 Diabetes: Self-reported | Positive | Positive |
| Metabolic Conditions | Singh, 2006 [22] | African American adults (n/r) Foreign-born Black adults (n/r) US and foreign-born White; Asian; Latino populations | National (NHIS) | Type 2 Diabetes: Prevalence | Positive | Not applicable |
| Metabolic Conditions | Oza-Frank, 2013 [179] | African American adults (1179) Foreign-born Black adults (93) | Multi-site (MESA) | Type 2 Diabetes | Mixed | Not applicable |
| Metabolic Conditions | Ford, 2015 [180] | African American adults (42,379) African-born Black adults (1533) Latin American/Caribbean-born Black adults (3839) | National (NHIS) | Type 2 Diabetes: Self-reported, doctor diagnosed | Positive | Positive |
| Metabolic Conditions | O'Connor, 2015 [181] | African American Youth (53) East African Immigrant Youth (60) | Washington | Type 1 Diabetes: Medically diagnosed | Negative | Not applicable |
| Metabolic Conditions | Commodore-Mensah, 2017 [173] | African American adults (40,838) African-Born Black adults (36,881) Caribbean-Born Black adults (1660) | National (NHIS) | Hypertension: self-reported doctor diagnosed | Positive | Positive |
| Metabolic Conditions | Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|----------------------|-------------|----------------------|--------|-----------------|-----------|--------------|
|                      | Harvey, 2017 [182] | African American women (10) Caribbean-born women in US (8) Caribbean-born women in US Virgin Islands (24) | Connecticut & US Virgin Islands | Diabetes self-management behaviors: self-reported diet, physical activity, medication adherence, foot care | Positive | Not applicable |
|                      | Horlyck-Romanovsky, 2019 [183] | US born Black adults (6297) Foreign born Black adults (3701) | New York | Type 2 Diabetes: Prevalence | Mixed | Mixed |
|                      | Engel, 2019 [184] | U.S. born NH Black adults Foreign born NH Black adults US and foreign-born White; Asian; Latino populations | National (NHIS) | Type 2 Diabetes: Prevalence | Positive | Mixed |
|                      | Ogunwole, 2022 [185] | US born Black adults Foreign born Black adults (6444) US and foreign-born White; Asian; Latino populations | National (NHIS) | Gestational diabetes mellitus | Negative | Mixed |
|                      | Choi, 2022 [186] | US born Black adults (n/r) Foreign born Black adults (n/r) US and foreign-born White; Asian; Latino populations | National (NHANES) | Type 2 Diabetes: Prevalence | Negative | Negative |
|                      | Antecol, 2006 [187] | African American adults (35,642) Foreign-born Black adults (2446) US and foreign-born White; Latino populations | National (NHIS) | Obesity: BMI derived from height/weight | Positive | Positive |
|                      | Bennett, 2007 [188] | African American adults (394) Foreign-born Black adults (157) | Massachusetts | Obesity: BMI derived from height/weight | Positive | Positive |
|                      | Sanchez-Vaznaugh, 2008 [189] | African American adults (1835) Foreign-born Black adults (106) US and foreign-born White; Asian; Latino populations | California | Obesity: BMI derived from height/weight | Positive | Positive |
|                      | Barrington, 2010 [190] | African American adults (n/r) Foreign-born Black adults (n/r) US and foreign-born White; Latino populations | National (NHIS) | Obesity: BMI derived from height/weight | Positive | Positive |
|                      | Wen, 2013 [191] | African American adults (952) Foreign-born Black adults (102) | National (NHANES) | BMI: Clinically measured Abdominal obesity; Calculated waist circumference (≥102 cm) | Positive | Positive |
|                      | Assari, 2014 [192] | African American adults (3570) Caribbean Black adults (1621) | National (NSAL) | Obesity: BMI derived from height/weight | Not applicable | Mixed |
| Study Type          | Author, Year | Study Population (N) | Sample | Measured Outcome                  | Bivariate | Multivariate |
|---------------------|--------------|----------------------|--------|-----------------------------------|-----------|--------------|
| Metabolic Conditions | O'Connor, 2014 [170] | African American adults (76) African-born Black adults (138) | Washington, DC | BMI: Calculated Waist Circumference: measured Subcutaneous adipose tissue: Computerized tomographic scans | Positive | Positive |
| Metabolic Conditions | Sullivan, 2014 [193] | African American adults (3570) Caribbean Black adults (1621) Non-Hispanic white (891) | National (NSAL) | Obesity: BMI derived from height/weight | Not applicable | Positive |
| Metabolic Conditions | Mehta, 2015 [194] | African American adults (33,771) African-born Black adults (1435) Latin American/Caribbean-born Black adults (2520) | National (NHIS) | Obesity: BMI derived from height/weight | Positive | Positive |
| Metabolic Conditions | Cuevas, 2019 [195] | US born Black adults (n/r) Foreign born Black adults (n/r) US and foreign-born White; Asian; Latino populations | National (NESARC-III) | Obesity: BMI derived from height/weight | Positive | Positive |
| Cancer              | Fruchter, 1985 [196] | African-American women (237) English, Caribbean-born women (227) Spanish, Caribbean-born women (70) Haitian-born women (361) | New York City, NY | Cancer screening: Breast, Cervical | Negative | Not applicable |
| Cancer              | Fruchter, 1986 [197] | African-American women (1477) English, Caribbean-born women (256) Haitian-born women (121) | New York City, NY | Cancer screening: Cervical | Positive | Not applicable |
| Cancer              | Fang, 1997 [157] | U.S. born Black adults (Southern) (366,853) U.S. born Black adults (Northeastern) (1,008,677) Caribbean-born Black adults (309,380) | New York City, NY | Cancer survival: All sites | Not applicable | Mixed |
| Cancer              | Magnus, 2004 [198] | African-American men (56) Caribbean-American men (29) Haitian-American men (11) African-born Black men (4) | Southern Florida | Cancer screening: Prostate | Not applicable | Not applicable |
| Cancer              | Garbers, 2006 [199] | African-American women (148) Caribbean-born women (146) | New York City, NY | Cancer screening: Breast | Negative | Negative |
| Cancer              | Bennett, 2008 [200] | African American men (447) Foreign-born Black men (218) | Boston, MA | Tobacco use: Self-reported smoking status | Not applicable | Positive |
| Cancer              | Taioli, 2010 [201] | African American women (593) Trinidad and Tobago women (2618) Guyana (499) | New York, NY, Trinidad and Tobago, Guyana | Cancer survival: Breast | Negative | Negative |
| Author, Year               | Study Population (N)                                                                 | Sample             | Measured Outcome                                      | Bivariate | Multivariate |
|---------------------------|--------------------------------------------------------------------------------------|--------------------|--------------------------------------------------------|-----------|--------------|
| Cancer Odedina, 2011 [202]| African-American men (2405)                                                          | National (NHANES)  | Cancer screening: Prostate                             | Positive  | Positive      |
|                           | African-Born Black men (315)                                                         |                    |                                                         |           |              |
|                           | Caribbean-Born Black men (320)                                                        |                    |                                                         |           |              |
| Cancer Wade, 2013 [203]   | African American adults (4253)                                                        | National (US Census)| Tobacco use: Self-reported smoking status              | Not applicable | Positive      |
|                           | Foreign-born Black adults (460)                                                       |                    |                                                         |           |              |
| Cancer Consedine, 2014 [204]| Black Caribbean Descendent adults (n/a)                                              | Not available      | Cancer screening: Breast, Prostate, Colorectal, Cervical| Negative  | Not applicable |
|                           | Caribbean-Born Black adults (n/a)                                                     |                    |                                                         |           |              |
| Cancer Forney-Gorman, 2016 [205]| African-American women (620)                                                          | National (NHIS)    | Cancer screening: Pap smear test                       | Negative  | Negative      |
|                           | African-Born Black women (36)                                                        |                    |                                                         |           |              |
| Cancer Pinheiro, 2016 [206]| U.S. born Black adults (16,119)                                                       | Southern Florida   | Cancer survival: All sites                             | Not applicable | Positive      |
|                           | Foreign-born Black adults (4113)                                                      |                    |                                                         |           |              |
| Cancer Ashing, 2017 [207]  | African American Black women (129)                                                   | Southern California| HPV vaccine safety: self-reported                     | Negative  | Not applicable |
|                           | Foreign-born Black women (53)                                                        |                    | HPV vaccine efficacy: self-reported                    |           |              |
|                           | US-born Latina women (57)                                                            |                    |                                                         |           |              |
|                           | Foreign-born Latina women (144)                                                       |                    |                                                         |           |              |
| Cancer Barreto-Coelho, 2019 [208]| African American adults (507)                                                         | Southern Florida   | Cancer survival: Breast                               | Positive  | Positive      |
|                           | US-born Caribbean Black adults (624)                                                  |                    |                                                         |           |              |
| Cancer Hallowell, 2019 [209] | US born Black adults (7172)                                                           | National (US Census)| Cancer survival: Cervical                             | Positive  | Positive      |
|                           | Foreign-born Black adults (591)                                                       |                    |                                                         |           |              |
|                           | US and foreign-born White; Asian; Latino populations                                 |                    |                                                         |           |              |
| Cancer Schlumbrecht, 2019 [210]| African American adults (105)                                                         | Southern Florida   | Cancer survival: Endometrial                          | Positive  | Positive      |
|                           | Caribbean Black adults (90)                                                           |                    |                                                         |           |              |
| Cancer Cofie, 2019 [211]   | US born Black women (140,670)                                                        | National (NHIS)    | Cancer screening: Breast                               | Positive  | Positive      |
|                           | Foreign born Black women (14,837)                                                    |                    |                                                         |           |              |
|                           | US and foreign-born White; Asian; Latino populations                                 |                    |                                                         |           |              |
| Cancer Bhattacharya, 2019 [212]| US born Black adults (621)                                                            | National (NHANES)  | HPV infection                                          | Positive  | Positive      |
|                           | Foreign born Black adults (81)                                                        |                    |                                                         |           |              |
|                           | US and foreign-born White; Latino populations                                         |                    |                                                         |           |              |
| Cancer Boakye, 2019 [213]   | US born Black men (1319)                                                             | National (NHIS)    | HPV vaccine safety: self-reported                      | Negative  | Negative      |
|                           | Foreign born Black men (204)                                                         |                    | HPV vaccine efficacy: self-reported                    |           |              |
|                           | US and foreign-born White; Latino populations                                         |                    |                                                         |           |              |
Table 1. Cont.

