and (2) the possibility that the gender-health profile of Caribbean blacks depends on nativity status. Of these issues, the largest body of work addresses inconsistencies in gender’s impact on health, relying primarily on patterns outlined in the gender-health paradox (e.g., Bird and Rieker 2008; Gorman and Read 2006; Read and Gorman 2006). Less attention has been given to the role of nativity status, but this analysis emphasizes a mediation model of resources as indicated by socioeconomic status (SES), social roles, and self-concept. This research will inform wider discussions on gender disparities in health, especially as patterns may be associated with nativity status.

LITERATURE REVIEW

The Gender-Health Paradox

Women’s lower mortality rate but higher morbidity rate, compared to men, is referred to as the gender-health paradox (Bird and Rieker 2008; Cooper 2002; Idler and Benyamini 1997). The relationship between gender and health, however, is more complicated than suggested by this paradox. Gender differences in mortality are robust in the United States (Gorman and Read 2007), but the association between gender and morbidity is often contingent on the measure of morbidity status. For example, men experience more life-threatening chronic diseases (e.g., heart disease) than women, whereas women have more nonfatal acute and chronic conditions (e.g., arthritis) than men (Bird and Rieker 2008; Courtenay 2001; Williams 2008). In an initial attempt to speak to the broader issue of gender disparities in health within the U.S. black population, this study focuses on the morbidity dimension of the paradox. I use three often adopted and interrelated measures of morbidity: self-rated health, chronic illness, and functional limitations.

Self-rated health is one of the most common measures of health in medical sociology. Reports of better assessments of self-rated health have been on the rise among black women since 1976 but have only recently (2000 to 2004) surpassed black men’s reports of health (Cummings and Jackson 2008). Relatedly, using 1997 to 2001 data from the National Health Interview Survey, Read and Gorman (2006) found that black women are significantly more likely than their male counterparts to report life-threatening chronic diseases and to report better self-rated health. The cause behind this discrepancy remains unresolved. Perhaps the heterogeneity of the category “black” is driving these contradictory results, because the National Health Interview Survey was collected at a critical peak in Caribbean immigration (1980 to 1999) to the United States (Kent 2007). This study further explores this finding by drawing particular attention to the diversity within the black population.

Another important marker of poor health is having multiple functional limitations. Scales of functional limitations are developed using a range of activities of daily living (e.g., standing for long periods of time, moving around inside one’s home) as well as instrumental activities of daily living (e.g., washing one’s whole body, getting dressed). The female excess in functional limitations is consistent across bodies of research, and the disparity is quite striking (see Bird and Rieker 2008). For example, Read and Gorman (2006) found that women, regardless of race or ethnicity, were more likely to report functional limitations relative to men in their same racial group.

This study uses these indicators, drawing attention to gender differences in health within the U.S. black population. The health outcomes used in this article are often applied to research on U.S.-born groups, but research on gender differences in health among immigrants is scarce (but see Antecol and Bedard 2006; Gorman, Read, and Krueger 2010). Below, I briefly discuss factors that inform an understanding of Caribbean blacks’ health, because this is a necessary foundation for expectations of differences (or similarities) between U.S. blacks.

Theorizing the Role of Gender for Caribbean Black Health

The Caribbean immigrant population. Research on immigrant health considers the impact of policy in the selection of adults who bring with them valued social resources. The selectivity effects of immigration policy primarily allow the educated and highly skilled (and their family members) the
opportunity to immigrate; consequently, the U.S. Caribbean black immigrant population has higher educational attainment and income levels in comparison with native-born African Americans (Logan 2007). In addition, black immigrants experience a health advantage relative to their U.S.-born African American counterparts (Akresh and Frank 2008; Read and Emerson 2005; Singh and Siahpush 2002). To the extent that selective immigration is in effect, there may be few gender differences in health within the Caribbean black immigrant population. This study addresses this possibility and also provides a comparison between Caribbean blacks (both U.S. born and foreign born) and African Americans.

Instead of finding no gender differences in health among Caribbean black immigrants, women may be disadvantaged relative to men. Gender socialization is as much in operation in the Caribbean context as in other societies. Llácer et al. (2007) proposed that studying immigrant health from a gender perspective “involves recognition that men and women operate in a historically configured relationship of subordination which influences all aspects of their lives, rendering them differentially vulnerable” (p. ii4). In addition, the fundamentally disparate experiences of women and men as they adjust to the host culture and society to which they immigrate could have implications for their health. When immigrating to another country, gender inequality is perpetuated in part through unequal distributions of employment opportunities that favor men and expected female gender roles related to household work that disfavor women (Llácer et al. 2007).

