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Social Capital's Influence on the Likelihood of Mexican Immigrants Having Type 2 Diabetes or Being Obese in Los Angeles County

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Most social capital research in the United States has tended to address issues concerning a middle class white population (Putnam 2000) and little has addressed specific health outcomes. Even though it is frequently presented positively, social capital might have a negative relationship for more socially and economically vulnerable populations like Mexican immigrants. For example, social capital is negatively related to Mexican women's wages (Granberry and Marcelli 2007), while positively related for non-Latino white women (Caiazza and Putnam 2005). It is clear that social capital does not guarantee positive outcomes. The currency of social capital is found in the relationships that people have, as the resources embedded in the community remain dormant until they are activated by individuals who pass along information through social interactions. Often overlooked is that negative information and resources can be transferred as well as positive (Portes 1998).

This paper examines two health outcomes--diabetes and obesity--to explore how social capital is related to an individual's health, controlling for the influence that might be experienced by a vulnerable lower socioeconomic group like Mexican immigrants. Immigrants and Latino immigrants in particular live longer and have better health outcomes than non-Latino whites (Hummer, Rogers et al. 2000; Franzini, Ribble et al. 2001; Cho, Frisbie et al. 2004; Dey and Lucas 2006). Protective culture has been theorized as one explanation for this epidemiological or Latino health paradox (Abraido-Lanza, Dohrenwend et al. 1999; Cho, Frisbie et al. 2004). Social capital could be one mechanism through which this protective culture is transferred as good nutritional, exercise, and non-smoking habits could play a factor to influence positive health outcomes. Social isolation and segregation, on the other hand, could create negative influences by limiting access to information and resources, and override any positive benefits found in social capital and lead to negative influences (Portes 1998).

The Centers for Disease Control and Prevention (2005) find that nearly 14 percent of Latinos twenty years and older are affected by diabetes, and Mexican Americans are 1.7 times more likely to have diabetes than non-Latino whites. Diabetes is correlated with obesity. Using earlier data, Hayes-Bautista (2002) finds that Mexican immigrants also are more likely to be diabetic. Obesity rates for Mexican immigrants differ by sex. Mexican

female immigrants have higher rates of obesity measured by Body Mass Index (BMI) but Mexican male immigrants have lower BMI than their non-Latino white counterparts (Sundquist and Winkleby 2000). The health conditions are important for Mexican immigrants so that they can limit any negative affects they pose in order to enhance their well-being and participation in the larger society.

With 3.9 million Mexican immigrants residing in California, representing 11.5 percent of the state's population and 1.5 million, or nearly half of these immigrants, residing in Los Angeles County, according to the 2000 Census, it is host to the largest concentration of Mexican immigrants in the United States, and a good place to study the health of Mexican immigrants. With no end to this immigration stream in the foreseeable future, finding mechanisms to lower Mexican immigrants' risk of developing type 2 diabetes and becoming obese is important to enhance their contribution to society.

Individuals from a lower socioeconomic population and who live in poorer neighborhoods experience higher incidences of diabetes, obesity, and depression (Everson, Maty et al. 2002). Efforts to mitigate increased incidences of diabetes and obesity through social capital could help diminish health and social inequalities by increasing a person's quality of life and economic productivity (Hogan, Dall et al. 2003). Initial evidence on other low-income populations suggests social capital might play an important role in Mexican immigrant health and warrants further study. Area level measures of social capital accumulated through civic participation and levels of social trust find that social capital is negatively related to mortality (Kawachi, Kennedy et al. 1997). Social capital is positively related to having better self-related health (Kawachi, Kennedy et al. 1999; Wen, Browning et al. 2003). In sum, increasing Mexican immigrants' stock of social capital might facilitate lower incidences of type 2 diabetes and obesity, but first we must determine if social capital is positively related to the health of a lower socio-economic group like Mexican immigrants. This paper tests the relationship of social capital to the likelihood of Mexican naturalized citizens, legal permanent residents, and other Mexican immigrants who by default consist of visa holders and the unauthorized along with other foreign-born populations to having type 2 diabetes or being obese.

Social Capital and Mexican Immigrant Health

Social capital is the stock of available resources and information that an individual can access by participating in social structures. Social capital possibly influences health in three ways. First, social capital can influence health related behaviors by facilitating the diffusion of health information and by enforcing a sense of

control of deviant health behaviors. Weak ties can diffuse information quickly and broadly, and strong ties can be instrumental in reinforcing positive health related behaviors. Second, social capital offers access to information about health services and amenities. Neighborhoods with strong social capital may unite to ensure that vital services are provided in the community. Third, social capital affects the psychological processes that influence health. People who are well connected to their neighborhood perceive a sense of support that may allow them to face difficult tasks and lessen stress that accompanies problems (Kawachi and Berkman 2000; Carpiano 2006).