| Author, Year            | Study Population (N)                                                                 | Sample              | Measured Outcome         | Bivariate | Multivariate |
|-------------------------|-------------------------------------------------------------------------------------|---------------------|--------------------------|-----------|--------------|
| Cancer                  | US born Black men (17,712) Foreign born Black men (1104) US and foreign-born White; Asian; Latino populations | National (NCHS)     | Cancer survival: Liver   | Positive  | Positive      |
| Endeshaw, 2019 [214]    | US born Black men (17,712) Foreign born Black men (1104) US and foreign-born White; Asian; Latino populations |                     |                          |           |              |
| Hallowell, 2019 [215]   | US born Black adults (310,684) Foreign born Black adults (15,788) US and foreign-born White; Asian; Latino populations | National (NCHS)     | Cancer survival: All sites | Positive  | Positive      |
| Pinheiro, 2020 [217]    | African-American adults (7,350,702) Afro-Caribbean adults (1,227,555) African adults (372,082) | California, Florida, Minnesota and New York | Cancer survival: All sites | Positive  | Positive      |
| Amuta-Jimenez, 2020 [218] | African American women (335) Black immigrant women (115) | National (NHIS)     | Cancer screening: Cervical | Positive  | Positive      |
| Donley, 2020 [219]      | U.S.-born and foreign-born women aged 21–74 years; Black/African-American, European, Asian/Pacific Islander, and other Hispanic/Latino. | Independent         | Cancer screening: Cervical and Breast | Positive  | Positive      |
| McRoy, 2021 [220]       | US born Black adults (4544) Foreign born Black adults (572) | National (NHANES)   | Cancer survival: All sites | Negative  | Negative      |
| Blackman, 2021 [221]    | Caribbean born Black adults (208) African-born Black adults (46) | Philadelphia, PA    | Cancer screening: Colorectal | Positive  | Positive      |
| McElfish, 2021 [222]    | US born Black adults (n/a) Foreign born Black adults (n/a) US and foreign-born White; Asian; Latino populations | National (NHIS)     | HPV vaccine safety: self-reported | Negative  | Negative      |
| Pinheiro, 2021 [223]    | US born Black adults (3568) Caribbean Black adults (1381) US and foreign-born White; Latino populations | Florida, New York   | Cancer survival: Endometrial | Positive  | Positive      |
| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|-------------|----------------------|--------|-----------------|-----------|--------------|
| **Cancer**  | Llanos, 2022 [224]   | US born Black adults (38,834) Foreign born Black adults (5433) New Jersey | Cancer survival: All sites | Positive | Positive |
| **Cancer**  | Millender, 2022 [225]| US born Black adults (n/a) Foreign born Black adults (n/a) US and foreign-born White; Latino populations Independent | Cancer screening: Prostate | Positive | Positive |
| **Alcohol** | Cabral, 1990 [118]   | African American women (616) Foreign-born Black women (201) Boston, MA | Alcohol use during pregnancy: Self-reported | Positive | Positive |
| **Alcohol** | Cohen, 1997 [80]     | African American adults (135) Caribbean-born Black adults (91) New York City, NY | Alcohol dependence: Medical chart review | Positive | Positive |
| **Alcohol** | Epstein, 2002 [226]  | African American adolescents (2281) Caribbean-born Black adolescents (931) New York City, NY | Alcohol use: Self-reported frequency | Positive | Mixed |
| **Alcohol** | Lucas, 2003 [59]     | African American men (13,921) Foreign-born Black men (1486) National (NHIS) | Alcohol use: Self-reported quantity/frequency past 12 months | Positive | Positive |
| **Alcohol** | Hunte, 2012 [227]    | African American adults (3917) Foreign-born Black adults (1091) National (NSAL) | Alcohol use disorder (DSM-IV): WMH-CIDI assessed | Positive | Positive |
| **Alcohol** | Lo, 2012 [228]       | African American adults (2110) Foreign-born Black adults (193) National (NHIS) | Binge drinking: Days in past year consumed 5 drinks/day Quantity of alcohol consumed: Average # drinks consumed/day | Mixed | Mixed |
| **Alcohol** | Gibbs, 2013 [100]    | African American adults (7529) Caribbean Black adults (469) National (NESARC) | Alcohol use (DSM-IV): AUDADIS-IV assessed | Positive | Positive |
| **Alcohol** | Szafarki, 2017 [229]| African American adults (3969) Foreign-born adults (319) National (NESARC) | Alcohol use disorder: DSM-IV assessed | Positive | Negative |
| **Substance Use** | Cabral, 1990 [118]  | African American women (616) Foreign-born Black women (201) Boston, MA | Cigarette use: Self-reported Marijuana use: Self-reported Cocaine use: Self-reported Opiate use: Self-reported | Positive | Positive |
| **Substance Use** | King, 1999 [58]     | African American adults (15,660) Foreign-born Black adults (1078) National (NHIS) | Smoking status: Self-reported | Positive | Positive |
| **Substance Use** | Lucas, 2003 [59]    | African American adults (13,921) Foreign-born Black adults (1486) National (NHIS) | Smoking: Self-reported status | Positive | Positive |
| **Substance Use** | Broman, 2008 [230]  | African American adults (3570) Black Caribbean adults (1621) National (NSAL) | Substance abuse (DSM-IV): WMH-CIDI assessed Substance dependence (DSM-IV): WMH-CIDI assessed | Positive | Positive |
| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|--------------|----------------------|--------|------------------|-----------|--------------|
| Hoffman, 2008 [231] | African American adults (300) West Indian-born Black adults (287) | New York City, NY | Substance use: AUDIT scale | Positive | Positive |
| Bui, 2012 [232] | African American adolescents (3828) Foreign-born Black adolescents (75) | National (Add Health) | Tobacco use: use 30 days prior; yes/no Marijuana use: use 30 days prior; yes/no | Mixed | Mixed |
| Gibbs, 2013 [100] | African American adults (7529) Caribbean Black adults (469) | National (NESARC) | Substance use (DSM-IV): AUDADIS-IV assessed | Positive | Positive |
| Lacey, 2016 [233] | African American adults (3570) Caribbean Black adults (1621) Guyanese Black adults (1142) Jamaican Black adults (1176) | National (NSAL); Guyana; Jamaica | Substance use (DSM-IV): WMH-CIDI assessed | Positive | Positive |
| Molina, 2012 [234] | African American adults (3570) Asian American adults (2095) Caribbean Black adults (1621) Latino adults (2554) Non-Hispanic white adults (4180) | National (NSAL; CPES) | Substance use disorder (DSM-IV): WMH-CIDI assessed | Not applicable | Positive |
| Mays, 2018 [235] | African American men (1222) U.S.-born Caribbean Black men (176) Caribbean Black men (461) | National (NSAL) | Substance use disorder (DSM-IV): WMH-CIDI assessed | Mixed | Mixed |
| Nguyen, 2018 [236] | US-born Black adults (626) Foreign-born Black adults (41) US and foreign-born Asian; Latino populations | Nationals (HINTS) | Smoking: Self-reported status | Positive | Positive |
| Saint-Fort, 2019 [237] | US-born Black adults (43,560) Africa-born Black adults (1911) West-Indies-born Black adults (2194) Europe-born Black adults (192) | National (US Census) | Smoking: Self-reported status | Mixed | Mixed |
| Jones, 2020 [238] | US-born Black women (2242) U.S. born Caribbean women (264) Foreign-born Caribbean Black women (705) | National (NSAL) | Substance use disorder (DSM-IV): WMH-CIDI assessed | Positive | Positive |
| Jegede, 2021 [239] | US-born Black adults w/one immigrant parent (441) U.S.-born Black adults (6683) Caribbean-born Black adults (332) African-born Black adults (218) | National (NESARC-III) | Substance use disorder (DSM-V): WMH-CIDI assessed | Positive | Positive |
Table 1. Cont.

| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|--------------|----------------------|--------|-----------------|-----------|--------------|
| **Substance Use** | Okpala, 2022 [240] | US-born Black adults (n/a) Foreign-born Black adults (n/a) US and foreign-born Asian; Latino populations | National (NHIS) | Cigarette use: Self-reported | Positive | Positive |
| **Substance Use** | Cano, 2022 [241] | US born Black adults (56,233) Foreign born Black adults (2218) US and foreign-born White; Asian; Latino populations | National (NCHS) | Drug overdose mortality | Positive | Positive |
| **HRQoL: Self-report** | Lucas, 2003 [59] | African American adults (13,921) Foreign-Born Black adults (1486) | National (NHIS) | Self-rated health status: Self-reported item | Positive | Positive |
| **HRQoL: Self-report** | Read, 2005 [17] | African American adults (24,540) Foreign-born Black adults (2931) | National (NHIS) | Self-rated health: Self-reported physical health Activity limitation: Self-reported | Positive | Positive |
| **HRQoL: Self-report** | Antecol, 2006 [187] | African American adults (35,642) Foreign-born Black adults (2446) US and foreign-born White; Latino populations | National (NHIS) | Self-rated health: Self-reported physical health Activity limitation: Self-reported | Positive | Positive |
| **HRQoL: Self-report** | Singh, 2006 [22] | African American adults (n/r) Foreign-born Black adults (n/r) US and foreign-born White; Asian; Latino populations | National (US Census; NHIS) | Self-rated health: Self-reported | Positive | Not applicable |
| **HRQoL: Self-report** | Elo, 2008 [68] | African American adults (22,545) Hispanic-born Black adults (283) Caribbean/South American-born Black adults (1485) African-born Black adults (574) European-born Black adults (93) | National (US Census; NHIS) | Self-rated health: Self-reported chronic conditions | Positive | Positive |
| **HRQoL: Self-report** | Keane, 2009 [242] | African American adults (50) Black Caribbean adults (50) | Florida | Self-rated health: 8-item SF Health Survey | Positive | Positive |
| **HRQoL: Self-report** | Acevedo-Garcia, 2010 [243] | First-Gen Black adults (6244) Second-Gen Black adults (1306) Third-Gen Black adults (61,391) | National (US Census) | Self-rated: Reported physical health | Positive | Positive |
| **HRQoL: Self-report** | Griffith, 2011 [244] | African American adults (3570) US-born Caribbean Black adults (440) Caribbean-born Black adults (1166) | National (NSAL) | Self-rated: Reported physical health | Positive | Negative |
| Author, Year | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|--------------|----------------------|--------|------------------|-----------|--------------|
| Hamilton, 2011 [14] | African-born adults (2128) South American-born Black adults (609) Caribbean-born Black adults (4333) European-born Black adults (164) Central American-born Black adults (945) | National (US Census) | Self-rated health: Self-reported measures | Positive | Positive |
| Krieger, 2011 [57] | African American adults (193) Foreign-born Black adults (275) Boston, MA | National (NSAL) | Self-rated health: 12-item SF Health Survey | Positive | Positive |
| Christie-Mizell, 2017 [246] | African American adults (2960) US-born Caribbean Black adults (311) Caribbean-born Black adults (820) | National (NSAL) | Self-rated health: Self-reported | Positive | Mixed |
| Maskileyson, 2021 [247] | US born Black adults (21,185) Foreign born Black adults (2967) US and foreign-born White; Asian; Latino populations | National (NHIS) | Self-rated: Reported physical health | Positive | Mixed |
| Singh, 2002 [249] | African American adults (25,655) Foreign-born Black adults (777) | National (NLMS) | All-cause mortality: Combined risk of mortality from all major causes | Positive | Positive |
| Singh, 2004 [20] | African American adults (n/r) Foreign-born Black adults (n/r) US and foreign-born Asian and Hispanic groups | National (NVSS; NHIS; US Census) | Mortality risk: Risk of mortality from all major causes | Positive | Positive |
| Singh, 2006 [22] | African American adults (n/r) Foreign-born Black adults (n/r) US and foreign-born White; Asian; Latino populations | National (US Census; NHIS) | Life expectancy: Death records Childhood obesity: Prevalence rate | Positive | Positive |
| Singh, 2013 [21] | African American adults (n/r) Foreign-born Black adults (n/r) | National (NVSS; NHIS) | Life expectancy: Death records Childhood obesity: Prevalence rate | Positive | Not applicable |
| Singh, 2002 [249] | African American adults (3318) Foreign-born Black adults (40) | National (NLMS) | All-cause mortality: Combined risk of mortality from all major causes | Positive | Positive |
### Table 1. Cont.

| Author, Year  | Study Population (N) | Sample | Measured Outcome | Bivariate | Multivariate |
|---------------|----------------------|--------|------------------|-----------|--------------|
| HRQoL: Aging  | Jackson, 2005 [16]   | African American adults (3430) Foreign-born Black adults (1167) National (NSAL) | Self-reported health: self-reported Mental disorders: DSM-IV assessed | Positive | Not applicable |
| HRQoL: Aging  | Doamekpor, 2015 [250] | African American adults (2745) Foreign-born Black adults (152) National (NHANES) | Allostatic load score: comprised systolic blood pressure, diastolic blood pressure, c-reactive protein, high-density lipoprotein, total cholesterol, creatinine clearance, serum albumin) | Positive | Positive |

Positive: Black immigrants have a better health outcome than African Americans; Negative: Black immigrants have a worse health outcome than African Americans; Mixed: the disparities in health outcomes are not conclusive; Not applicable: the test was not conducted/reported. Abbreviations: AUDIT, Alcohol Use Disorders Identification Test; WMH-CIDI, World Mental Health—Compositive International Diagnostic Interview.
Figure 1. Number of Publications Comparing native- and foreign-born Blacks, By Year.

(a) 

Figure 2. (a); Proportion of studies affirming hypothesis, Bivariate results (b) Proportion of studies affirming hypothesis, Multivariate results.

6. Mental Health

According to Table 1, the most often studied set of health outcomes falls under the scope of mental health. A total of 40 studies examined differences in mental health between native and foreign-born Blacks. Studies that assessed mental health disorders used either clinical assessments or validated self-report scales. A total of 26 studies used clinical, structured interviews that diagnosed the respondent using classifications in the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition (DSM-IV). Some studies that used DSM-IV classifications also used the World Mental Health Composite International Diagnostic Interview (WMH-CIDI). Cohen and colleagues [80] used clinically diagnosed mental health disorders assessed by medical chart reviews. A few studies used The Center for Epidemiologic Studies Depression Scale (7, CES-D), all of which used the NSAL. The remaining studies used validated self-report scales evaluating self-rated mental health and the Short Form–8 or 12 scales.

