



Ethnic enclaves and birth outcomes of immigrants from India in a diverse U.S. state



Jennifer B. Kane^{a,*}, Julien O. Teitler^b, Nancy E. Reichman^c

^a Department of Sociology, University of California, Irvine, 4171 Social Sciences Plaza A, Irvine, CA, 92697, USA

^b School of Social Work, Columbia University, 1255 Amsterdam Avenue, New York, NY 10027, USA

^c Department of Pediatrics, Robert Wood Johnson Medical School, Rutgers University, 89 French Street, New Brunswick, NJ 08903, USA

ARTICLE INFO

Keywords:

Ethnic enclave
Adverse birth outcomes
Low birthweight
Preterm birth
Prenatal smoking
Immigrants
Immigrants from India
USA

ABSTRACT

Sociological theory suggests that ethnic enclaves promote immigrant health. Existing studies of ethnic enclaves and immigrant birth outcomes have generally focused on blacks and Hispanics, while few have focused on immigrants from India — the second largest immigrant group in the U.S., after Mexicans. Paradoxically, this group generally exhibits worse birth outcomes than non-Hispanic whites, despite their high levels of education. This study investigates associations between residence in South Central Asian ethnic enclaves and both birth outcomes and prenatal behaviors of immigrant mothers from India, using population-level birth record data from the state of New Jersey in the U.S. (1999–2012; $n = 64,375$). Results indicate that residence in a South Central Asian enclave is associated with less prenatal smoking and earlier prenatal care, but not with birthweight- or gestational-age related outcomes, among immigrant mothers from India. These findings are consistent with theory suggesting that social support, social capital, and social norms transmitted through the social networks present in ethnic enclaves foster health-promoting behaviors. Notably, the prenatal behaviors of non-Hispanic white mothers were not associated to a large degree with living in South Central Asian enclaves, which is also consistent with theory and bolsters our confidence that the observed associations for immigrant mothers from India are not spurious.

1. Introduction

Adverse birth outcomes, including preterm birth (< 37 weeks, PTB) and low birth weight (< 2500 g, LBW), and are important markers of future life chances. PTB and LBW are strong risk factors for infant mortality (Callaghan et al., 2006; Goldenberg and Culhane, 2007) and are associated with health and educational risks for survivors that cumulate over time (Chomitz et al., 1995; Conley and Bennett, 2000; Goldenberg et al., 2008; Reichman, 2005; Behrman and Butler, 2007). In the U.S., adverse birth outcomes vary considerably by race, ethnicity and nativity, with some immigrant groups, including Mexican-born women, having more favorable birth outcomes than would be expected given their relatively low socioeconomic status. This immigrant paradox has been observed for many health outcomes, and has been hypothesized to operate through a number of mechanisms (later described) and/or reflect selection biases (e.g., a healthy immigrant effect). Racial and ethnic disparities in birth outcomes are not unique to the U.S. For example, racial and ethnic disparities in LBW in England are as large as those in the U.S., with the rate among black mothers almost twice that of white mothers and the rate among Asian mothers

from the Indian subcontinent (India, Pakistan or Bangladesh) even higher than that of black mothers (Teitler et al., 2007).

Considerable and longstanding sociological theory supports the notion of ethnic enclaves as promoting immigrant health. Social capital arising from dense networks can foster health-promoting behaviors and facilitate connections to resources that foster economic, social, and physical well-being (Zorbaugh and Warren, 1983; Park Robert et al., 1925; Wirth, 1928; Portes, 1987). As such, ethnic enclaves can provide access to employment, health care resources, and social support. Enclaves have been hypothesized to explain at least some of the health advantages of immigrants compared to both non-Hispanic whites and their native born racial-ethnic counterparts.