Limited research has addressed the relationship of social capital to the health outcomes of Mexican immigrants. Mexican immigrants who participate in civic organizations are more likely to receive needed medical care and obtain public insurance (Marcelli 2004). Civic organizations appear to direct Mexican immigrants including the unauthorized, to medical care and to have information about public health insurance that is not readily available elsewhere.   From this perspective, information about the prevention of type 2 diabetes and obesity might be useful as the social capital accumulated in these organizations might be a vehicle to lower the incidences of these health outcomes.

One study examines the relationship of social capital to obesity and diabetes, but it does not control for Mexican immigrants. Holtgrave and Crosby (2006) using Behavioral Risk Factor Surveillance System (BRFSS) and Putnam's fourteen state-level measures of social capital find that social capital is negatively related to both the likelihood of a person being obese or developing type 2 diabetes, while poverty is positively related. Because Mexican immigrants have lower incomes, this income effect may be stronger than the social capital effect. I am aware of no research that addresses social capital's relationship to Mexican immigrant health outcomes.

In particular, social capital is accumulated in the neighborhood and at work for Mexican immigrants (Granberry and Marcelli 2007). These are two domains in which individuals spend a significant part of their time. Neighborhoods with dense social networks developed through community participation facilitate the sharing of information and resources that should prove beneficial in a variety of outcomes (Putnam 2000). However, as been theorized, trusting behavior may not be the correct measure for social capital, as a trusting individual would quickly be taken advantage of and no longer continue to be trusting (Glaeser, Laibson et al. 2002). Instead, developing reciprocity in social network relationships may be a better measure of social capital

(Granberry and Marcelli 2007). If people know their neighbors and believe that their neighborhood is inhabited with people who share the same values, these neighborhoods might be better locations for social capital to be developed. In addition, perceptions of public safety can shed valuable light on how a person interacts with his or her neighborhood. If a person is afraid to go out at night, feel the need to organize crime prevention groups or more concretely if a person has ever been robbed; this would add stress to a person's life, limit interactions with neighbors, and thus limit social capital accumulation.

Concentration of immigrant groups and other minority populations is hypothesized to affect health through a concentration of poverty, the quality of the neighborhood resources, its environmental quality, and the socio-economic attainment of other residents (Acevedo-Garcia and Lochner 2003). Williams and Collins (2001) posit that segregated neighborhoods negatively affect minority residents health because poor whites are more likely to live near non-poor people, while poor blacks and Latinos are concentrated in poor neighborhoods. They identify mechanisms like poor quality of housing stock and lack of neighborhood amenities like parks and swimming pools, while being targeted by marketing strategies from the tobacco and alcohol industries. Poor neighborhoods are also more likely to be the place for violent crime and homicides (Sampson 1985; Krivo and Petterson 1996).

In particular, the make up of one's neighborhood might not only indirectly influence a person's health through social capital but also through other socioeconomic factors. Living in neighborhoods with higher rates of homeownership augments a person's social capital (Granberry and Marcelli 2007) because homeownership limits mobility which hinders access to accumulated community resources (Glaeser and Sacerdote 2000; Glaeser, Laibson et al. 2002). In addition, individuals develop relationships more easily with individuals they perceive to have similar demographic traits (McPherson, Smith-Lovin et al. 2001), and therefore, Mexican immigrants might develop social capital more easily in neighborhoods with higher percentages of minorities. In contrast poorer neighborhood may not have access to pecuniary resources, but ethnographic work has highlighted how individuals in low-income communities have tapped into their social networks to access support (Stack 1974). In sum, poor neighborhoods are expected to lack resources to promote health.

Data Analysis and Methodology

This paper uses 2003 California Health Interview Survey (CHIS) and 2000 U. S. Census Summary File 3 (SF 3) data to test hypotheses concerning the relationship of

social capital and neighborhood characteristics to the likelihood of a person being obese and diabetic. The 2003 CHIS data is a population based, computer assisted telephone interview survey and uses geographically stratified random-digit dialing sampling technique and was collected between August 2003 and February 2004. Information was obtained on 42,044 individuals from forty-one counties or groups of counties in California, of which 9,438 resided in Los Angeles County. In addition to collecting information on the health status, health conditions, health-related behaviors, health insurance coverage and access to and use of health care services, these data identify place of birth along with self-reported racial and ethnic identification. Individuals were asked if they were United States citizens or legal permanent residents, but not if they were non-immigrant visa holders, which would have allowed for the determination of unauthorized status by the process of elimination for foreign-born Mexicans (Marcelli 2004).