These studies present a mixed picture across both national and local community samples and within and across mental health categories. Most of the studies used nationally representative samples (37 of 40), of which 34 of the 37 used data from the NSAL. Studies using the NSAL evaluated a range of mental health outcomes including, but not limited to, depressive symptomatology, mania, panic disorders, phobias, anxiety disorders, suicidality and developmental disorders. Even when accounting for the variability across mental health outcomes, there was no clear pattern in mental health disparities between native and foreign-born Blacks. For example, the most common mental health outcome, depressive symptomatology, had studies that varied in results, with most studies either having better or the same depressive symptoms for these populations. This pattern was also evident in the three local studies, which took place in a range of metropolitan areas [81,101,242].

7. Maternal and Child Health

We identified 42 maternal and child health studies in Table 1, making this the most studied physical health outcome. Of these 42 studies, 26 focused on low birthweight (LBW) and/or preterm birth (PTB). These studies mostly used vital records data, one study used census data, another study used data from the National Center of Health Statistics, and two studies relied on local samples. The study that used data from the U.S. Census [130], found a relatively equal rate of adverse birth outcomes between native and foreign-born Black women.
6. Mental Health

According to Table 1, the most often studied set of health outcomes falls under the scope of mental health. A total of 40 studies examined differences in mental health between native and foreign-born Blacks. Studies that assessed mental health disorders used either clinical assessments or validated self-report scales. A total of 26 studies used clinical, structured interviews that diagnosed the respondent using classifications in the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition (DSM-IV). Some studies that used DSM-IV classifications also used the World Mental Health Composite International Diagnostic Interview (WMH-CIDI). Cohen and colleagues [80] used clinically diagnosed mental health disorders assessed by medical chart reviews. A few studies used The Center for Epidemiologic Studies Depression Scale (7, CES-D), all of which used the NSAL. The remaining studies used validated self-report scales evaluating self-rated mental health and the Short Form–8 or 12 scales.

These studies present a mixed picture across both national and local community samples and within and across mental health categories. Most of the studies used nationally representative samples (37 of 40), of which 34 of the 37 used data from the NSAL. Studies using the NSAL evaluated a range of mental health outcomes including, but not limited to, depressive symptomatology, mania, panic disorders, phobias, anxiety disorders, suicidality and developmental disorders. Even when accounting for the variability across mental health outcomes, there was no clear pattern in mental health disparities between native and foreign-born Blacks. For example, the most common mental health outcome, depressive symptomatology, had studies that varied in results, with most studies either having better or the same depressive symptoms for these populations. This pattern was also evident in the three local studies, which took place in a range of metropolitan areas in the East and Midwest [81,101,242].

7. Maternal and Child Health

We identified 42 maternal and child health studies in Table 1, making this the most studied physical health outcome. Of these 42 studies, 26 focused on low birthweight (LBW) and/or preterm birth (PTB). These studies mostly used vital records data, one study used census data, another study used data from the National Center of Health Statistics, and two studies relied on local samples. The study that used data from the U.S. Census [130], found a relatively equal rate of adverse birth outcomes between native and foreign-born Blacks. The other 14 national and local studies consistently found that foreign-born Blacks had lower rates of adverse birth outcomes than native-born Blacks.

Studies that examined low birthweight, defined as an infant born under 2500 g, found that native-born Blacks had higher rates of infants born at a low birthweight than foreign-born Blacks [69,118,120,121,123–128]. For instance, a study using vital statistics data [126] found that foreign-born Blacks had a reduced risk of giving birth to a low birthweight infant by approximately 25% when compared to native-born Blacks.

Studies that examined preterm birth, defined as an infant born prior to 37 weeks of gestation, found that native-born Blacks had higher rates of infants born preterm than foreign-born Blacks [18,69,128,129,131]. A recent study that used birth record data from 27 states [131] found that, compared to native-born Blacks, foreign-born Blacks had significantly lower rates of PTB. When examining the foreign-born Blacks by region of origin, this study also found that Sub-Saharan African-born Black women had significantly lower rates of PTB compared to Caribbean-born Black women.

8. Cardiovascular

In Table 1, we list 26 studies of disparities in cardiovascular health between native and foreign-born Black populations. National studies consistently show higher blood pressure and a greater risk of hypertension among native-born Blacks, but several local studies paint a more complex picture. Nationally, about 37% of native-born Blacks report hypertension diagnosis, compared to a little over 20% of foreign-born Blacks [171,173]. Although much
less common, several studies consider other indicators of cardiovascular health, including heart trouble and problems with blood circulation. Native-born Blacks appear to have a higher rate of death by coronary heart disease than Blacks born in the Caribbean [157]. Foreign-born Black women have lower rates of myocardial infarction than native-born Black women [161], and a small study of 125 native-born and 150 Caribbean-born Black hospital patients in New York City found that the native-born were more likely to have suffered a myocardial infarction, but no differences in previous cerebrovascular disease or peripheral vascular disease [166]. Another study of the 1988–1994 NHANES III shows that foreign-born Blacks had a lower risk of stroke and heart attack than native-born Blacks [61].

9. Metabolic Conditions

Metabolic conditions include diabetes mellitus, abnormal cholesterol levels and potential complications with obesity. In Table 1, we identified 21 of these studies. Studies measured obesity using self-reported height and weight. Nine out of ten studies reported that native-born Black adults had higher obesity than foreign-born Black adults [170,187–191,194,251]. Most studies evaluated the NHIS or NHANES. The picture for diabetes was generally mixed [22,161,173,179–182]. Like obesity-related studies, national studies used NHIS or NHANES. National studies more often showed better outcomes for foreign-born Blacks. The three local studies reported similar trends between the two groups. The only study that reported better diabetes outcomes among native-born Blacks assessed type 1 diabetes (T1D) among youth in Washington state, showing that foreign-born Black populations had T1D prevalence rates that were four times higher than African American youth (6.20/1000 vs. 1.56/1000; [181]).

10. Cancer

We list 30 cancer studies in Table 1. The majority were local and primarily conducted in the Northeast [196,197,199,200,207]. While cancer encompasses a range of outcomes, the outcomes evaluated were specific to the reproductive system (e.g., breast, cervical, and the human papillomavirus). The national studies included data from the NHIS, NHANES and the U.S. Census [58,202,203,205]. The outcomes focused on cancer-related behaviors such as prostate cancer screening, pap smear tests and tobacco use. These studies presented mixed findings. Seven of the 17 local studies reported that foreign-born Blacks had worse cancer outcomes than native-born Blacks, and the other studies were generally mixed. The most recent of these studies found that native-born Black women reported that HPV vaccinations were more accessible to them than foreign-born Black women (X = 4.19, p < 0.05; [207]). Eight of the 12 national studies reported that foreign-born Blacks had better cancer outcomes and cancer-related behaviors than native-born Blacks. Some studies that reported that native-born Black populations had better cancer-related outcomes related to cancer screenings and outcomes ([OR=3.37, 95% CI (1.89, 5.96)]; [205]).

11. Substance Use and Alcohol Use

In Table 1, twenty-four studies focused on substance and alcohol use outcomes. Substance use disorders occur when recurrent use of alcohol and/or drugs clinically impedes personal health [252]. The 16 studies on substance use disorders evaluated marijuana use, tobacco use and use of controlled substances. Using the National Longitudinal Study of Adolescent to Adult Health (or Add Health), Bui and colleagues, 2013 [232] assessed substance use disorders in Black adolescents and found that there were no differences in substance use when comparing native and foreign-born Blacks. The remaining national studies reported that, among adults, foreign-born Blacks were less likely to report substance use disorders than native-born Blacks. The three studies that were conducted in local settings, in Northeastern cities, were consistent with the national studies [118,231].