Relative to the United States, women living in the Caribbean have less access to economic resources, continue to experience high levels of gender-based violence, and lack full control over their sexual and reproductive rights (Bailey 2003; Lewis 2003; Pargass and Clarke 2003). Although gender inequality persists in the United States, traditional gender roles and expectations are more entrenched in the Caribbean context, such that one would expect that women’s socialization is embedded in expectations associated with stereotypical gender roles and inequality in power, privilege, and access to resources. Accordingly, Caribbean immigrant women could be at a health disadvantage relative to Caribbean immigrant men. For U.S.-born Caribbeans, a group that shares the same ethnic background as Caribbean immigrants, it remains unknown if their gendered health patterns would most closely resemble their immigrant counterparts or African Americans.

The U.S.-born Caribbean population. The negative acculturation hypothesis proposes that as immigrants spend longer periods of time and become more integrated into U.S. society, they begin to develop the health lifestyles of their U.S.-born counterparts, and their original health advantage diminishes over time (Cho, Frisbie, and Rogers 2004; Read and Emerson 2005; Singh and Siahpush 2002). Volumes of research have focused on negative acculturation among Latinos (e.g., Cho et al. 2004; Crimmins et al. 2007). With the recent availability of the first national study of health focusing on a heterogeneous group of blacks in the United States, the National Survey of American Life (NSAL), more attention is paid to these issues among Caribbean blacks (e.g., Broman et al. 2007; Jackson and Antonucci 2005; Nazroo et al. 2007). For example, Jackson and Antonucci (2005) examined average group differences in self-reported health scores for African Americans and Caribbean blacks in the United States. The best self-reported health scores were found among Caribbean black immigrants (i.e., first generation), followed by African Americans, second-generation Caribbean blacks and, last, third-generation Caribbean blacks. Thus, as it relates to self-reported health, U.S.-born Caribbean blacks resemble African Americans more so than their Caribbean black immigrant counterparts.

This initial description of the health profile of black Americans provides an intriguing glimpse into the possibility that African Americans and U.S.-born Caribbean blacks may have similar gender-health patterns. The framework from which I theorize about gender and health is drawn from the broader medical sociology literature, which has shown that an unequal distribution of valued resources is associated with differences in physical health. The three areas of resource availability examined in this study are SES, social roles, and self-concept, heretofore referred to as mediators of the gender-health relationship (or the mediation model).

Mechanisms Underlying Gender Differences in Health

SES. Prior research on U.S. adults has demonstrated that the SES profiles of women and men are vastly different. Women are more likely to work part-time, participate in unwaged labor, and receive
unequal wages in the labor market (Gorman and Read 2006; Padavic and Reskin 2002; Williams 2002). Educational attainment and income are common measures of SES in studies examining gender differences in health, demonstrating that these factors are strongly associated with health outcomes for both women and men (Gorman and Read 2006; McDonough et al. 1999; Pavalko, Gong, and Long 2007; Pavalko and Smith 1999). These resources are also incorporated into this study in its exploration of the relationship between gender and health among blacks in the United States.

Blatant gender disparities in education and income are also prevalent in the Caribbean context. In college settings, men are more heavily concentrated in the areas of the natural sciences, information technology, and technical craft subjects; in contrast, women are more likely to pursue humanities and domestic crafts. These stereotypical gendered educational paths lead to a female disadvantage across role domains. In fact, women’s education does not provide the knowledge and skills that are in high demand in the labor force in the Caribbean (Bailey 2003). These skills may be equally devalued in the United States.

Women’s share of earnings is also far below that of men in several Caribbean countries, including Belize, Guyana, Trinidad and Tobago, and Barbados. More specifically, women’s shares of earnings in comparison with men’s shares in these countries were estimated at 18 percent, 27 percent, 27 percent, and 40 percent, respectively (United Nations Development Programme 1998, as cited in Andaiye 2003). The context in which gender is experienced by Caribbean women would suggest an overall female disadvantage in economic resources, particularly income. As such, SES may be an important explanatory factor in understanding the gender-health relationship among Caribbean blacks who currently reside in the United States.

Social roles. The norms, values, and social sanctions that determine male and female behavior, roles, and life opportunities undoubtedly affect health (Bird and Rieker 2008). The social role hypothesis proposes that roles provide existential meaning and social support. Although occupying many social roles is beneficial up to a point (Thoits 1987), the mental health benefits of social roles outweigh any disadvantages resulting from multiple role involvement. Much of this research focuses on the primary roles of worker, spouse, and parent (see Jackson 1997). Despite gender differences in labor force participation, the work role can be beneficial to the physical health of women overall; longitudinal research has shown that length of employment is positively associated with physical health among women (Pavalko et al. 2007; Pavalko and Smith 1999; Ross and Mirowsky 1995). Waldron, Weiss, and Hughes (1998) found that employment and marriage roles tend to have beneficial effects on the physical health of women, but previous literature suggests that the more children, the higher the likelihood of role strain, which contributes to harmful health effects among those occupying the parental role (McLanahan and Adams 1987; Waldron et al. 1998).