CHIS data requires a complex weighting design to give reliable population estimates that result from the stratified survey design that accounts for the probability of the telephone number being selected in each stratum. This process accounts for households not having telephones or having only cell phones. A jackknifed weighting procedure was applied using replicate weights that are post-stratified to one set of population control totals, and then these controls are applied to another dimension until the process control totals for all dimensions are satisfied.

Prior to accessing the CHIS data, 2000 U. S. Census Summary File 3 (SF 3) data was used to create several neighborhood level variables on the census tract level. These neighborhood level variables were then merged at the census tract level. These variables include percentage homeownership, percentage minority, and percentage of individuals receiving public assistance at the census tract level.

The two dependent variables are type 2 diabetes and obesity. The diabetes variable is created by identifying those individuals who have been told by a doctor that they have type 2 diabetes. Men have higher incidences of type 2 diabetes 7.7 percent compared to women 5.3 percent. The obesity variable consists of those who have a Body Mass Index (BMI) over 30, and women are obese at a slightly higher rate 20.2 percent than men 20.0 percent.

Table 1 reports the means and standard deviations of the variables for both models. Eight variables are used to test for social capital. Seven address people's perception of the neighbors and neighborhood. One measures participation in

organizations. Four of the neighborhood perception variables are constructed positively to measure social capital. *Neighborhood Trust* takes a value of one if a person agrees or strongly agrees that neighbors can be trusted. *Neighborhood Help* takes a value if a person agrees or strongly agrees that people in the neighborhood are willing to help each other. *Know Neighbors* take on a value of one if a person agrees or strongly agrees that neighbors know each other. *Crime Watch* takes on a value of one if the neighborhood has a crime watch. Three variables are constructed in a way that would limit social capital. *Neighborhood Values* takes on a value of one if a person agrees or strongly agrees that neighbors do not share values. *Afraid Night* takes on a value if a person agrees or strongly agrees that people in the neighborhood are afraid to go out at night. And *Robbed* takes on a value if a person's current home was ever broken into. One variable measures participation in community organizations. *Worship* takes on a value if a person attended a religious service the week previous to the survey.

The ethno-racial variables are constructed by grouping individuals in categories of Mexican immigrants who are naturalized U. S. citizens, legal permanent residents (LPR), and other Mexican immigrant who by default are either visa holders or unauthorized. The other ethno-racial categories are foreign- and native-born Latinos, native-born blacks, native-born Asians others, foreign-born whites, foreign-born Asians and others. This leaves native-born whites, which is the control group. Model for men and women test for only adults and excludes those under age twenty-five to standardize for educational attainment comparisons. Other individual characteristics in the model are if a person is married, a homeowner, a current smoker, employed, and if a person's income is less than 100 percent of the national poverty level. In addition, the models control for having at least a high school education, having medical insurance, currently smoker, exercise by walking more than ten minutes for fun the previous week of the survey, and a regular place for receiving medical care. The diabetes model controls for BMI.

Results

Results of a logistic regression are reported in Table 2 for individuals in Los Angeles County likely to have type 2 diabetes. Controlling for the above mentioned individual characteristics, Mexican naturalized citizens, LPRs and other Mexican male immigrants are more likely to have type 2 diabetes and LPRs and the other category for Mexican female immigrants are more likely to have type 2 diabetes compared to native-born whites. Foreign-born Latinos and Asian and other males are more likely to

develop type 2 diabetes, while native-born blacks in addition to same two groups for women are more likely to be diabetic. Both men and women who are employed are less likely to have type 2 diabetes, while those with higher BMI and who receive medical care are more likely to develop type 2 diabetes. As men and women age, they are more likely to develop diabetes until they are into their eighties when men first show a decline possibly to increased mortality. Men who have a regular place to receive medical care are also more likely to have type 2 diabetes, but this is not the same for women.

One social capital variable is statistically significant for women. As expected, women who are afraid to go out at night are more likely to have type 2 diabetes. None of the social capital measures are statically significant for men, and none of the neighborhood level variables are statistically significant for men or women. In the initial model controlling for individual characteristics, poverty is positively related for men. The social capital variables explain this variation as it is no longer statistically significant after the social capital variables are included.

Results of a logistic regression for men and women in Los Angeles County likely to be obese are reported in Table 3. For obesity, all groups are compared to native-born non-Latino whites. All foreign-born Mexican male and female are less likely to be obese. Female Mexican naturalized citizens are more likely to be obese until controlling for social capital when the statistical significance disappears. Foreign-born Latinas are more likely to be obese until controlling for neighborhood characteristics. Native-born Latinas are more likely to be obese, as are native-born black women. Both the foreign- and native-born Asian and other women are less likely to be obese, as well as foreign-born whites. For men, native-born Latinos are more likely to be obese, while foreign-born Asians and others and foreign-born whites are less likely to be obese.