Eight of the 24 studies focused on alcohol use disorders. Alcohol use encompassed studies that evaluated binge drinking, alcohol abuse and alcohol use initiation. These studies trended towards better outcomes for foreign-born Blacks. Three studies deviated
from this general pattern. A local study that evaluated alcohol initiation in Black adolescents found that Caribbean-born adolescents were more likely to have been in contact with alcohol than the native-born adolescents ([OR = 1.51; 95%CI (1.18–1.95)]; [226]). An examination of the National Epidemiological Survey on Alcohol and Related Conditions (NESARC) assessed alcohol use in the past 12 months and risky alcohol use behaviors (i.e., binge drinking) and found that, before adjusting for relevant covariates, foreign-born Blacks were less likely than native-born Blacks to drink or drink in a risky manner [229]. However, the adjusted estimates showed that foreign-born Black women were more likely to report using alcohol in the past 12 months than native-born women [229]. Overall, substance and alcohol use disorders are more likely among native-born than foreign-born Black adults; however, this pattern may not hold for adolescents.

12. Health-Related Quality of Life

We list 23 studies related to health-related quality of life in Table 1. For our review, health-related quality of life studies included self-rated physical and mental health, aging, as well as epidemiological studies assessing morbidity and mortality. Most of the studies evaluated national data, with the majority being from the NHIS (8), U.S. Census (7), and the NSAL (5). Two studies focused on local populations in Boston, Massachusetts and Florida [242,253]. When compared to foreign-born Blacks, all studies found that native-born Blacks reported poorer physical and/or mental health.

13. Discussion

We have joined others in offering the comparative study of native and foreign-born Blacks as a useful approach to the study of the social determinants of population health disparities and for improving our understanding of the complex interplay between social context and population characteristics in various health outcomes [12–17]. Our assessment is that, while disparities in mental health are complex, across a variety of physical health outcomes, on average, foreign-born Black populations have better health profiles than native-born Black populations—before and after controlling for various measures of health behaviors, socioeconomic status, environmental factors and/or genomics. As very few studies have been able to account for health differences between these populations, there is much more for us to learn. We conclude with some preliminary thoughts on the trends we reviewed, what we believe to be important omissions and promising opportunities for largely descriptive research in the near term, and how studies might use this comparative research design to advance our understanding of the social determinants of (racialized) population health over the longer term.

Most of the studies we reviewed are on mental health outcomes; however, the overall pattern of findings in this area is less clear than the pattern for physical health. There might be a range of explanations for this pattern. One thing to consider is that this is an artifact of measurement bias. Not only is mental health more difficult than physical health to assess in survey studies, but our current measures may not be culturally equivalent for these populations [254,255]. Conversely, measures of physical health outcomes might be more valid and reliable across these populations. That said, it is also possible that existing studies have revealed the true underlying pattern; however, mental health is complex, and so, for different dimensions of mental health, disparities between native and foreign-born Blacks are different. Therefore, we believe that, in addition to paying greater attention to disparities within a given mental health outcome, we need more studies that assess the relative construct validity of mental health measures across these populations.

We also observed a few areas of research that could benefit from more attention. For example, there are very few studies of cancer disparities. Most of the work on cancer draws on small local studies and involves screening for the presence of disease. We also need more studies that include the children and grandchildren of foreign-born Blacks. Exceedingly few studies considered the role of time since migration or the ways in which return migration might shape these disparities. While some have likely avoided an assessment of years
since migration because of concerns about model identification, studies from the labor market show that these models are “identified” [34,44]. Another strategy is to estimate separate models, parsing foreign-born Blacks by different groups of years since migration (e.g., <1 to 5, >5 to 10, etc.). Finally, we only found two studies that considered any genetic differences between these populations [38,74].

In addition to a more refined description of health disparities between native and foreign-born Blacks, we continue to believe that the comparative study of these populations can improve our larger understanding of the social determinants of (racialized) disparities in population health. First, since these populations are both racially classified as Black in the U.S., sharing a multivariate distribution of skin color, hair texture and craniofacial bone structure and very likely have similar distributions of African genetic ancestry, health disparities between these populations are not likely to invoke explanations that, knowingly or unknowingly, promote the notion that race is a biological or genetic construct. That is, when or if social factors (e.g., health behaviors, socioeconomic status, and environmental factors) do not account for health disparities between native and foreign-born Blacks, any speculation on unobserved genetic differences will not be mired in contentious debates on the genetic basis of racial classification. Indeed, our review shows that several studies considered various social factors but that there remained a residual health difference between native and foreign-born Blacks. We cannot attribute this residual difference to differences in racialized notions of population genetics. This restriction will improve clarity on the nature of racialized differences in population health by muting such speculation.

The comparative study of these populations might also provide greater insight into the links between racial discrimination and health. While native and foreign-born Blacks both report experiences with racial discrimination, they may interpret or process these experiences differently. Differences in perception include differences in whether an act constitutes racial discrimination and differences in the meaning or importance of the experience. While these differences are also present among native-born Blacks, there are potentially unique reasons for similar differences between native and foreign-born Blacks. For instance, while any given two native-born Blacks might disagree on whether an experience was racially discriminatory or may differ on the importance of their experience, similar differences in perception between native and foreign-born Blacks might be uniquely motivated by nativity or differences in orientation to the centrality of American slavery in their life histories. As foreign-born Blacks are not decedents of the American “colonial situation” of chattel slavery [29] and are largely in the country by choice, except for instances of forced migration (and often with previous knowledge of American racism), their interpretation of the event might resonate differently than for native-born Blacks. While the former might understand the experience as an inconvenient nuisance in their immediate circumstance, for the latter, the same experience might trigger psycho-historical traumas that are rooted in the belief that this experience is a continuance of generations of dehumanization and restricted freedoms. While foreign-born Blacks often hail from countries with histories of slavery and colonialism, foreign-born Blacks might experience or read anti-Black and/or racialized experiences in the United States as existing outside of or unrelated to histories of slavery and colonialism in their sending countries, resulting in a different level or kind of “dose response”. Therefore, studies that compare these stress processes might help us to better understand the psychosocial factors that help link historical traumas to health outcomes [77,78].

14. Conclusions

Finally, there is the issue of the collection and availability of nationally representative data on these populations. For the first time, between 2001 and 2004, the Program for Research on Black Americans at the Institute for Social Research at the University of Michigan at Ann Arbor collected nationally representative data on both native-born Blacks and Afro-Caribbeans (including known f probabilities; [16,79]). While researchers have found this dataset tremendously fruitful (as shown above), the dataset is aging (very well),
but it does not include a representative sample of foreign-born Blacks from African or other countries. It is also cross-sectional and does not include biomarkers for health and genomics. As we approach the 20th anniversary of this novel and productive data collection, it may be time to begin the process of planning the next major national data collection with the aim of understanding “Race, Ethnicity and the African Diaspora in the United States”—one that might take the best from other national data collections, such as the National Survey of Black Americans, the National Survey of American Life, the National Longitudinal Study of Adolescent to Adult Health and the Health and Retirement Survey.

**Author Contributions:** M.A.I.: Lead in the development of the conceptual framing, lead in the writing of the manuscript, managed and directed the literature search, advised on the development of tables and figures; Y.F.: contributed to the conceptual framing, contributed to the writing of the manuscript, contributed to the development of the tables, assisted with finding studies; W.L.: assisted with the development of the tables and figures, assisted with finding studies, provided copy editing; D.W.: contributed to the conceptual framing, contributed to the writing of the manuscript, lead in the development of the tables and figures, assisted with finding studies. All authors have read and agreed to the published version of the manuscript.