Social relations in the Caribbean are constructed such that men and women fulfill social roles that perpetuate male dominance (Reddock 2004). With their primary responsibility being that of housewives and mothers, Caribbean women are treated as secondary workers (Bailey 2003; Massiah 1997; Reddock 2004; Scott 1997). However, the responsibility of work for some women is even greater as more fragile economic situations within the household, community, and/or country place a greater burden on women (Andaiye 2003). Female-headed households are more likely to fall below the poverty lines, and women in these predicaments typically must find additional means of survival, often piecing together multiple sources of waged work or income (Andaiye 2003). This study explores the relationship between work and physical health among Caribbean blacks and African Americans. Given the presence of gender inequality in both contexts, social roles may play an important part in mediating the relationship between gender and physical health for both groups of Caribbean black adults.

Self-concept. Self-concept is “the totality of the individual’s thoughts and feelings with reference to the self as an object” (Rosenberg 1989:34). Mastery and self-esteem, in particular, have been widely recognized as important dimensions of the self-concept and serve as psychological resources that are protective of physical well-being (Antonucci and Jackson 1983; Lachman and Weaver 2000; Lincoln, Chatters, and Taylor 2003; Pearlin 1999; Thoits 1995; Umberson, Williams, and Sharp 2000). Although these aspects of self-concept are important for coping with stress and enhancing health outcomes, women typically experience lower levels of mastery and self-esteem than men (Pearlin 1989; Rieker and Bird 2000; Thoits 1995).
Using National Survey of Black Americans data, Christie-Mizell et al. (2010) found an inverse association between self-esteem and physical health limitations. However, Livingston et al. (2007) found no gender differences in self-esteem among Caribbean black immigrants who were living in Washington, D.C. Studies have commonly described mastery and self-esteem as mediators or moderators in the relationship between SES and health (e.g., Lachman and Weaver 2000; Schnittker 2004); this study contributes to the literature by examining the extent to which these psychological resources may account for gender differences in multiple indicators of physical health among a diverse sample of U.S. blacks.

The current study addresses the following questions: (1a) Are there gender differences in health across distinct groups within the U.S. black population? (1b) If so, how much of the gender disparity in the health outcomes can be explained, or mediated, by SES, social roles, and self-concept? and (2) How are the effects of SES, social roles, and self-concept on gender differences in health distinct for African Americans, U.S.-born Caribbean blacks, and Caribbean black immigrants?

DATA AND METHODS

Data for this study are drawn from the NSAL. Similar to the overarching purpose of the NSAL (see Heeringa et al. 2004; Jackson et al. 2004), the current study further explores diversity within the black population (through the lens of gender). The survey population includes African American, Caribbean black, and non-Hispanic white noninstitutionalized adults aged 18 years and older who reside in households in the coterminous United States. In the NSAL, African Americans are persons who self-identify as black but do not report Caribbean ancestry. Caribbean blacks are persons who self-identify as black and answered affirmatively to any of the following inclusion criteria: (1) of West Indian or Caribbean descent, (2) born within a Caribbean area country, or (3) had parents or grandparents who were born in a Caribbean-area country. Individuals living on military bases and non-English speakers are excluded from the study. The screening methods ensured that every African American household in the continental United States had a known, nonzero probability of selection, permitting first-time estimates of the influence of nonrandom, missing household members on sampling outcomes. To increase comfort level, respondents were matched with interviewers of the same racial background. Interviews lasted an average of 2 hours 20 minutes. The final overall response rate was 71.5 percent.

A total of 6,082 face-to-face interviews were completed and consisted of 1,621 Caribbean blacks and 3,570 African Americans. Non-Hispanic white adults (n = 891), non-Caribbean black immigrants (n = 64), and respondents who were missing sociodemographic and health data (n = 235) were excluded. Thus, the sample for this study includes 1,562 Caribbean blacks and 3,330 African Americans.

**Dependent Measures**

The following health outcomes are used: self-reported health, an index of chronic medical conditions, and functional limitations. For self-reported health, respondents rated their health in general on a five-point scale (1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent); in the results that follow, all five categories are included in the multivariate analyses. To measure chronic medical conditions, respondents were asked a series of yes-or-no questions regarding health conditions: “Please indicate whether a doctor or health professional has ever told you that you have that problem.” I use these questions to develop an index of chronic medical conditions including cancer, high blood pressure (hypertension), diabetes, stroke, blood circulation problems, and heart trouble. On the basis of responses to these questions, I created a summed index of the number of chronic medical conditions, ranging from zero to six illnesses. Functional limitations were assessed by asking respondents about the amount of difficulty they experienced performing six different tasks: standing for long periods, such as 30 minutes; moving around inside their homes; walking a long distance, such as a kilometer or half a mile; washing their bodies; getting dressed; and staying alone for a few days. In the analyses, responses to these items are combined, and the comparison is between those who report one or more functional limitations and those who report no functional limitations (see Gorman and Read 2006; Read and Gorman 2006).

**Independent Measures**

The predictor variable is gender (1 = female, 0 = male). SES is indicated by two variables: household income and education. Household income is a