Individual demographic factors influence obesity. Men continue to be more likely to be obese until they are 49.6 years of age. Men who smoke and exercise by walking more than ten minutes for fun are less likely to be obese, while those who have medical insurance are more likely to be obese. For women, they continue to be more likely to be obese until they are 53.0 years of age. Women with a high school education or above are more likely to be obese, but women who are homeowners, employed, have medical insurance, and exercise are less likely to be obese.

Not all the social capital measures have the expected relationship to the likelihood of being obese. For men, those that participate in religious services are less

likely to be obese, but those that know their neighbors are surprisingly more likely to be obese. For women, both those that know their neighbors and believe that their neighbors can be trusted, are more likely to be obese.

Neighborhood characteristics are related to the likelihood of being obese. Men who live in neighborhoods with a greater percentage of individuals receiving public assistance and men who live in neighborhoods with larger percentages of homeowners are more likely to be obese. For women, only those that lived in neighborhoods with increased percentages of individuals receiving public assistance are more likely to become obese.

Discussion

One can easily imagine vibrant neighborhoods where individuals have access to community resources and health information placing them at a lower risk for being obese or developing type 2 diabetes. However, the results from adults in Los Angeles County do not strongly support the idealized protective benefits of this idealized social capital. The social capital measures in this paper help explain Mexican women who are naturalized citizens and foreign-born Latinas having low incidences of type 2 diabetes. However, these social capital measures are not strongly related to the prevalence of diabetes. One strong indicator of the potential dispersion of social capital, knowing neighbors that is hypothesized to be a mechanism for the transfer of information and access to resources is surprisingly positively related to being obese for both men and women. As Portes (1998) cautions, negative as well as positive resources and information can be transferred through social capital. One possible explanation of this unexpected outcome is that the strong ties of neighborhood relationships are conducive to creating an environment that promotes obesity. People associate with individuals similar to themselves, and they gradually take on negative behaviors (McPherson, Smith-Lovin et al. 2001). In other words, people become comfortable gaining weight if they see it replicated among peers in their neighborhood. Neighborhood relationships not only reinforce but might also promote the negative information that being overweight is an acceptable health behavior. A bridging form of social capital that incorporates non-redundant information or access to resources could possibly a better mechanism to promote health behaviors. Therefore, the mechanism and type of network relationship to transfer the social capital is important to promote positive social capital.

Controlling for social capital and neighborhood characteristics, Mexican immigrants continue to be more likely to have type 2 diabetes than native-born whites. Social capital's promise as a protective measure through social control reinforcing positive behaviors is not able to overcome Mexican immigrants' higher propensity to have type 2 diabetes. Social capital does not appear to offer enough support to promote positive behavior like eating a good diet or exercising more frequently and is unable to reduce Mexican immigrants' propensity to have type 2 diabetes.

Both the diabetes and obesity models control for individuals living below the poverty level. After controlling for social capital, living in poverty is not statistically significant for either men or women. However, being employed is negatively related to the likelihood of being both diabetic and obese. Individuals who are employed have greater opportunities to develop social capital (Granberry and Marcelli 2007). While in the workplace, individuals not only perform their work responsibilities but they have access to resources and information that can assist them in promoting their well-being. This can occur through information that they obtain through specific on-the-job activities, but it can also happen informally through interaction with individuals they encounter while doing work-related activities.

One reason that the workplace may be beneficial is that it is one of the most diverse social places that individuals encounter. Because the workplace is regulated, it ensures that people of divergent backgrounds cannot be discriminated against. This cannot be said of other institutions like neighborhood groups, churches, and even to some extent the family, which may limit individual expression. This might explain some of the surprising findings for the neighborhood level social capital measures. The neighborhood is an important domain for the accumulation of social capital (Granberry and Marcelli 2007), but this social capital might promote negative as well as positive behaviors. Neighborhoods frequently are defined by their racial and ethnic makeup and lack economic and social diversity. This lack of diversity could be one factor to enable social capital to promote information and resources that are positively related to obesity. Future research on the type of social capital accumulated in the workplace and the neighborhood would be helpful to better understand what aspects of having a job and what neighborhood factors are important for positive social capital accumulation.