**Funding:** This research received no external funding.

**Institutional Review Board Statement:** Not applicable.

**Informed Consent Statement:** Not applicable.

**Data Availability Statement:** Not applicable.

**Conflicts of Interest:** The authors declare no conflict of interest.

**References**

1. Arul, K.; Mesfin, A. The Top 100 Cited Papers in Health Care Disparities: A Bibliometric Analysis. J. Racial Ethn. Health Disparities 2017, 4, 854–865. [CrossRef] [PubMed]

2. Du Bois, W.E.B. The Philadelphia Negro; University of Pennsylvania Press: Philadelphia, PA, USA, 1899.

3. Rogers, R.G.; Lawrence, E.M.; Hummer, R.A.; Tilstra, A.M. Racial/Ethnic Differences in Early-Life Mortality in the United States. Biodemography Soc. Biol. 2017, 63, 189–205. [CrossRef] [PubMed]

4. Singh, G.K.; Jemal, A. Socioeconomic and Racial/Ethnic Disparities in Cancer Mortality, Incidence, and Survival in the United States, 1950–2014: Over Six Decades of Changing Patterns and Widening Inequalities. J. Environ. Public Health 2017, 2017, 2819372. [CrossRef] [PubMed]

5. Smith, J.M. On the Fourteenth Query of Thomas Jefferson’s Notes on Virginia. Anglo-Afr. Mag. 1859, 1, 225–238.

6. Williams, D.R.; Jackson, P.B. Social Sources of Racial Disparities in Health. Health Aff. 2005, 24, 325–334. [CrossRef] [PubMed]

7. Hicken, M.T.; Kravitz-Wirtz, N.; Durkee, M.; Jackson, J.S. Racial inequalities in health: Framing future research. Soc. Sci. Med. 2018, 199, 11–18. [CrossRef]

8. Kawachi, I.; Daniels, N.; Robinson, D.E. Health Disparities by Race and Class: Why Both Matter. Health Aff. 2005, 24, 343–352. [CrossRef] [PubMed]

9. Williams, D.R.; Collins, C. Us Socioeconomic and Racial Differences in Health: Patterns and Explanations. Annu. Rev. Sociol. 1995, 21, 349–386. [CrossRef]

10. Kent, M.M. Immigration and America’s Black Population. Popul. Bull. 2007, 62, 5–17.

11. Tamir, C. The Growing Diversity of Black America; Pew Research Center: Washington, DC, USA, 2021.

12. Arthur, C.M.; Katkin, E.S. Making a Case for the Examination of Ethnicity of Blacks in United States Health Research. J. Health Care Poor Underserved 2006, 17, 25–36. [CrossRef]

13. Davis, R.A. Black Ethnicity: A Case for Conceptual and Methodological Clarity. West. J. Black Stud. 1992, 16, 147–151.

14. Hamilton, T.G.; Hummer, R.A. Immigration and the health of U.S. black adults: Does country of origin matter? Soc. Sci. Med. 2011, 73, 1551–1560. [CrossRef] [PubMed]

15. Jackson, J.; Hamilton, T.; Ifatunji, M.A.; Lacey, K.; Lee, H.; Rafferty, J. Using Analytic Domains within the Black Population to Understand Disparities in Population Health; Volume Princeton; Robert Wood Johnson Foundation and Policy Link: Princeton, NJ, USA, 2018.

16. Jackson, S.J.; Torres, M.; Caldwell, C.H.; Neighbors, H.W.; Nesse, R.M.; Taylor, R.J.; Trierweiler, S.J.; Williams, D.R. The National Survey of American Life: A Study of Racial, Ethnic and Cultural Influences on Mental Disorders and Mental Health. Int. J. Methods Psychiatr. Res. 2004, 13, 196–207. [CrossRef] [PubMed]

17. Read, J.G.; Emerson, M.O. Racial Context, Black Immigration and the U.S. Black/White Health Disparity. Soc. Forces 2005, 84, 181–1999. [CrossRef]
80. Cohen, C.I.; Berment, F.; Magai, C. A Comparison of Us-Born African-American and African-Caribbean Psychiatric Outpatients. J. Natl. Med. Assoc. 1997, 89, 117.

81. Miranda, J.; Siddique, J.; Belin, T.R.; Kohn-Wood, L.P. Depression Prevalence in Disadvantaged Young Black Women. Soc. Psychiatry Psychiatr. Epidemiol. 2005, 40, 253–258. [CrossRef]

82. Joe, S.; Baser, R.E.; Breeden, G.; Neighbors, H.W.; Jackson, J.S. Prevalence of and Risk Factors for Lifetime Suicide Attempts among Blacks in the United States. JAMA 2006, 296, 112–123. [CrossRef]

83. Jackson, J.S.; Govea, I.O.; Forsythe-Brown, I. Age Cohort, Ancestry, and Immigrant Generation Influences in Family Relations and Psychological Well-Being among Black Caribbean Family Members. J. Soc. Issues 2007, 63, 729–743. [CrossRef]

84. Williams, D.R.; Gonzalez, H.M.; Neighbors, H.; Nesse, R.; Abelson, J.M.; Sweetman, J.; Jackson, J.S. Prevalence and Distribution of Major Depressive Disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results from the National Survey of American Life. Arch. Gen. Psychiatry 2007, 64, 303–315. [CrossRef]

85. Williams, D.R.; Haile, R.; Gonzalez, H.M.; Neighbors, H. The Mental Health of Black Caribbean Immigrants: Results from the Survey of American Life. Am. J. Public Health 2007, 97, 52–59. [CrossRef] [PubMed]

86. Taylor, J.Y.; Caldwell, C.H.; Baser, R.E.; Faison, N.; Jackson, J.S. Prevalence of eating disorders among Blacks in the National Survey of American Life. Int. J. Eat. Disorder. 2007, 40, S10–S14. [CrossRef] [PubMed]

87. Himle, J.A.; Muroff, J.R.; Taylor, R.J.; Baser, R.E.; Abelson, J.M.; Hanna, G.; Abelson, J.L.; Jackson, J.S. Obsessive-compulsive disorder among African Americans and blacks of Caribbean descent: Results from the national survey of American life. Depress. Anxiety 2008, 25, 993–1005. [CrossRef]

88. Himle, J.A.; Baser, R.E.; Taylor, R.J.; Campbell, R.D.; Jackson, J.S. Anxiety disorders among African Americans, blacks of Caribbean descent, and non-Hispanic whites in the United States. J. Anxiety Dist. 2009, 23, 578–590. [CrossRef]

89. Lincoln, K.D.; Taylor, R.J.; Chae, D.H.; Chatters, L.M. Demographic correlates of Psychological Well-Being and Distress Among Older African Americans and Caribbean Black Adults. Best Pract. Ment. Health 2010, 6, 103–126.

90. Boyd, R.C.; Joe, S.; Michalopoulou, L.; Davis, E.; Jackson, J.S. Prevalence of Mood Disorders and Service Use among Us Mothers by Race and Ethnicity: Results from the National Survey of American Life. J. Clin. Psychiatry 2011, 72, 15442. [CrossRef] [PubMed]

91. Soto, J.A.; Dawson-Andoh, N.A.; Belue, R. The Relationship between Perceived Discrimination and Generalized Anxiety Disorder among African Americans, Afro Caribbeans, and Non-Hispanic Whites. J. Anxiety Dist. 2011, 25, 258–265. [CrossRef]

92. Taylor, R.J.; Chatters, L.M.; Joe, S. Religious involvement and suicidal behavior among African Americans and Black Caribbeans. J. Nerv. Ment. Dis. 2011, 199, 478. [CrossRef]

93. Assari, S.; Lankarani, M.M.; Lankarani, R.M. Ethnicity Modifies the Additive Effects of Anxiety and Drug Use Disorders on Suicidal Ideation among Black Adults in the United States. Int. J. Prev. Med. 2013, 4, 1251.

94. Gibbs, T.A.; Okuda, M.; Oquendo, M.A.; Lawson, W.B.; Wang, S.; Thomas, Y.F.; Blanco, C. Mental Health of African Americans and Caribbean Blacks in the United States: Results from the National Epidemiological Survey on Alcohol and Related Conditions. Am. J. Public Health 2013, 103, 330–338. [CrossRef] [PubMed]

95. Henning-Smith, C.; Shippee, T.P.; McAlpine, D.; Hardeman, R.; Farah, F. Stigma, Discrimination, or Symptomatology Differences in Self-Reported Mental Health Between US-Born and Somalia-Born Black Americans. Am. J. Public Health 2013, 103, 861–867. [CrossRef]

96. Levine, D.S.; Himle, J.A.; Taylor, R.J.; Abelson, J.M.; Matusko, N.; Muroff, J.; Jackson, J. Panic Disorder among African Americans, Caribbean Blacks and Non-Hispanic Whites. Soc. Psychiatry Psychiatr. Epidemiol. 2013, 48, 711–723. [CrossRef]

97. Marshall, G.L.; Hooyman, N.R.; Hill, K.G.; Rue, T.C. Association of socio-demographic factors and parental education with depressive symptoms among older African Americans and Caribbean Blacks. Aging Ment. Health 2013, 17, 732–737. [CrossRef]

98. Woodward, A.T.; Taylor, R.J.; Abelson, J.M.; Matusko, N. Major depressive disorder among older african americans, caribbean blacks, and non-hispanic whites: Secondary analysis of the national survey of american life. Depress. Anxiety 2013, 30, 589–597. [CrossRef]
159. Osei, K.; Schuster, D.P. Effects of Race and Ethnicity on Insulin Sensitivity, Blood Pressure, and Heart Rate in Three Ethnic Populations: Comparative Studies in African-Americans, African Immigrants (Ghanaians), and White Americans Using Ambulatory Blood Pressure Monitoring. *Am. J. Hypertens.* 1996, 9, 1157–1164. [CrossRef]

160. Hyman, D.J.; Ogbonnaya, K.; Pavlik, V.N.; Poston, W.S.; Ho, K. Lower Hypertension Prevalence in First-Generation African Immigrants Compared to Us-Born African Americans. *Ethn. Dis.* 2000, 10, 343–349.