More specifically, dense social networks within ethnic enclaves may transmit social norms governing health behaviors, attitudes, practices, and tangible resources that promote health (e.g., knowledge of how to access local health-promoting resources) (Portes and Rumbaut, 2006). Such networks may also facilitate a higher degree of social control that in turn limits the opportunity for individuals to engage in harmful behavior (Sampson et al., 1997). By virtue of being surrounded by a high concentration of individuals of the same racial or ethnic group,

* Corresponding author.

E-mail address: jbkane@uci.edu (J.B. Kane).

residents of ethnic enclaves may be somewhat protected from the risk of experiencing discrimination on a regular basis, which could abate the uptake of unhealthy behaviors as a coping mechanism (Portes and Rumbaut, 2006). Additionally, the built environment within ethnic enclaves may contain group-specific resources, such as ethnic food stores, that facilitate healthier dietary habits (Osypuk et al., 2009). Finally, although pathways of acculturation vary by group, generation status, and migration history (Portes, 1996; Portes and Zhou, 1993; Salant and Lauderdale, 2003), lower levels of acculturation to the U.S. observed among some recently-arrived immigrants tends to be associated with healthier behaviors and better health outcomes (Scribner and Dwyer, 1989; Institute of Medicine and National Research Council, 1998).

Existing studies of ethnic enclaves and immigrant birth outcomes have focused primarily on black or Hispanic immigrants [e.g., (Mason et al., 2010; Messer et al., 2010; Vang and Elo, 2013; Shaw et al., 2010; Osypuk et al., 2010; Grady and McLafferty, 2007)], groups with generally low levels of human capital upon arrival in the U.S. (Portes and Rumbaut, 2006). Findings from this literature are mixed. Residential isolation and residential clustering of individuals of the same ethnicity are not protective against the risk of low birthweight for Latinos or blacks (Walton, 2009). Exposure to a higher concentration of U.S.-born Mexican-origin residents is associated with lower birthweight among U.S.-born Mexican-origin women but not among Mexican-born women (Osypuk et al., 2010). For foreign-born black women, high levels of same-ethnic density are associated with a decreased risk of infant mortality (Shaw et al., 2010; Bell et al., 2007), but an increased risk of preterm birth (Shaw et al., 2010), particularly for those born in Africa (Mason et al., 2010). High levels of neighborhood minority diversity are positively associated with birthweight for black women (Vang and Elo, 2013). Other studies find no associations between ethnic density and the risk of preterm birth for many ethnic groups (Messer et al., 2010; Mason et al., 2011), except for a deleterious association of ethnic density on the difference in preterm birth risk for non-Hispanic black women (Mason et al., 2011). This mixed literature, which is based solely on U.S. settings, is difficult to reconcile because of varying measures of ethnic enclaves and model specifications.

The extent to which enclaves are associated with birth outcomes in other immigrant populations and subpopulations has been much less explored. Studies examining Asians as a broad group show that residing in an Asian enclave can have a protective effect on low birthweight (Walton, 2009); greater interaction between Asians and whites is also associated with maternal smoking during pregnancy—a strong risk factor for adverse birth outcomes (Yang et al., 2014). Conversely, a study of Bangladeshi women in New York City in 2000 found that residence in both low-density and high-density enclaves was associated with a higher risk of low birthweight (McLafferty et al., 2012). Ethnic density was not associated with preterm birth risk however for South Asian women (a group that combined women reporting any one of the following ethnic origins: Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal, Pakistan, and Sri Lanka), although ethnic enclave residence was protective among women living in poorer neighborhoods (Mason et al., 2011).