Conclusion

Social capital research has typically addressed middle class white populations and only recently has started to address how social capital is related to different

populations. Health research has not examined how social capital is related to Mexican immigrant health outcomes. For Mexican immigrants, those who are naturalized citizens, LPRs and who are either visa holders or are unauthorized are all more likely to be diabetic, after controlling for social capital. This relationship is not enough to lower Mexican immigrants' propensity of having type 2 diabetes to that of non-Latino whites. Efforts to strengthen social capital through providing non-redundant resources and information and developing a sense of support in communities with high concentrations of Mexican immigrants could be a mechanism to assist this lower socio-economic group in not developing type 2 diabetes. The preliminary findings here warrant further research to more clearly identify how community resources promoted by social capital might lower incidences of type 2 diabetes.

Several cautions must be recognized when interpreting these results. First, the social capital variables used in this analysis measure individuals' perception of their community and not community participation other than attending religious services, and does not investigate reciprocity in interpersonal relationships. These variables measure only one of the three domains identified in the social capital literature (Kawachi, Kim et al. 2004). Reciprocity in social network relationships has also been found to be negatively related Mexican men's wages (Granberry and Marcelli 2007). Reciprocity in relationships might also be negatively related for Mexican immigrants, but this relationship requires further investigation with another data set. These social capital variables address an individual's perception of his or her community and are important for the community participation domain. We have no indication if these individuals' perceptions of their relationships are accurate or if they invest more in relationships outside of their neighborhood and the neighborhood relationships are not as important as others. In light of these limitations, this lack of measurement of reciprocity limits these results to only this one domain of social capital and could give an incomplete analysis. Second, the CHIS data is cross-sectional and gives only a picture of people at one point in time. As a result, no inferences about causation can be drawn. CHIS data was collected in 2001 and has now been collected for 2005.

Future research on social capital's relationship to medical conditions needs to measure the three forms of social capital. Two forthcoming immigrant studies in the metropolitan Boston area will measure the sociological perspective of reciprocity in social networks, the political science perspective of civic participation, and the public

health perspective of area level factors of trust and neighborhood cohesion. With these data, a better analysis of health conditions will be possible.

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Table 1: Descriptive Statistics of Explanatory Variables Used in the Logistic Regression of the Likelihood of Type 2 Diabetes and Obesity in Los

Variable	Definition	Mean	SD	Mean	SD
Diabetes	Dummy=1 if a person has been told by doctor that has type 2 diabetes	0.0568	0.2315	0.0776	0.2675
Obesity	Dummy=1 if a person has BMI greater than 30	0.2094	0.4069	0.2001	0.4001
EthnoRacial Nativity Categories					
Mexican Naturalized Citizen	Dummy=1 if a person is Naturalized Mexican Immigrant	0.0459	0.2093	0.0464	0.2103
Mexican LPR	Dummy=1 if a person is Mexican Legal Permanent Resident	0.0323	0.1769	0.0359	0.1860
Mexican Other	Dummy=1 if a person is Other Mexican Foreign-Born	0.0376	0.1902	0.0377	0.1904
Foreign-Born Latino	Dummy=1 if a person is Foreign-Born Latino	0.0636	0.2441	0.0564	0.2307
Native-Born Latino	Dummy=1 if a person is Native-Born Latino	0.0909	0.2875	0.0917	0.2887
Native-Born Black	Dummy=1 if a person is Native-Born Black	0.1006	0.3009	0.0746	0.2627
Native-Born Asian and Others	Dummy=1 if a person is Native-Born Asian and Others	0.0470	0.2116	0.0482	0.2141
Foreign-Born Asian and Others	Dummy=1 if a person is Foreign-Born Asian and Others	0.1048	0.3063	0.1130	0.3166
Foreign-Born White	Dummy=1 if a person is Foreign-Born White	0.0652	0.2469	0.0658	0.2480
Individual Characteristics					
Age (+)	Age in years (mean)	50.9	16.3	49.7	15.6
Age Squared	Age in years squared	2854	1802	2713	1701
High School (-)	Dummy=1 if person has completed high school but not college	0.2576	0.4374	0.2223	0.4159
Married (-)	Dummy=1 if a person is married	0.4934	0.5000	0.6033	0.4893
Homeowner (+)	Dummy=1 if a person is a homeowner	0.5783	0.4939	0.5939	0.4912
Poverty (-)	Dummy=1 if a person lives below 100 percent poverty level	0.1557	0.3626	0.1058	0.3076
Employed (-)	Dummy=1 if a person is employed	0.5235	0.4995	0.7022	0.4574
Insurance (+)	Dummy=1 if a person has health insurance	0.8683	0.3382	0.8414	0.3653
Smoke (-)	Dummy=1 if a person smokes	0.1254	0.3312	0.2021	0.4016
BMI (+)	Body Mass Index (mean)	26.2	6.4	27.1	4.9
Exercise (-)	Dummy=1 if a person exercise 10 minutes for pleasure week previous to sur	0.5709	0.4950	0.5368	0.4987
Medical Care (+)	Dummy=1 if a person has regular place for medical care	0.9169	0.2761	0.8606	0.3464
Social Captal Measures					
Worship (-)	Dummy=1 if a person attended religious service previous week	0.4284	0.4949	0.3456	0.4756
Robbed (+)	Dummy=1 if a person was robbed at present address	0.1420	0.3491	0.1371	0.3440
Crime watch (+/-)	Dummy=1 if a person lives in a neighborhood with a crime watch	0.4864	0.4999	0.4827	0.4998
Neighborhood Help (-)	Dummy=1 if a person agrees or strongly agrees neighbors help each other	0.8322	0.3738	0.8519	0.3553
Neighborhood Trust (-)	Dummy=1 if a person agrees or strongly agrees neighbors can be trusted	0.8140	0.3891	0.8312	0.3746
Neighborhood Values (+)	Dummy=1 if a person agrees or strongly agrees neighbors do not share valut	0.4046	0.4909	0.4263	0.4946
Afraid Night (+)	Dummy=1 if a person agrees or strongly agrees neighbors are afraid to go ot	0.2822	0.4501	0.2227	0.4161
Know Neighbors (-)	Dummy=1 if a person agrees or strongly agrees people in neighborhood kno	0.6556	0.4752	0.5819	0.4933
Neighborhood Characteristics					
PCT Homeownership (-)	Percentage of resident in census tract who own home (mean)	0.5372	0.2624	0.2708	0.0000
PCT Minority (+)	Percentage of resident in census tract who are non-white (mean)	0.2655	0.1873	0.2574	0.1786
PCT Public Assistance (+)	Percentage of resident in census tract who receive public assistance (mean)	0.0566	0.0519	0.0546	0.0499