161. Hicks, L.S.; Fairchild, D.G.; Cook, E.F.; Ayanian, J.Z. Association of region of residence and immigrant status with hypertension, renal failure, cardiovascular disease, and stroke, among African-American participants in the third National Health and Nutrition Examination Survey (NHANES III). *Ethn. Dis.* 2003, 13, 316–322.

162. Ryan, A.M.; Gee, G.C.; Laflamme, D.F. The Association between Self-Reported Discrimination, Physical Health and Blood Pressure: Findings from African Americans, Black Immigrants, and Latino Immigrants in New Hampshire. *J. Health Care Poor Underseens* 2006, 17, 116–132. [CrossRef]

163. Davis, E.E.; Huffman, F.G. Differences in Coronary Heart Disease Risk Markers among Apparently Healthy Individuals of African Ancestry. *J. Natl. Med. Assoc.* 2007, 99, 658.

164. Borrell, L.N.; Crawford, N.D.; Barrington, D.S.; Maglo, K.N. Black/White Disparity in Self-Reported Hypertension: The Role of Nativity Status. *J. Health Care Poor Underseens* 2008, 19, 1148–1162. [CrossRef]

165. White, K.; Borrell, L.N.; Wong, D.W.; Galea, S.; Ogedegbe, G.; Glymour, M.M. Racial/Ethnic Residential Segregation and Self-Reported Hypertension Among US- and Foreign-Born Blacks in New York City. *Am. J. Hypertens.* 2011, 24, 904–910. [CrossRef]

166. Ryan, A.M.; Gee, G.C.; Laflamme, D.F. The Association between Self-Reported Discrimination, Physical Health and Blood Pressure: Findings from African Americans, Black Immigrants, and Latino Immigrants in New Hampshire. *J. Health Care Poor Underseens* 2006, 17, 116–132. [CrossRef]

167. Davis, E.E.; Huffman, F.G. Differences in Coronary Heart Disease Risk Markers among Apparently Healthy Individuals of African Ancestry. *J. Natl. Med. Assoc.* 2007, 99, 658.

168. Borrell, L.N.; Crawford, N.D.; Barrington, D.S.; Maglo, K.N. Black/White Disparity in Self-Reported Hypertension: The Role of Nativity Status. *J. Health Care Poor Underseens* 2008, 19, 1148–1162. [CrossRef]

169. Dagadu, H.E.; Christie-Mizell, C.A. Heart trouble and racial group identity: Exploring ethnic heterogeneity among Black Americans. *Race Soc. Probl.* 2014, 6, 143–160. [CrossRef]

170. O'Connor, M.Y.; Thoreson, C.K.; Ricks, M.; Courville, A.B.; Thomas, F.; Yao, J.; Katzmarzyk, P.; Sumner, A.E. Worse Cardiometabolic Health in African Immigrant Men than African American Men: Reconsideration of the Healthy Immigrant Effect. *Metab. Syndr. Relat. Disord.* 2014, 12, 347–353. [CrossRef] [PubMed]

171. Brown, A.G.M.; Houser, R.F.; Mattei, J.; Mozaffarian, D.; Lichtenstein, A.H.; Foltz, S.C. Hypertension among Us-Born and Foreign-Born Non-Hispanic Blacks: National Health and Nutrition Examination Survey 2003–2014 Data. *J. Hypertens.* 2017, 35, 2380–2387. [CrossRef] [PubMed]

172. Cole, H.; Duncan, D.T.; Ogedegbe, G.; Bennett, S.; Ravenell, J. Neighborhood Socioeconomic Disadvantage; Neighborhood Racial Composition; and Hypertension Stage, Awareness, and Treatment among Hypertensive Black Men in New York City: Does Nativity Matter? *J. Racial Ethn. Health Disparities* 2017, 4, 866–875. [CrossRef]

173. Commodore-Mensah, Y.; Matthie, N.; Wells, J.; Dunbar, S.B.; Himmelfarb, C.D.; Cooper, L.A.; Chandler, R.D. African Americans, African Immigrants, and Caribbean blacks. *Ethn. Dis.* 2012, 22, 21–28.

174. Yu, S.S.K.; Ramsey, N.L.; Castillo, D.C.; Ricks, M.; Sumner, A.E. Triglyceride-Based Screening Tests Fail to Recognize Cardiometabolic Disease in African Immigrant and African-American Men. *Metab. Syndr. Relat. Disord.* 2013, 11, 15–20. [CrossRef]

175. Fang, J.; Yuan, K.; Gindi, R.M.; Ward, B.W.; Ayala, C.; Loustalot, F. Association of birthplace and coronary heart disease and stroke in African Immigrants, and Afro-Caribbeans Differ in Social Determinants of Hypertension and Diabetes: Evidence from the 2001–2016 National Health and Nutrition Examination Survey. *J. Racial Ethn. Health Disparities* 2018, 5, 995–1002. [CrossRef] [PubMed]

176. Brown, A.G.M.; Houser, R.F.; Mattei, J.; Mozaffarian, D.; Lichtenstein, A.H.; Foltz, S.C. Hypertension among Us-Born and Foreign-Born Non-Hispanic Blacks: National Health and Nutrition Examination Survey 2003–2014 Data. *J. Hypertens.* 2017, 35, 2380–2387. [CrossRef] [PubMed]

177. Cole, H.; Duncan, D.T.; Ogedegbe, G.; Bennett, S.; Ravenell, J. Neighborhood Socioeconomic Disadvantage; Neighborhood Racial Composition; and Hypertension Stage, Awareness, and Treatment among Hypertensive Black Men in New York City: Does Nativity Matter? *J. Racial Ethn. Health Disparities* 2017, 4, 866–875. [CrossRef]

178. Doamekpor, L.A.; Gleason, J.L.; Opara, I.; Amutah-Onukagha, N.N. Nativity and Cardiovascular Dysregulation: Evidence from the 2001–2016 National Health and Nutrition Examination Survey. *J. Racial Ethn. Health Disparities* 2021, 8, 136–146. [CrossRef] [PubMed]

179. Ford, N.D.; Venkat Narayan, K.M.; Mehta, N.K. Diabetes among US- and foreign-born blacks in the USA. *Ethn. Health* 2015, 21, 71–84. [CrossRef]

180. O’Connor, M.R.; Dobra, A.; Voss, J.; Pihoker, C.; Doorenbos, A. Type 1 Diabetes Among East African Immigrant and Nonimmigrant Black Youth in the U.S. *J. Pediatric Nurs. Nurs. Care Child. Fam.* 2015, 30, 834–841. [CrossRef]

181. Ryan, A.M.; Gee, G.C.; Laflamme, D.F. The Association between Self-Reported Discrimination, Physical Health and Blood Pressure: Findings from African Americans, Black Immigrants, and Latino Immigrants in New Hampshire. *J. Health Care Poor Underseens* 2006, 17, 116–132. [CrossRef]