No studies to date have explored associations between ethnic enclaves and birth outcomes specifically among immigrant mothers from India, who represent a large, growing, and interesting group. Immigrants from India are the second largest immigrant group in the U.S., after Mexicans (Zong and Batalova, 2015), and have high levels of education but generally worse birth outcomes (e.g., higher rates of low birth weight, growth retardation, small for gestational age, and fetal mortality) – than both native-born whites and other Asian Americans and Pacific Islanders (Alexander et al., 2007; Gould et al., 2003; Rao et al., 2006; Kurtyka et al., 2015). The generally worse birth outcomes of immigrants from India despite their high levels of education has been referred to as a paradox (Gould et al., 2003), one that is a conceptual mirror image of the Mexican paradox of unexpectedly favorable birth

outcomes given the relatively low socioeconomic status of that group (Markides and Coreil, 1986). That said, the concept of a paradox does not apply for all birth outcomes, as studies have found no differences in rates of preterm birth between immigrants from India and non-Hispanic Whites (Kurtyka et al., 2015), or between all South Asians (a grouping that includes, but is not limited to, those from India) and non-Hispanic Whites (Mason et al., 2011), suggesting that birthweight disadvantages operate through fetal growth rather than length of gestation. Prenatal health behaviors do not appear to explain the observed birth outcome disadvantages of immigrants from India, as this group typically reports low levels of prenatal smoking and high levels of adequate prenatal care (Gould et al., 2003).

Another distinguishing feature of immigrants from India to the U.S. is that, unlike most other immigrant groups, they tend to establish enclaves in middle-class, affluent neighborhoods rather than impoverished urban centers (Chakravorty et al., 2016). This pattern is consistent with ethnic resurgence theory, which suggests that some immigrants select into enclaves out of preference, not economic necessity, and that such enclaves therefore tend to be located in affluent suburbs (Logan et al., 2002; Walton, 2009). Thus, accounting for attributes of the neighborhood other than racial/ethnic composition is particularly important when exploring associations between ethnic enclaves and the health of immigrants from India. Some studies of ethnic enclaves and birth outcomes have included controls for neighborhood-level poverty (Finch et al., 2007; Osypuk et al., 2010), although studies have not routinely done so—possibly explaining some of the inconsistent findings in the previous literature. As far as we know, no previous studies on the topic have accounted for neighborhood affluence, a sociological construct distinct from neighborhood poverty or disadvantage, despite a growing literature showing that neighborhood affluence is consistently predictive of self-reported health, objectively-measured health status, and adverse birth outcomes (Browning and Cagney, 2003; Wen et al., 2003; Browning et al., 2003; Kane et al., 2017). Neighborhood affluence signals the presence of wealthy, well-educated residents employed in prestigious occupations that can attract local institutions and high-quality services to the neighborhood; these institutions can meet the needs of all neighborhood residents, regardless of individual-level socioeconomic status.

Using population-level data from the state of New Jersey, the second highest receiving state (after California) of immigrants from India in the U.S. (Zong and Batalova, 2015), we explore the extent to which ethnic enclaves are associated with birth outcomes and prenatal health behaviors of immigrant mothers from India. We take into account other key attributes of neighborhoods, captured in measures of neighborhood affluence and disadvantage. The state of New Jersey is a highly appropriate context for studying the health of immigrants from India: More than one in five New Jersey residents is an immigrant, with India being the top country of origin (American Immigration Council, 2017), and South Asian immigrants represent one of the fastest-growing subpopulations in the state (Wu, 2015).

2. Methods

2.1. Data and sample

This study utilizes data from Electronic Birth Certificate (EBC) records of all births taking place in the state of New Jersey from 1999 to 2012 ($N = 1,628,864$). Nearly all (94%) EBC records were successfully geocoded; the FIPS code was then used to append neighborhood-level data [at the census tract level, drawn from U.S. Decennial Census data files (1990, 2000, 2010), and the 2010–2014 American Community Survey] to the individual (birth record)-level data. The analytic sample includes all geocoded records ($n = 1,531,132$) of live ($n = 1,528,597$) singleton ($n = 1,462,836$) births, with plausible birth weights ($n = 1,455,611$), to mothers who were born in India (as reported on the birth certificate record; $n = 64,375$). In some analyses, we include

Download English Version:

<https://daneshyari.com/en/article/7327453>

Download Persian Version:

<https://daneshyari.com/article/7327453>

[Daneshyari.com](https://daneshyari.com)