**Table 2: Logistic Analysis of Individual, Social Capital
and Neighborhood Characteristics on the Probability of Men Having Type 2 Diabetes**

	Jackknieved		Jackknieved		Jackknieve	
	Coefficient	SE	Coefficient	SE	Coefficient	SE
mexcit	1.84846 ***	0.30909	1.86348 **:	0.30336	1.86649 ***	0.33060
mexlpr	1.22009 **	0.51012	1.24438 **	0.55301	1.24183 **	0.60105
mexotr	1.52741 ***	0.47643	1.59503 **:	0.47031	1.58925 ***	0.49534
fblat	0.60936	0.44482	0.61537	0.41581	0.60318	0.43460
nblat	0.89716 ***	0.27792	0.92236 **:	0.30297	0.92464 ***	0.31451
nbbl	0.59062 **	0.29527	0.60015 **:	0.30822	0.50221	0.34052
nbas_otr	0.68538	0.43046	0.70447	0.43562	0.66318	0.45024
fbas_otr	0.72677 **	0.32149	0.76298 **	0.31823	0.70625 **	0.33291
fbwhite	0.38370	0.33197	0.41456	0.33065	0.41674	0.33067
age	0.16734 ***	0.04403	0.16914 **:	0.04296	0.16985 ***	0.04311
agesq	-0.00100 **	0.00039	-0.00101 **	0.00038	-0.00102 **	0.00039
hs	0.29144	0.21888	0.28621	0.21890	0.27542	0.22091
married	0.04720	0.19638	0.07550	0.19694	0.06580	0.19811
homeown	0.10640	0.18816	0.09326	0.18701	0.08883	0.19599
pov	0.46304 *	0.27094	0.44050	0.27079	0.42407	0.26818
employ	-0.55179 ***	0.20240	-0.55106 **:	0.20297	-0.55791 ***	0.20532
insur	0.21333	0.33542	0.24030	0.33614	0.24940	0.33476
smoke	0.43339	0.26753	0.42904	0.26182	0.42342	0.26127
bmi	0.06621 ***	0.01778	0.06578 **:	0.01807	0.06516 ***	0.01783
exercise	0.18638	0.19317	0.17921	0.19770	0.17962	0.19709
mdcare	1.56617 ***	0.45918	1.57067 **:	0.46361	1.55576 ***	0.46254
worship			0.01988	0.18439	0.02018	0.18448
rob			0.24311	0.23824	0.22729	0.24011
crimewatch			0.04234	0.19244	0.03650	0.19173
hoodhelp			0.29918	0.31238	0.29899	0.31238
hoodtrust			-0.33807	0.26103	-0.34123	0.26475
hoodvalues			-0.00782	0.18075	-0.00909	0.18149
afraidnight			-0.04224	0.22737	-0.04408	0.22802
knowneigh			-0.14294	0.15747	-0.14267	0.15878
pcthomeowner					0.04910	0.40774
pctmin					0.34344	0.44003
pctpubass					0.23556	2.18221
intercept	-12.5353 ***	1.312643	-12.5741 **:	1.343562	-12.6422 ***	1.368878