182. Davis, E.E.; Huffman, F.G. Differences in Coronary Heart Disease Risk Markers among Apparently Healthy Individuals of African Ancestry. *J. Natl. Med. Assoc.* 2007, 99, 658.
182. Harvey, R.D.; Tenrial, R.; Banks, K.H. The Development and Validation of a Colorism Scale. *J. Black Psychol.* 2017, 43, 740–764. [CrossRef]
183. Horlyck-Romanovsky, M.F.; Wyka, K.; Echeverria, S.E.; Leung, M.M.; Fuster, M.; Huang, T.T.K. Foreign-born blacks experience lower odds of obesity but higher odds of diabetes than US-born blacks in New York City. *J. Immigr. Minority Health* 2019, 21, 47–55. [CrossRef]
184. Engelman, M.; Ye, L.Z. The immigrant health differential in the context of racial and ethnic disparities: The case of diabetes. *Immigr. Health* 2019, 19, 147–171.
185. Ogunwole, S.M.; Turkson-Ocran, R.A.N.; Boakye, E.; Creanga, A.A.; Wang, X.; Bennett, W.L.; Commodore-Mensah, Y. Disparities in cardiometabolic risk profiles and gestational diabetes mellitus by nativity and acculturation: Findings from 2016–2017 National Health Interview Survey. *BMJ Open Diabetes Res. Care* 2022, 10, e002329. [CrossRef]
186. Choi, D.; Narayan, K.V.; Patel, S.A. Disparities in diabetes between US-born and foreign-born population: Using three diabetes indicators. *Biodemography Soc. Biol.* 2022, 67, 16–27. [CrossRef] [PubMed]
187. Antecol, H.; Bedard, K. Unhealthy Assimilation: Why Do Immigrants Converge to American Health Status Levels? *Demography* 2006, 43, 337–360. [CrossRef] [PubMed]
188. Bennett, G.G.; Wolin, K.Y.; Askew, S.; Fletcher, R.; Emmons, K.M. Immigration and Obesity among Lower Income Blacks. *Obesity* 2007, 15, 1391–1394. [CrossRef] [PubMed]
189. Sanchez-Vaznaugh, E.V.; Kawachi, I.; Subramanian, S.V.; Sánchez, B.N.; Acevedo-Garcia, D. Differential Effect of Birthplace and Length of Residence on Body Mass Index (BMI) by Education, Gender and Race/Ethnicity. *Soc. Sci. Med.* 2008, 67, 1300–1310. [CrossRef]
190. Barrington, D.S.; Baquero, M.C.; Borrell, L.N.; Crawford, N.D. Racial/Ethnic Disparities in Obesity among Us-Born and Foreign-Born Adults by Sex and Education. *Obesity* 2010, 18, 422–424. [CrossRef]
191. Wen, M.; Kowaleski-Jones, L.; Fan, J.X. Ethnic-immigrant Disparities in Total and Abdominal Obesity in the US. *Am. J. Public Health Policy Rev.* 2019, 32, 353–371. [CrossRef]
192. Assari, S. Additive effects of anxiety and depression on body mass index among blacks: Role of ethnicity and gender. *Int. Cardiovasc. Res. J.* 2014, 8, 44.
193. Sullivan, S.M.; Brashear, M.M.; Broyles, S.T.; Rung, A.L. Neighborhood environments and obesity among Afro-Caribbean, African American, and Non-Hispanic white adults in the United States: Results from the National Survey of American Life. *Prev. Med.* 2014, 61, 1–5. [CrossRef]
194. Mehta, N.K.; Elo, I.T.; Ford, N.D.; Siegel, K.R. Obesity among Us-and Foreign-Born Blacks by Region of Birth. *J. Immigr. Minority Health* 2013, 15, 287–295. [CrossRef]
195. Cha, D.; Narayan, K.V.; Patel, S.A. Disparities in diabetes between US-born and foreign-born population: Using three diabetes indicators. *Biodemography Soc. Biol.* 2022, 67, 16–27. [CrossRef] [PubMed]
196. Sullivan, S.M.; Brashear, M.M.; Broyles, S.T.; Rung, A.L. Neighborhood environments and obesity among Afro-Caribbean, African American, and Non-Hispanic white adults in the United States: Results from the National Survey of American Life. *Prev. Med.* 2014, 61, 1–5. [CrossRef]
197. Mehta, N.K.; Elo, I.T.; Ford, N.D.; Siegel, K.R. Obesity among Us-and Foreign-Born Blacks by Region of Birth. *J. Public Health Policy Rev.* 2019, 32, 353–371. [CrossRef]
198. Sullivan, S.M.; Brashear, M.M.; Broyles, S.T.; Rung, A.L. Neighborhood environments and obesity among Afro-Caribbean, African American, and Non-Hispanic white adults in the United States: Results from the National Survey of American Life. *Prev. Med.* 2014, 61, 1–5. [CrossRef]
199. Fruchter, R.G.; Wright, C.; Habenstreit, B.; Remy, J.C.; Boyce, J.G.; Imperato, P.J. Screening for cervical and breast cancer among Caribbean immigrants. *J. Community Health* 1985, 10, 121–135. [CrossRef] [PubMed]
200. Fruchter, R.G.; Remy, J.C.; Burnett, W.S.; Boyce, J.G. Cervical Cancer in Immigrant Caribbean Women. *Am. J. Public Health* 1986, 76, 797–799. [CrossRef] [PubMed]
201. Mehta, N.K.; Elo, I.T.; Ford, N.D.; Siegel, K.R. Obesity among Us-and Foreign-Born Blacks by Region of Birth. *J. Immigr. Minority Health* 2013, 15, 287–295. [CrossRef]
202. Fruchter, R.G.; Wright, C.; Habenstreit, B.; Remy, J.C.; Boyce, J.G.; Imperato, P.J. Screening for cervical and breast cancer among Caribbean immigrants. *J. Community Health* 1985, 10, 121–135. [CrossRef] [PubMed]
203. Sullivan, S.M.; Brashear, M.M.; Broyles, S.T.; Rung, A.L. Neighborhood environments and obesity among Afro-Caribbean, African American, and Non-Hispanic white adults in the United States: Results from the National Survey of American Life. *Prev. Med.* 2014, 61, 1–5. [CrossRef]
204. Fruchter, R.G.; Wright, C.; Habenstreit, B.; Remy, J.C.; Boyce, J.G.; Imperato, P.J.; Burnett, W.S.; Boyce, J.G. Cervical Cancer in Immigrant Caribbean Women. *Am. J. Public Health* 1986, 76, 797–799. [CrossRef] [PubMed]
205. Magnus, M. Prostate cancer knowledge among multiethnic black men. *J. Natl. Med. Assoc.* 2004, 96, 650. [PubMed]
206. Garbers, S.; Chiasson, M.A. Breast Cancer Screening and Health Behaviors among African Immigrant and Non-Immigrant Women in New York City. *J. Health Care Poor Underserved* 2006, 17, 37–46. [CrossRef]
207. Bennet, G.G.; Wolin, K.Y.; Okechukwu, C.A.; Arthur, C.M.; Aske, S.; Sorensen, G.; Emmons, K.M. Nativity and Cigarette Smoking among Lower Income Blacks: Results from the Healthy Directions Study. *J. Immigr. Minority Health* 2008, 10, 305–311. [CrossRef] [PubMed]
208. Taito, E.; Attong-Rogers, A.; Layne, P.; Roach, V.; Ragin, C. Breast cancer survival in women of African descent living in the US and in the Caribbean: Effect of place of birth. *Breast Cancer Res. Treat.* 2010, 122, 515–520. [CrossRef]
209. Odedina, F.T.; Daghe, G.; Larose-Pierre, M.; Scrivens, J.; Emanuel, F.; Adams, A.; Pressey, S.; Odedina, O. Within-Group Differences in Perceived Health Among Native and Foreign-Born Black Men on Prostate Cancer Risk Reduction and Early Detection Practices. *J. Immigr. Minority Health* 2011, 13, 996–1004. [CrossRef]
210. Wade, B.; Lariscy, J.T.; Hummer, R.A. Racial/Ethnic and Nativity Patterns of U.S. Adolescent and Young Adult Smoking. *Popul. Res. Policy Rev.* 2013, 32, 353–371. [CrossRef]
211. Conedine, N.S.; Tuck, N.L.; Ragin, C.R.; Spencer, B.A. Beyond the Black Box: A Systematic Review of Breast, Prostate, Colorectal, and Cervical Screening among Native and Immigrant African-Descent Caribbean Populations. *J. Immigr. Minority Health / Cent. Minority Public Health* 2015, 17, 905–924. [CrossRef]
212. Forney-Gorman, A.; Kozhimannil, K.B. Differences in Cervical Screening Between African-American Versus African-Born Black Women in the United States. *J. Immigr. Minority Health* 2016, 18, 1371–1377. [CrossRef]
213. Pinheiro, P.S.; Callahan, K.E.; Ragin, C.; Hage, R.W.; Hylton, T.; Kobetz, E.N. Black heterogeneity in cancer mortality: US-Blacks, Haitians, and Jamaicans. *Cancer Control* 2016, 23, 347–358. [CrossRef] [PubMed]