* p < .10 ** p < .05 *** p < .01

Table 3: Logistic Analysis of Individual, Social Capital and Neighborhood Characteristics on the Probability of Women Having Type 2 Diabetes

	Coefficient	Jackknieved SE	Coefficient	Jackknieved SE	Coefficient	Jackknieve SE
mexcit	0.79323 *	0.42468	0.61416	0.44612	0.55858	0.43243
mexlpr	1.90754 ***	0.39843	1.80353 ***	0.37586	1.76808 ***	0.38315
mexotr	1.37204 ***	0.48718	1.23672 **	0.49506	1.19650 **	0.48405
fblat	0.76031 *	0.38157	0.60244	0.41167	0.61754	0.41961
nblat	1.10831 ***	0.36732	0.98899 **	0.39284	0.98143 **	0.39754
nbbl	0.47530 *	0.24198	0.38311	0.25445	0.46671 *	0.27326
nbas_otr	0.77414 *	0.45827	0.69267	0.46699	0.74000	0.47090
fbas_otr	1.03660 ***	0.34425	0.90116 ***	0.33877	0.95971 ***	0.36087
fbwhite	-0.01130	0.38431	-0.05854	0.38222	-0.06655	0.38084
age	0.15432 ***	0.04576	0.15426 ***	0.04452	0.15429 ***	0.04454
agesq	-0.00078 **	0.00038	-0.00080 **	0.00037	-0.00080 **	0.00037
hs	-0.22090	0.17960	-0.24316	0.17953	-0.24046	0.17981
married	-0.02429	0.22500	0.01671	0.22779	0.02062	0.22692
homeown	-0.16421	0.21363	-0.10435	0.21437	-0.10300	0.23844
pov	0.04942	0.28300	-0.01454	0.27582	-0.02947	0.27612
employ	-0.19696	0.23656	-0.13198	0.23986	-0.13674	0.24168
insur	0.78018 *	0.39326	0.82530 **	0.38440	0.81787 **	0.38148
smoke	0.33482	0.26201	0.32692	0.26662	0.31908	0.27076
bmi	0.07097 ***	0.01089	0.07092 ***	0.01073	0.07070 ***	0.01096
exercise	0.20546	0.19848	0.24870	0.18848	0.25999	0.19242
mdcare	0.23587	0.59684	0.15983	0.57643	0.16391	0.57684
worship			0.07481	0.16501	0.08148	0.16627
rob			0.01767	0.23312	0.02065	0.23278
crimewatch			-0.01806	0.21811	-0.00785	0.22039
hoodhelp			-0.36458	0.24695	-0.36287	0.24461
hoodtrust			0.14196	0.24357	0.14810	0.25527
hoodvalues			0.29986	0.19590	0.29706	0.19713
afraidnight			0.43894 **	0.21800	0.43081 *	0.22120
knowneigh			0.00002	0.21438	0.00140	0.21392
pcthomeowner					-0.02769	0.46522
pctmin					-0.53824	0.44820
pctpubass					0.61298	1.93435
intercept	-12.1693 ***	1.3817	-12.2237 ***	1.404248	-12.1411 ***	1.454164

* p < .10 ** p < .05 *** p < .01

**Table 4: Logistic Analysis of Individual, Social Capital
and Neighborhood Characteristics on the Probability of Men Being Obese**

	Coefficient		Jackknifed SE	Coefficient		Jackknifed SE	Coefficient		Jackknifed SE
mexcit	0.2504		0.2350	0.2341		0.2417	0.1613		0.2516
mexlpr	0.3056		0.2920	0.2398		0.2959	0.1338		0.3178
mexotr	0.4465		0.3166	0.3760		0.3197	0.3055		0.3153
fblat	0.1671		0.2580	0.1183		0.2630	0.0938		0.2728
nblat	0.6994	***	0.1623	0.6490	***	0.1628	0.5780	***	0.1653
nbbl	0.3813	*	0.2025	0.3714	*	0.2031	0.3259		0.2423
nbas_otr	0.1947		0.3314	0.1919		0.3253	0.1918		0.3283
fbas_otr	-1.2880	***	0.3628	-1.3133	***	0.3718	-1.3236	***	0.3801
fbwhite	-0.3676	*	0.2080	-0.3865	*	0.2057	-0.3561	*	0.2054
age	0.1107	***	0.0280	0.1102	***	0.0284	0.1097	***	0.0284
agesq	-0.0011	***	0.0003	-0.0011	***	0.0003	-0.0011	***	0.0003
hs	0.2810	**	0.1257	0.2774	**	0.1249	0.2579	**	0.1254
married	0.1474		0.1251	0.1792		0.1263	0.1670		0.1286
homeown	-0.0183		0.1332	0.0092		0.1400	-0.0732		0.1355
pov	0.1578		0.1662	0.1238		0.1707	0.0997		0.1710
employ	-0.1525		0.1435	-0.1352		0.1486	-0.1281		0.1505
insur	-0.2707		0.1955	-0.2470		0.1939	-0.2301		0.1967
smoke	-0.0832		0.1336	-0.1143		0.1362	-0.1178		0.1378
exercise	-0.4359	***	0.1136	-0.4191	***	0.1137	-0.4246	***	0.1139
mdcare	0.5096	**	0.2141	0.5048	**	0.2091	0.4856	**	0.2117
worship				-0.2329	*	0.1212	-0.2424	*	0.1226
rob				0.0227		0.1674	0.0185		0.1663
crimewatch				-0.1367		0.1205	-0.1432		0.1223
hoodhelp				-0.0364		0.1789	-0.0361		0.1789
hoodtrust				-0.1641		0.1757	-0.1582		0.1737
hoodvalues				0.0950		0.1230	0.0934		0.1227
afraidnight				0.0420		0.1491	0.0196		0.1534
knowneigh				0.2567	*	0.1298	0.2345	*	0.1298
pcthomeowner							0.5307	*	0.2848
pctmin							-0.2035		0.3592
pctpubass							2.5745	**	1.1222
intercept	-3.95365	***	0.68611	-3.88704	***	0.67847	-4.14613	***	0.67106

* p < .10 ** p < .05 *** p < .01

Table 5: Logistic Analysis of Individual, Social Capital and Neighborhood Characteristics on the Probability of Women Being Obese

	Coefficient		Jackknifed SE	Coefficient		Jackknifed SE	Coefficient		Jackknifed SE
mexcit	0.4201	**	0.1922	0.3176		0.1946	0.1829		0.2073
mexlpr	0.2237		0.2351	0.1338		0.2375	-0.0133		0.2487
mexotr	0.2088		0.3131	0.1024		0.3217	-0.0892		0.3385
fblat	0.4610	**	0.1842	0.3902	**	0.1897	0.2702		0.1881
nblat	0.6514	***	0.1646	0.5778	***	0.1684	0.4706	***	0.1747
nbbl	0.6476	***	0.1470	0.6103	***	0.1496	0.3014	*	0.1805
nbas_otr	-0.3693		0.2618	-0.3837		0.2636	-0.4553	*	0.2702
fbas_otr	-1.9764	***	0.2586	-2.0467	***	0.2624	-2.1841	***	0.2712
fbwhite	-0.6550	**	0.2533	-0.6805	***	0.2558	-0.6433	**	0.2553
age	0.1744	***	0.0213	0.1734	***	0.0217	0.1733	***	0.0220
agesq	-0.0016	***	0.0002	-0.0016	***	0.0002	-0.0016	***	0.0002
hs	0.2214	**	0.1003	0.2224	**	0.1006	0.2128	**	0.1008
married	0.0391		0.1028	0.0244		0.1021	0.0307		0.1018
homeown	-0.3009	***	0.0974	-0.2879	***	0.0977	-0.3007	***	0.1085
pov	0.1050		0.1266	0.0767		0.1276	0.0728		0.1280
employ	-0.3275	***	0.1107	-0.3044	***	0.1103	-0.2809	**	0.1135
insur	-0.3712	***	0.1303	-0.3607	***	0.1316	-0.3371	**	0.1319
smoke	-0.1182		0.1508	-0.1042		0.1507	-0.1471		0.1532
exercise	-0.3806	***	0.1013	-0.3758	***	0.1001	-0.3547	***	0.1000
mdcare	0.1458		0.2256	0.1190		0.2208	0.1283		0.2189
worship				0.1054		0.1012	0.0925		0.1017
rob				-0.0478		0.1423	-0.0818		0.1442
crimewatch				-0.0919		0.0982	-0.0690		0.0987
hoodhelp				-0.0530		0.1404	-0.0550		0.1420
hoodtrust				0.2144		0.1371	0.2677	*	0.1449
hoodvalues				0.0521		0.1014	0.0232		0.1038
afraidnight				0.2251	*	0.1170	0.1547		0.1143
knowneigh				0.3251	***	0.1015	0.3025	***	0.1033
pcthomeowner							0.2952		0.2314
pctmin							0.3333		0.2446
pctpubass							4.3954	***	1.2375
intercept	-4.99067	***	0.61906	-5.31181	***	0.64834	-5.78414	***	0.65689

* p < .10 ** p < .05 *** p < .01